Royal United Hospitals Bath
NHS Foundation Trust

Innovation and Quality Improvement

Current Awareness Bulletin

July 2025

Our Current Awareness Bulletins provide details of recently published articles in a given subject. They are a quick and easy way to keep up to date.

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- **Bitesize searching databases for evidence: a quick guide to help you develop your literature searching skills**
  45 minutes. Learn how to transform a question into a search strategy, and how to find the best evidence in a database.

  Next sessions: 27th August @ 1pm, 25th September @ 9am & 3rd October @ 10am

- **Simple and painless evidence into practice (BMJ Best Practice and the LKS Hub)**
  30 minutes. Learn about quick and hassle-free ways to seamlessly incorporate evidence into your daily work.

  Next sessions: 7th August @ 3pm, 5th September @ 3pm & 6th October @ 9am

- **Quickfire health literacy: communicating with patients more effectively**
  30 minutes. Learn about the communication barriers patients may encounter, and ways to ensure they get the most from their care.

  Next sessions: 12th August @ 9am, 10th September @ 10am & 2nd October @ 11am

Book a session today at https://forms.office.com/e/HyiSXfDaYV (these sessions will be held on a monthly basis)

Asking patients to share a short biography establishes a better connection and improves care

BMJ

Hearing a patient's story in their own words has changed our working culture, write **Pietro Majno-Hurst and colleagues**

For the past four years we have been asking patients who are scheduled for major surgery to write and share a short biography with the healthcare team: “Introduce yourself as you want to be known by the people who will look after you. Tell us also what is important to you, and what is important that the staff knows to care for you as a person and not just as the bearer of your disease.” We didn’t expect such a positive response from patients and families.

We initially discuss our project with patients when we see them in the clinic and then follow up shortly afterwards with a letter explaining it. On hearing our request, almost every patient eases back into their chair and thanks us for this opportunity. They often say that this is the first time a physician has asked them to do this. Family members, who are often present during the visit, also begin to engage with us in a more forthcoming way, as if they feel more confident to leave their loved ones in our care.

In our experience almost all patients accept the opportunity to send us their biography, and we find that this has a positive effect on our interactions. The time we spend with patients has not changed, but the quality of our connections is noticeably different. We have a mutual sense that we are closer to appreciating each other as partners and that we can take up the role of guides who will accompany them through their treatment and care rather than just being skilled technicians for their operation.

Colleagues involved with our patients for shorter times, such as anaesthetists and intensivists, are eager to receive the biographies we send to them the day before the surgery. Nurses on the ward now include the biographies as an important part of their records. This experience has shifted our culture. When a patient is admitted through the emergency pathway and we have not had the opportunity to share our project, we feel that something is missing until we can hear their story in their own words.

Colleagues often ask us whether this project has added a burden to our work. But the opposite is true. The additional time required to read and acknowledge the biographies, which are generally sent by email, amounts to only a few minutes per patient. We find that we receive information from the biographies that should be collected regardless, and that it otherwise comes inconsistently from multiple disparate sources. Having a better understanding of our connection with patients and their families has helped with our interactions with them, especially during difficult times when we must deal with complications or deliver bad news.

We have reciprocated by offering access to some biographical information about ourselves by way of an internet link in the request letter. Patients and families have never misused this opportunity. The knowledge that patients and their families also know about us as individuals gives us confidence in our mutual relationship.

After they have recovered, we ask patients how they felt about the project. They usually express gratitude for the opportunity, confident that they could be recognised as individuals, with their own strengths, weaknesses, and needs. After more than one hundred requests so far, refusal to provide a biography has been rare (<5%). Some patients have remarked on a positive difference in their interactions with staff who had read the biography versus those who had not. It is important to set aside time in the care pathway to read the patient's text.

We are our biographies. Seeing ourselves and each other as unique human beings in the face of challenges should be an important part of clinical practice, but it is missing when the individuality of patients and health professionals is pushed aside.

Perhaps it is not by chance that the idea of allowing patients and doctors to introduce themselves this way arose in a surgical ward, where technical competence and formality of the setting may feel detached and impersonal. Sharing biographies has shown us an accessible and effective tool for establishing better connection and care.

https://doi.org/10.1136/bmj.r1157

Pee in Pot (PiP) – A Sustainable Shift in Urine Testing Now Available via NHS Supply Chain

NHS Supply Chain

Developed within Somerset NHS Foundation Trust, the PiP (Pee in a Pot) is a sustainable, single-solution pulp vessel that simplifies mid-stream urine (MSU) collection while cutting carbon emissions by up to 85%. Now available through the NHS Supply Chain catalogue, PiP replaces multiple plastic items used in conventional testing, reducing waste, spillage risk, and costs.

Read online at https://www.supplychain.nhs.uk/news-article/sustainable-innovation-in-urine-testing-pee-in-pot-pip-now-available-through-nhs-supply-chain/

One Year Of Reusable Theatre Hats - Project Saves 84,000 Hats a Year

County Durham and Darlington NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust's Reusable Theatre Hats Project, which launched in February 2024, has celebrated its first anniversary. It has achieved a lot in the past year, helping to reduce carbon emissions and waste while improving patient experience.

Read online at https://www.cddft.nhs.uk/about-us/news/one-year-reusable-theatre-hats-project-saves-84000-hats-year

Hospital of the future: hospital as a service, not a building

Re:State

This report outlines a model that fundamentally changes the configuration of the modern hospital. The paper proposes a model that combines a radical increase in virtual care with renewed approaches at system-wide integration. It argues that instead of inefficiently relocating hospital staff and infrastructure to communities, hospital-level care should be delivered as a service through entirely new care pathways, shifted financial incentives, and remote digital tools.

Read online at https://re-state.co.uk/publications/hospital-of-the-future-hospital-as-a-service-not-a-building/

Defining the size of the health innovation prize

Frontier Economics

This report, commissioned by the Health Innovation Network, aims to quantify the economic cost of ill health and the value health innovation can bring by addressing ill health. It details the potential for innovation in health care to help address the economic impacts of ill health, by helping people return to work sooner.

Read the report at https://cdn.thehealthinnovationnetwork.co.uk/wp-content/uploads/2025/06/Defining-the-Size-of-the-Health-Innovation-Prize-report.pdf

Exploring the sustainability of virtual care interventions: A scoping review

PLOS Digital Health

The objectives of this scoping review were to construct a conceptualization of of virtual care sustainability and to describe factors influencing the sustainability of virtual care, shedding light on the determinants that shape its longevity and continued use. Findings indicate that there is no “one size fits all” approach to achieving sustainability of virtual care interventions, but instead identify factors that may support or hinder sustainability.

Read online at https://doi.org/10.1371/journal.pdig.0000893

'Innovator passports' set to accelerate cutting-edge NHS care

GOV.UK

A new 'innovator passport' will speed up the adoption of cutting-edge tech across the NHS by slashing red tape and duplication. Part of the 10-Year Health Plan, it allows proven innovations to be rolled out nationwide faster, boosting patient access to advanced treatments and supporting the life sciences sector. Delivered via the MedTech Compass digital platform, it streamlines approvals and makes innovations more visible. This aims to modernise healthcare, reduce waiting times, and strengthen NHS-industry collaboration for future-ready care.

Read online at https://www.gov.uk/government/news/innovator-passports-set-to-accelerate-cutting-edge-nhs-care

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1. **Improving patient safety culture in hospitals: A scoping review.**

Authors: AiresMoreno G.T.;Marques L.G.;Ramos S.F.;de Castro AraujoNeto F.;de Oliveira Santos Silva R.;Fernandes B.D.;Dos Santos Alcantara T.;Mesquita A.R.;Chemello C. and Lyra, D.

Publication Date: 2025

Journal: Research in Social & Administrative Pharmacy : RSAP (pagination), pp. Date of Publication: 06 Jun 2025

Abstract: CONTEXT: Patient safety culture is the product of individual and group behaviors that determine the commitment, style, and proficiency of a healthy and safe healthcare organization. To improve a hospital's patient safety culture, it is necessary to understand the strategies that exist and those that best impact health outcomes. AIM: Analyze strategies that modify patient safety culture in the hospital environment.
METHOD(S): A scoping review was conducted of experimental or quasi-experimental studies published until March 2025 on different strategies that determine patient safety culture. The terms used were related to "Patient Safety," "Safety Management," "Organizational Culture," "Experimental or Quasi-experimental studies," and "Hospitals" and for the search, the databases Cochrane, Embase, PubMed, Scopus, and Web of Science. Subsequently, two researchers independently analyzed the titles, abstracts, and full texts, and a third evaluator resolved divergences in the selection of studies.
RESULT(S): Fifty one studies were included in this systematic review. 17 studies were named before and after, 16 quasi-experimental studies, 11 randomized controlled trial and seven as interrupted time-series studies. Regarding strategies to improve safety culture, educational strategies were used in 31 (60.8 %) studies, cooperative work strategies were identified in nine (17.6 %), and organizational change strategies were applied in 11 (21.6 %). Five studies correlated the strategies applied in patient safety culture with the clinical outcomes in patient health, and only one study measured the economic impact.
CONCLUSION(S): It can be concluded that the strategies that brought the most relevant results to the patient safety culture in hospitals were those with greater cooperation from health professionals with a focus on teamwork, those with a duration and follow-up of over one year, those focused on optimizing the relationship between professionals and the institution's

leaders, and those that optimized clinical and economic outcomes.

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2. **Learning From Quality Improvement Initiatives for In-hospital Newborn Falls Prevention From a Sleeping Mother: A Literature Review**

Authors: Duthie, Elizabeth Ann

Publication Date: 2025

Journal: The Journal of Nursing Administration

Abstract: Competing Interests: The author declares no conflicts of interest.; Newborns experiencing skull fractures and brain bleeds after a fall from a slumbering mother generate a clinical crisis necessitating urgent resolution. Studies spanning 15 years inferred newborn falls from a sleeping mother as preventable, although aggregate data contradict this conclusion. An analysis of the literature identifies impediments to progress and ramifications for quality improvement leaders. (Copyright © 2025 Wolters Kluwer Health, Inc. All rights reserved.)

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3. **Patient Safety Ratings of Hospitals by Registered Nurses, Managers and Executives.**

Authors: Emory D.J. and Kippenbrock, T. A.

Publication Date: 2025

Journal: SSRN (pagination), pp. Date of Publication: 18 Jun 2025

Abstract: This study investigated the differences in patient safety ratings among registered nurses (RNs), managers, and executives in U.S. hospitals, using data from the AHRQ Patient Safety Culture survey 2.0. The analysis reveals significant disparities in safety culture perceptions, with RNs reporting lower mean scores compared to managers and executives. These differences highlight the impact of direct patient interaction on safety perceptions, as RNs, who have the most patient contact (90%), identify more challenges in maintaining safety. The study underscores the importance of incorporating frontline nursing perspectives into patient safety policies and emphasizes the need for enhanced collaboration between RNs, managers, and executives to address perceptual gaps. By understanding these differences, healthcare organizations can develop more comprehensive strategies to improve patient safety culture, ensuring that policies and practices are informed by the experiences of those directly involved in patient care.

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4. **Medication Safety Officers: A pillar of patient safety in hospital pharmacy**

Authors: Ford, Elizabeth Hess and Michalek, Christina

Publication Date: 2025

Journal: Farmacia Hospitalaria : Organo Oficial De Expresion Cientifica De La Sociedad Espanola De Farmacia Hospitalaria

Abstract: The role of a Medication Safety Officer has emerged as a critical element in hospital pharmacy, addressing the persistent issue of medication errors. These errors, which can cause significant patient harm, have been documented for decades, prompting the establishment of formal roles dedicated to medication safety. Organizations such as the Institute for Safe Medication Practices (ISMP), the American Society of Health System Pharmacists (ASHP) as well as the United Kingdom's Medicines and Healthcare products Regulatory Agency (MHRA) and National Health Service (NHS) have been instrumental in supporting the Medication Safety Officer role. Medication errors can result in severe consequences, including patient harm and death. Landmark publications like the Institute of Medicine's "To Err is Human" and "Crossing the Quality Chasm" have highlighted the prevalence and impact of these errors, advocating for system improvements and the necessity of dedicated safety roles. Medication Safety Officers lead strategies and processes related to medication safety, develop strategic plans, and implement error prevention strategies. They analyze medication error reports, collaborate with healthcare staff, and optimize medication safety technologies. Medication Safety Officers play a key role in fostering a culture of safety within organizations, influencing practices to minimize harm and support second victim programs. Studies have shown that employing a Medication Safety Officer can significantly improve hospital safety scores, demonstrating the effectiveness of this role in enhancing patient safety. The daily responsibilities of a Medication Safety Officer include reviewing medication errors, assessing harm, attending meetings, and collaborating with healthcare practitioners. Overall, the role of a Medication Safety Officer is essential in identifying and mitigating medication risks, making hospitals safer, and ensuring the delivery of high-quality patient care.

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5. **Unveiling the complexities of patient safety in hospital settings: A holistic approach to overcoming challenges.**

Authors: Gupta A.;Shah P.;Sohal P.;Gupta V.;Anamika F.;Bowman C. and Jain, R.

Publication Date: 2025

Journal: Geriatric Nursing (New York, N.Y.) 64, pp. 103357

Abstract: Medical science and technologies have made tremendous progress in treating patients, however cases of avoidable harm done to the patients are still present. Many hurdles impede the achievement of optimal patient safety within hospital settings. There are many factors that affect overall patient care and are related to physicians, nursing staff, hospital administrators, labs, and most importantly patients themselves. Some systemic problems addressed include poor communication, understaffed teams, weak coordination, and lack of psychological safety among health practitioners. These factors intertwine and affect the quality of safety the hospital environment offers. The findings underscore the need for a holistic and proactive approach combining improved communication strategies, optimized staffing ratios, a culture of transparency, and thoughtful technology integration. Addressing these challenges foremost is crucial for fostering a safer hospital environment and ultimately enhancing patient

care and safety. The aim of this article is to identify critical factors contributing to compromised patient safety.

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6. **Transforming the Structure and Operations of a Large Acute Care Therapy Department A Quality Improvement Project.**

Authors: Hoffman A.;Griffin M.;Hagburg E.;King D.;White C. and Gottenborg, E.

Publication Date: 2025

Journal: Journal of Acute Care Physical Therapy 16(3), pp. 94–99

Abstract: Background and Purpose: As hospitals continue to grow and focus on value, rehabilitation leaders must reassess the way in which they operate to ensure alignment with hospital objectives and key results. This article describes the quality improvement project of an acute care therapy department within an academic medical center that changed from discipline-specific accountability to an integrated service-line-based team structure and operations. Quality Improvement Process: In 2022-2023, 4 experienced acute care rehabilitation leaders at a large academic medical center undertook a yearlong quality improvement initiative. Their goals were to enhance employee engagement, improve customer satisfaction, increase operational efficiency and agility, develop sustainable processes for future growth, and build robust data-driven decision-making systems. Kotter's 8 Steps for Leading Change served as the primary framework for this effort.
Result(s): Rehabilitation department productivity, staff experience, and direct leader-to-staff ratios improved through the transformation. The cost of an additional supervisor position was offset by positive productivity variances.
Discussion(s): This quality improvement project demonstrated that structural and operational changes, including the addition of administrative roles, can improve morale and operations when systematically led through a quality improvement framework.

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7. **The Patient Safety Management Activities of Hospital Nurses: An Importance and Performance Analysis.**

Authors: Ryoo E.;Park H.;Shin N.Y. and Yu, S.

Publication Date: 2025

Journal: The Journal of Nursing Research : JNR 33(3), pp. e396

Abstract: BACKGROUND: To improve patient safety performance, medical personnel may utilize patient safety systems to perform patient safety nursing activities and suggest future directions for improvement. Patient safety nursing activities refer to systematic activities taken to prevent injuries or accidents during diagnosis, treatment, and other medical services.
PURPOSE: This study was designed to analyze the importance placed by hospital nurses on patient safety management activities and their actual performance of these activities.
METHOD(S): An importance and performance analysis of patient safety management

activities was conducted on 163 nurses with over 1 year of experience working at one of three hospitals in South Korea. Data were collected using questionnaires prepared based on criteria related to nurse-implemented patient safety management activities (three areas, 15 categories, 104 questions).
RESULT(S): The average score for the importance of the developed patient safety management activities was 3.65 (SD = 0.14), and the average performance score was 3.42 (SD = 0.211). Using distinct importance and performance analysis frames, items corresponding to the "concentrate here" area included "securing enough human resources," "provide training for employees," "efforts to prevent violence in institutions and establish a proper organizational culture," "a rapid response system to urgent patient conditions," "checking the correct patients," and "CPR team operating regulations." CONCLUSION/IMPLICATIONS FOR PRACTICE: The indicators for most patient safety management activities indicate their strong performance in South Korean nursing workplaces. To further improve the patient safety management practices of hospital nurses, nursing managers should create nursing work environments that promote safety activity performance efficacy.

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8. **Streamlining and improving controlled drug dispensary workload in a London teaching hospital following the implementation of automated dispensing cabinets on wards: A quality improvement project.**

Authors: Walsh A.;Jeffrey E. and Lai, K.

Publication Date: 2025

Journal: Exploratory Research in Clinical and Social Pharmacy 18(pagination), pp. Article Number: 100594. Date of Publication: 01 Jun 2025

Abstract: An efficiently run pharmacy dispensary has the potential to positively impact patients stay in hospital. Pharmacy dispensary providers work in a fast-paced, hectic environment and are finding it increasingly difficult to keep up with workload demands. In order to meet the increasing demand on resources, pharmacy teams are incorporating Quality Improvement (QI) initiatives to improve efficiencies within systems for the purpose of freeing up nursing and pharmacy staff time, improve patient flow and improve patient safety. This QI project sought to develop a standardised inventory control formula for controlled drugs (CDs) stocked in ADCs in clinical locations in order to reduce the frequency of CD stock orders, minimise the requirement for manual nurse generated orders and in doing so streamline workload for dispensaries whilst ensuring sufficient CD stock holding levels in clinical locations. The introduction of ADCs corresponded with an increase in dispensary workload at the main hospital site at King's College Hospital (KCH). Retrospective time series analysis of the monthly CD dispensing data was analysed for Surgical and Trauma wards over a 27-month period using the Statistical Control Process (SPC) tool. Volume of stock CD dispensing transactions, volume of stock Vs non-stock CD dispensing transactions, volume of weekday vs weekend, morning, afternoon and out of hours CD stock workload were measured. Two interventions were implemented: (i) stock optimisation informed by the utilisation of CD dispensing data issued from the ADC in central pharmacy; (ii) stocklist rationalisation to ensure the most commonly used CDs were added to CD stocklists and the least commonly used CDs were removed from stocklists in addition to the development of a standardised inventory

management formula. The main outcome measure was the volume of stock CD dispensing transactions processed by central pharmacy. Secondary outcome measures included the volume of stock CD dispensing transactions at weekends Vs weekdays in addition to the split in workload between mornings, afternoons and out of hours. A reduction in stock CD workload for Surgical and Trauma wards was demonstrated following the stock optimisation review whereas this was not significantly impacted by the stock rationalisation or application of the standardised inventory management formula. Weekend workload reduced by 30 % in comparison to pre-ADC baseline period. Morning, afternoon and out of hours CD stock workload demonstrated a sustained improvement following stock optimisation, stock rationalisation and following the application of the standardised inventory management formula. The only exception to this sustained improvement was in October 2023 following the implementation of a new Trust wide EMPA system. The perfect formula to determine CD stock inventory levels remains elusive, however, as nurses are still required to order stock manually via CD requisition books for stock CD requests. Continual cycles of reviews are made possible through improved ease of data availability with the use of ADCs. Suggestions to further improve the formula are explored although not tested as part of this QI. The proposed improvements to the standardised formula together with more widespread application to different specialties is recommended as the next steps to this QI.

Sources Used:

A number of different databases and websites are used in the creation of this bulletin.

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