Royal United Hospitals Bath
NHS Foundation Trust

Innovation and Quality Improvement

Current Awareness Bulletin

September 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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New training via MS Teams available from the Academy Library:

- **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: 25th September @ 9am, 3rd October @ 10am & 10th November @ 11am

- **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: 5th September @ 3pm, 6th October @ 9am & 11th November @ 10am

- **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: 10th September @ 10am, 2nd October @ 11am & 28th November @ 12 noon

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

Centralisation of specialised healthcare services: a scoping review of definitions, types, and impact on outcomes.

National Institute for Health and Care Research (NIHR)

Centralising specialised healthcare services into high-volume centres is proposed to improve patient outcomes and efficiency. Most reviews focus on relatively few conditions and a limited range of outcomes. The aim of this research was to review the evidence on centralisation of a range of specialised acute services, to analyse (1) how centralisations are defined; (2) how centralisations are organised and delivered; and (3) the relationship between centralisation and several key outcomes.

Read online at https://www.journalslibrary.nihr.ac.uk/hsdr/published-articles/REMD6648

Hospital-based innovation labs to accelerate digital health transformation: lessons learned from twenty types of experts.

BMC Digital Health

An exploratory, qualitative study using semi-structured interviews was performed at two innovation labs in Dutch academic hospitals. Authors identified five major themes: experts' own definitions of their roles, factors influencing the probability of success of an innovation,

fundamentals of the innovation process, potential improvements in the current innovation processes, and cultural aspects of the organization pertaining to innovation.

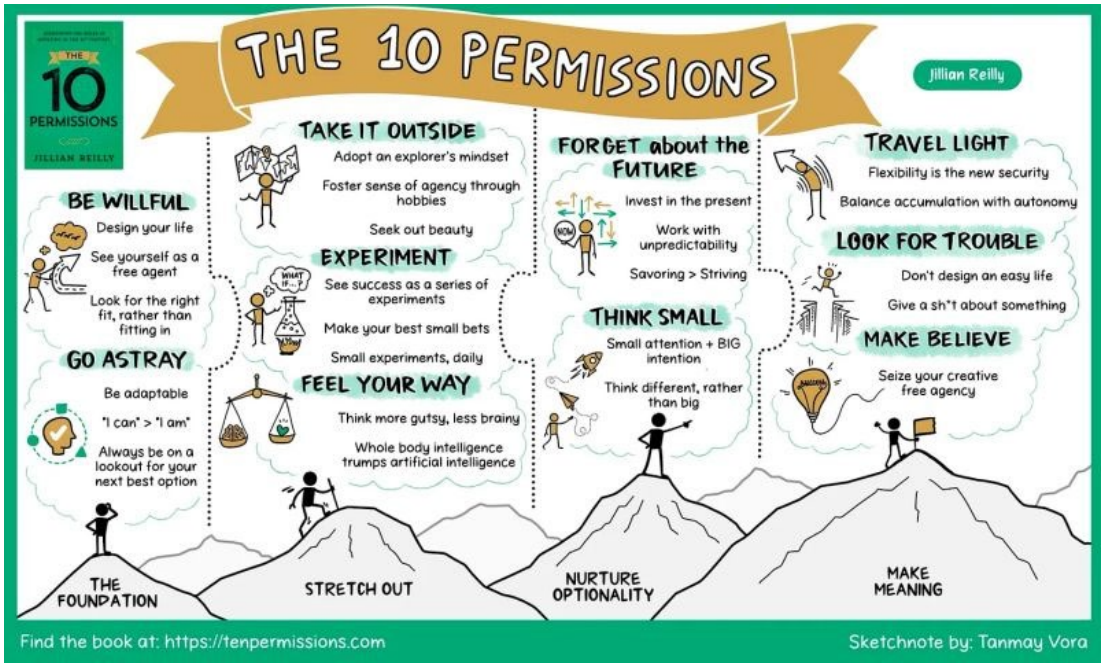
Read online at https://bmcdigitalhealth.biomedcentral.com/articles/10.1186/s44247-025-00173-5

Helen Bevan

Strategic adviser, health and care | Innovation | Improvement | Mobilising | Large Scale Change. Views my own

One of the biggest frustrations of internal change/improvement leaders are organisational "rules". These are processes & policies that add little value but create obstacles to change & innovation & sap our energy. A common mantra is that we need to "break the rules". I often say we should flip our thinking. Rather than breaking the rules (which implies risk & danger in undermining authority) we need to give ourselves "permission" (which implies believing in our own authority & positive intent to find ways to move forward). So I appreciated this sketchnote & podcast from **Tanmay Vora**, based on a new book by **Jillian Reilly**. It identifies "ten permissions" to move beyond inherited rules & develop new, intentional ways of thinking, acting & leading. We can all give ourselves permission to: •Experiment: Try new approaches, projects & roles, treating leadership as an ongoing journey of learning & discovery. •Take it outside: Seek diverse perspectives from outside traditional boundaries—collaborating, exploring & staying curious. •Feel your way: Trust emotion & intuition, using self-awareness as an asset in complex, people-centred work. •Forget about the future: Focus on the present & immediate next steps, rather than over-planning in uncertain environments. •Think small: Value small wins & the compounding power of incremental improvement. •Travel light: Let go of unnecessary baggage—whether that's limiting beliefs, old roles, or redundant processes. •Look for trouble: Welcome challenges & tricky conversations as opportunities for development & positive disruption. •Make believe: Imagine alternative futures & cultivate creativity.

Helen Bevan social media post, highlighting this article https://claritycanvas.substack.com/p/the-10-permissions-with-jillian-reilly



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 and Administrative Pharmacy 21(10), pp. 765–783

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(s): 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. **Reassessing hospital patient safety culture: from survey limitations to moral injury.**

Authors: Boussat B.;Tran B.X.;Doan L.;Do M.N.H.;Francois P.;Ducki S. and Boyer, L.

Publication Date: 2025

Journal: Journal of Epidemiology and Population Health 73(4) (pagination), pp. Article Number: 203137. Date of Publication: 01 Aug 2025

3. **One Size Fits None. How can we do better? using patient reported experience measure findings to drive local quality improvement across wards in a large Australian metropolitan hospital**

Authors: Engstrom, Teyl;Petrie, Christine;Pinzon Perez, William;Sullivan, Clair and Pole, Jason D.

Publication Date: 2025

Journal: International Journal of Medical Informatics 204, pp. 106078

Abstract: Competing Interests: Declaration of competing interest The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.; Introduction: Patient reported experience measures (PREMs) are being collected across entire jurisdictions, resulting in large volumes of rich qualitative patient feedback. However, this collection of data is often not connecting with local quality improvement efforts. This study aims to answer the question: "Are there meaningful differences in the patient experience of care, as measured through qualitative survey feedback, among wards at a large metropolitan hospital?" to assess the need to analyse PREMs data at a ward level to identify actionable insights.; Methods: We utilise 6-months of PREMs surveys from a jurisdictional level survey in a large metropolitan hospital in Australia, focusing on Gynaecology, Maternity, Surgical and Short Stay wards. Responses to two qualitative questions concerning (i) what was good about their care, and (ii) what could be improved about their care were analysed using a semi-automated machine learning based content analysis tool, Leximancer. We performed a quantitative comparison between the hospital wards of the concepts identified from the text and their frequencies, estimated with the Cramer's V, and a qualitative comparison between wards of the three most prevalent concepts and the details reported by patients.; Results: In the quantitative comparison, we found a moderate association of the concepts reported between the wards (Cramer's V: 0.36-0.67). The qualitative analysis showed that even when the high-level issue being reported was shared across wards, the nuances often differed, especially for feedback related to improvements in care.; Conclusion: Our study found there were substantial differences between the issues and details reported by patients across different wards, highlighting the importance of analysing PREMs at a ward level to inform quality improvement. We demonstrated a standardised way to analyse this data at ward level by employing semi-automated content analysis. These findings provide a clear method that health services can use to analyse PREMs data to drive on-the-ground quality improvement for patients.

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4. **The prevalence of incivility in hospitals and the effects of incivility on patient safety culture and outcomes: A systematic review and meta-analysis**

Authors: Freedman, Benjamin;Li, Wendy Wen;Liang, Zhanming;Hartin, Peter and Biedermann, Narelle

Publication Date: 2025

Journal: Journal of Advanced Nursing 81(9), pp. 5603–5622

Abstract: Aim: Workplace incivility is a barrier to safe and high-quality patient care in nursing workplaces and more broadly in tertiary hospitals. The present study aims to systematically review the existing evidence to provide a comprehensive understanding of the prevalence of co-worker incivility experienced and witnessed by nurses and other healthcare professionals, the effects of incivility on patient safety culture (PSC) and patient outcomes, and the factors which mediate the relationship between incivility and patient safety.; Methods: A systematic review with narrative synthesis and meta-analysis was undertaken to synthesize the data from 41 studies.; Data Sources: Databases searched included MEDLINE, PubMed, SCOPUS, CINAHL, PsycInfo, ProQuest, Emcare and Embase. Searches were conducted on 17 August 2021 and repeated on 15 March 2023.; Results: The pooled prevalence of experienced incivility was 25.0%. The pooled prevalence of witnessed incivility was 30.1%. Workplace incivility was negatively associated with the PSC domains of teamwork, reporting patient safety events, organization learning/improvement, management support for safety, leadership, communication openness and communication about error. The composite pooled effect size of incivility on these domains of PSC was OR = 0.590, 95% CI 0.515, 0.676]. Workplace incivility was associated with a range of patient safety outcomes (PSOs) including near misses, adverse events, reduced procedural and diagnostic performance, medical error and mortality. State depletion, profession, psychological responses to incivility, information sharing, help seeking, workload and satisfaction with organizational communication were found to mediate the relationship between incivility and patient safety.; Conclusion: Experienced and witnessed incivility is prevalent in tertiary hospitals and has a deleterious effect on PSC and PSOs. A better understanding of the mechanisms of this relationship will support the development of interventions aimed at reducing both incivility and patient harm.; Implications for the Profession And/or Patient Care Impact: This study quantifies the effect of incivility on PSC and outcomes. It provides support that interventions focusing on incivility are a valuable mechanism for improving patient care. It guides intervention design by highlighting which domains of PSC are most associated with incivility. It explores the profession-specific experiences of workplace incivility.; Reporting Method: This report adheres to PRISMA reporting guidelines.; Patient or Public Contribution: No patient or public contribution. The focus of this study is the nursing and healthcare workforce, therefore, patient or public involvement not required. (© 2024 The Authors. Journal of Advanced Nursing published by John Wiley & Sons Ltd.)

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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.

Sources Used:

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

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