Royal United Hospitals Bath
NHS Foundation Trust

Innovation and Quality Improvement

Current Awareness Bulletin

December 2025

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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: 22nd January 2026 @ 2pm and 13th February 2026 @ 3pm

- **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: 16th January 2026 @ 10am and 2nd February 2026 @ 11am

- **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: 7th January 2026 @ 2pm and 19th February 2026 @ 3pm

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

Improving departmental Quality Improvement Plans through standardisation, structured peer-to-peer feedback and building improvement capacity and culture.

Hobbs H. *BMJ Open Quality* 2025;14(4):e003531.

Quality Improvement Plans (QIPs) can improve healthcare quality by raising awareness and providing a focus for improvement efforts. The physician-led quality committee at this institution set out to improve the previously heterogenous quality and content of clinical department QIPs and increase alignment between clinical department and hospital quality improvement (QI) priorities. The authors describe these initiatives and assess their impact on the quality of departmental QIPs.

Read online at https://bmjopenquality.bmj.com/content/14/4/e003531

Qling your QI: a 13-year experience of a paediatric residency QI programme.

Molina AL. *BMJ Quality & Safety* 2025;34(12):824-832.

QI education is essential for resident physicians with established requirements from the Accreditation Council for Graduate Medical Education outlining the necessary components. Literature supports the inclusion of both didactic and experiential learning, however, most studies review knowledge and attitude based assessments of residency QI programs. This 13-year intiative demonstrates how systematic, iterative improvement can improve the rigor of resident QI projects.

Read online at https://qualitysafety.bmj.com/content/34/12/824

Guide to managing ethical issues in quality improvement or clinical audit projects.

Healthcare Quality Improvement Partnership (HQIP); 2025

This guide, which was updated in October 2025, is intended to help those responsible to review and develop arrangements for the effective ethics oversight of quality improvement and clinical audit activities.

Read online at https://www.hqip.org.uk/resource/guide-to-managing-ethical-issues-in-quality-improvement-or-clinical-audit-projects/

The hospital washing its hands of sinks

BBC News

At Wexham Park Hospital dozens of sinks have been removed from across the hospital as part of the fight against antimicrobial-resistant superbugs. It follows the introduction of similar practices in the Netherlands and Germany as part of a landmark “water-safe” initiative

Anti-microbial resistant superbugs have killed an estimated one million people worldwide every year since 1990, according to research.

But Slough's Wexham Park Hospital has worked out that your average superbug loves nothing more than a damp hospital sink, as well as the drains and waste pipes that come with them.

In what's thought to be the first experiment of its kind in the UK, it has removed nearly all of the sinks on its intensive care unit to minimise the risk to patients from water-borne contamination.

Wexham's bosses say it could help turn the tide in the battle against superbugs.

In a world where hand washing has long been deemed the best way to keep hospital wards free of infections, it may sound counterintuitive.

But not according to Dr Manjula Meda, a consultant microbiologist at the Frimley Health Trust, which runs Wexham Park.

"Previously we said washing your hands is the single most important thing you can do to protect patients," she said.

"But we now know that washing hands is ineffective in the majority of instances because people don't do it properly.

"For it to be effective you have to wash your hands thoroughly for 20 seconds and then dry them properly afterwards, something most people don't do."

Dr Manjula Meda says we need to completely change the way we think about controlling infection in healthcare environments

Walking around the Slough hospital's intensive care unit, where patients are highly vulnerable to infection, it's no surprise that everything is spotlessly clean.

The sheets are pristine white, there are no rubbish bins in public view, and bottles of hand sanitisers are everywhere.

All but a couple of the unit's sinks have been removed to reduce the risk of contamination, and the ones that do remain look nothing like the ones we're used to seeing.

One of the few remaining sinks on Wexham Park Hospital's intensive care unit

There's a tap coming out of the wall, but you don't set the water running by physically turning anything on.

Rather you sweep your hand under a sensor to get things moving and there's no basin underneath this faucet.

That means no drain and no waste pipe, two locations identified by the hospital's microbiologists as superbug hotspots.

For nurses wanting to wash a patient in their bed, this means putting a bowl under a faucet with a plastic sleeve wrapped around it, to limit any water-borne splashes from the slowly running water.

After washing their patients they then have to carry away the waste water and wipes they have been using.

They are then disposed of safely elsewhere, away from the intensive care unit and its often immunocompromised patients.

Wexham Park Hospital says its water-safe project could help the NHS stay ahead in its fight against superbugs

Dr Meda says: "If you want to control these bugs it has to be in hospital settings, because waste water is a super reservoir for these superbugs.

"Changing practices that we are pioneering at Wexham Park could be one of the ways we start to win the battle against these bugs."

The hospital says its initial surveillance shows that removing sinks hasn't compromised anyone's safety, while it has started to reduce many types of hospital-acquired infections.

Hospital bosses are so convinced that they're onto something, they are now rolling out their new "water-safe" approach to other wards.

And last week a medical team from Japan flew over to see what they could learn from Wexham's project.

While the government's NHS Hospital programme, which is looking at how it can build more than 40 new hospitals over the next decade or so, is also showing an interest.

The Slough hospital's microbiologists hope their work could act as a blueprint for the wider NHS.

Read online at https://www.bbc.co.uk/news/articles/c0593drvrl1o

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1. **Utilizing a Nurse Discharge Navigator to Reduce Readmissions for Hospitalized Patients With Sepsis: A Quality Improvement Feasibility Study**

Authors: Pruitt, Marta;Matusik, Abby;Patel, Neelam and Kreider, Kathryn

Publication Date: 2026

Journal: Professional Case Management 31(1), pp. 27–34

Abstract: Competing Interests: The authors report no conflicts of interest.; Purpose/objectives: The purpose of this project was to evaluate the impact of a nurse discharge navigator implementing an education and structured outpatient follow-up program on reducing 30-day readmissions for adult patients with sepsis.; Primary Practice Setting: This project was implemented at an 847-bed academic hospital in the southeastern United States.; Findings/conclusions: Patient capture in the study was poor, driven by high rates of cancer diagnoses, comfort-directed care, and frequent discharges to postacute care. Readmission rates for patients receiving the full intervention (n = 16) were 25% (n = 4). Overall readmission rates for patients with sepsis in 2024 were 13.3% (n = 61). The outcomes of this project were influenced by the advanced comorbidities of the participants.; Implications for Case Management Practice: Case management of patients with sepsis should be comprehensive. Caregivers should be involved early to initiate education on the disease process, have clear communication with the follow-up team, and involve close, structured follow-up that can be adapted to the postacute care setting. One promising area for improvement of this intervention would be the inclusion of a Hospital at Home program as a transition program to the transition clinic.

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2. **Factors Associated With Patient Safety Activities of Clinical Nurses: A Cross-Sectional Secondary Data Analysis**

Authors: Lee, JuHee;Nam, Keum-Hee;Suh, Yujin;Lee, Yoonju and Lee, Deokhyun

Publication Date: 2025

Journal: International Nursing Review 72(4), pp. e70127

Abstract: Aims: To examine the associations between patient safety silence, culture, competency, and activities among clinical nurses.; Background: Patient safety ensures harm prevention and quality of care. Factors such as silence, culture, and competency are widely recognized as significantly associated with patient safety activities, but limited research has examined their interrelationships.; Design: Cross-sectional secondary data analysis.; Methods: This study used data from a study that investigated the patient safety educational needs of 291 nurses from general hospitals located in the Busan, Ulsan, and Gyeongsangnamdo regions of South Korea. To assess patient safety activities, silence, culture, and competency, the study employed the Patient Safety Activities Questionnaire, Patient Safety Silence Scale, Hospital Survey on Patient Safety Culture, and Patient Safety Competency Self-Evaluation Tool, respectively. The analysis involved descriptive statistics, correlation analysis, and multiple regression using SPSS 27.0.; Results: The factors of silence and receiving patient safety education only once were negatively associated with patient safety activities. Positive associations were found for teamwork within the culture subdomain, skills within the competency subdomain, and hospital size.; Conclusions: These findings provide a basis for educational programs to improve nursing skills and highlight the need to build an open and collaborative organizational culture.; Implications for Nursing: Clinical nurses should develop patient safety skills, report patient safety incidents, and collaborate with team members to foster an open and cooperative organizational culture.; Implications for Nursing Policy: To

minimize silence, while strengthening teamwork, organizations actively foster a culture of openness and collaboration. Education should be managed to meet minimum standards, and hospital-specific policies should be tailored according to each institution's size and characteristics. (© 2025 The Author(s). International Nursing Review published by John Wiley & Sons Ltd on behalf of International Council of Nurses.)

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3. **Hospital Employees View Patient Safety Culture Differently According to Their Role**

Authors: Quigley, Denise D.;Elliott, Marc N.;Schulson, Lucy B. and Dick, Andrew W.

Publication Date: 2025

Journal: Journal of Patient Safety

Abstract: Objectives: Limited evidence exists about differences in patient safety culture by employee role. We examine the relationship between role and patient safety culture.; Methods: Using 2021 to 2022 Hospital Survey on Patient Safety Culture (HSOPS) cross-sectional data (245,252 HSOPS respondents, 371 hospitals), we fit separate employee/respondent-level OLS regression models for 10 aspects of patient safety culture and 2 summary measures as a function of the employee's role, controlling for year, employee and hospital characteristics with hospital-level clustered standard errors (SEs) weighted to represent the nation.; Results: C-suite/executive/senior leaders reported the highest proportions of positive ratings for overall patient safety and all 10 aspects of patient safety culture. Managers/supervisors were most likely and unit staff (assistants/secretaries/clerks) were least likely to report safety events. Physicians reported the lowest proportion of positive overall patient safety ratings and ratings for communication and improvement. Care aides reported the lowest for teamwork, staffing/work pace, and response-to-error, nurses lowest for hospital management support and pharmacists lowest for handoffs and information exchange.; Conclusions: C-suite/executives/senior leaders, supervisors and managers have different perspectives of patient safety culture than physicians, care aides, nurses, and staff, revealing the need to improve patient safety culture for those who provide direct patient care and to improve communication across leaders and all employee roles. Hospitals should focus on improving communication and management support related to patient safety for physicians and on teamwork, staffing and work pace for care aides. Understanding the root of variability in how pharmacists assist and support patient handoffs and information exchange and how physicians, care aides and staff communicate, accept managerial input, and learn from errors are critical as they may affect safety and event reporting. Hospital leaders could also hold discussions at the microclimate level (unit) for those doing well and those not doing to discuss focusing on the culture of patient safety performance. Ensuring that communication is open and transparent across all hospital employees is critical to providing safe, effective patient care. (Copyright © 2025 Wolters Kluwer Health, Inc. All rights reserved.)

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4. **Restoring the core acute medical unit (AMU) function - a quality improvement initiative from a district general hospital.**

Authors: Wijewardane A. and Dyer, P.

Publication Date: 2025

Journal: Future Healthcare Journal 12(4) (pagination), pp. Article Number: 100486. Date of Publication: 01 Dec 2025

Abstract: The acute medical unit (AMU) is a specialist area, focused on delivering timely, effective acute care for adults with acute medical illness. AMUs were first established to provide timely physician review, risk stratification and multidisciplinary management in the first 72 h. They are designed to improve patient care, prevent unnecessary admissions and reduce morbidity and mortality. However, national benchmarking and local audit data showed that core acute medicine processes at Frimley Park Hospital's AMU had drifted from these standards. A structured quality improvement programme was therefore implemented to restore AMU function and align operational processes and workforce to national guidance and national Getting it Right First Time (GIRFT) principles. Real-time oversight, standardised multidisciplinary team board rounds and rota alignment to peak demand, halved AMU length of stay, doubled daily discharges and increased emergency department-to-AMU transfers. These improvements were associated with enhanced hospital-wide throughput and more effective early acute care.

Sources Used:

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

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