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Holmgren AJ. *BMJ Quality & Safety* 2020;29(1):52-59.
Conclusion: Hospital medication order safety performance has improved over time but is far from perfect. The specifics of EHR medication safety implementation and improvement play a key role in realising the benefits of computerising prescribing, as organisations have substantial latitude in terms of what they implement. Intentional quality improvement efforts appear to be a critical part of high safety performance and may indicate the importance of a culture of safety.
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2019;:doi:10.1016/j.jemermed.2019.11.015.
This review enhances our awareness of contributing factors to patient safety incidents within emergency departments and encourages researchers from different disciplines to investigate the causes of practice errors and formulate safety improvement strategies.
Freely available online

Amalberti R. *BMJ Quality & Safety* 2020;29(1):60-63.
Conclusions: ...We need in parallel to develop and implement prepared strategies for managing risk at times when ordinary standards cannot be met and the safety of patients is compromised. Finally, in making these proposals, we emphasise that we are not accepting defeat or suggesting that a certain level of harm is inevitable. We argue, in contrast, that the recognition of threats hazards and the development of active, practical risk management strategies is the route to safer healthcare.
Freely available online

Aiken LH. *BMJ Quality & Safety* 2020;29(1):1-3.
Empirical evidence from many published studies indicates that better hospital professional registered nurse (RN) staffing is associated with better patient outcomes, including lower mortality and failure to rescue, shorter lengths of stay, fewer readmissions, fewer complications, higher patient satisfaction and more favourable reports from patients and nurses alike related to quality of care and patient safety...
Freely available online

Moynihan R. *BMJ* 2019;367:l6576.
We argue that endemic financial entanglement is distorting the production and use of healthcare evidence, causing harm to individuals and waste for health systems. Building on the evidence and practical examples cited below, we propose pathways towards financial independence from industry across healthcare decision making. We hope that our proposals will catalyse and inform development of more detailed

Boulton R. *BMC Health Services Research* 2019;19(1):923.
This paper reports findings from an implementation study of an evidence-based intervention called Patient and Family Centred Care (PFCC) designed to tap into patient experiences as a basis for improvement. In this study the PFCC intervention was spread to a new service area (end of life care) and delivered at scale in England.
Freely available online

Thomas EJ. *BMJ Quality & Safety* 2020;29(1):4-6.
We should be clear about what types of harms can or cannot be prevented and anticipated, work to eliminate those where there is good evidence for preventability by adopting evidence-based practices, improve the ability of everyone responsible for safety to identify risks, conduct better risk analyses to anticipate and reduce unintended harms, measure and celebrate the routine adaptations that prevent harm, and reward organisational learning and improvement.
Freely available online

Margadant C. *Critical Care Medicine* 2020;48(1):3-9.
Studies have shown contradicting results on the association of nursing workload and mortality. Most of these studies expressed workload as patients per nurse ratios; however, this does not take into account that some patients require more nursing time than others. Nursing time can be quantified by tools like the Nursing Activities Score. We investigated the association of the Nursing Activities Score per nurse ratio, respectively, the patients per nurse ratio with in-hospital mortality in ICUs.
Freely available online

Monique K. *Nurse Education in Practice* 2019;41:102628.
Clinical evaluation of undergraduate nursing students is one of the most challenging aspects of baccalaureate nursing education, especially for novice clinical instructors. Early identification of unsafe student behaviours is necessary to ensure students obtain adequate support and guidance. The degree to which clinical instructors are certain about what is safe and unsafe varies, and greatly influences their decisions about evaluative processes and which patients to assign to students.
Available with an NHS OpenAthens password (select NHS England)

Green T. *BMJ Quality & Safety* 2020;29(1):64-76.
Experience-based codesign (EBCD) is used predominantly for quality improvement, but has potential to be used for intervention design projects. There is variation in the use of EBCD, with many studies eliminating or modifying some EBCD stages. Moreover, there is no consistency in reporting. In order to evaluate the effect of

modifying EBCD or levels of EBCD fidelity, the outcomes of each EBCD phase should be reported in a consistent manner.
Available with an NHS OpenAthens password

Tingle J. *British Journal of Nursing* 2019;28(22):1492-1493.
The author discusses some recent patient safety crises, litigation claims and a new patient safety publication from NHS Resolution. Unfortunately, it is never too long before a major patient safety crisis hits the NHS and we saw this recently with the Shrewsbury and Telford Hospital NHS Trust maternity scandal.
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The King's Fund; 2019.
https://www.kingsfund.org.uk/publications/unconventional-health-care
Each of the organisations studied in this long read has found radically different ways of supporting the people in its care. Breathe Arts uses magic to improve children's fine motor skills; Off the Record creates movements for young people with mental health problems to lobby for social change; Hope Citadel intervenes directly to address the underlying social causes of ill health in a deprived community rather than simply handing out medication to address anxiety and depression.
Freely available online

NHS England; 2019.
https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review.pdf
This action plan to implement the recommendations of the Neonatal Critical Care Transformation Review sets out how the NHS will further improve neonatal care with the support of funding set out in the NHS Long Term Plan.
Freely available online

Nuffield Trust; 2019.
https://www.nuffieldtrust.org.uk/resource/respect-and-dignity
The Nuffield Trust examine whether patients feel they are treated with respect and dignity. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 made is800000e

https://www.nationalelfservice.net/treatment/digital-health/nasss-framework-mindtech2019/
Imogen Bell summarises Trish Greenhalgh's paper on her recent NASSS framework (Nonadoption, Abandonment, Scale-up, Spread, and Sustainability), which is aimed at improving the success of digital health interventions in healthcare.
Freely available online

https://www.gov.uk/government/publications/e-learning-modules-medicines-and-medical-devices/e-learning-modules-medicines-and-medical-devices
These MHRA educational modules on medicines have been written for trainees and healthcare professionals responsible for prescribing, supplying or administering medicines. The modules cover clinically-relevant aspects of medicines regulation as well as topics on the risks of commonly-prescribed specific classes of medicines. Updated December 2019.
Freely available online