

# Innovation and Quality Improvement

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**April 2026**

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- **Simple and painless evidence into practice (BMJ Best Practice and the LKS Hub)**  
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### A system that learns: embedding best practice across the NHS

The Medical Technology Group

This analysis shows most NHS systems do not track outcomes, NICE adherence or pathways in gynaecology – despite more than 750,000 women waiting for care. The report warns that widespread failures to collect data and monitor best practice in gynaecology services are leaving women facing longer delays to diagnosis and treatment. The findings come as part of the MTG's Commission on NHS Culture, an investigation into how organisational culture across the NHS affects the adoption and spread of innovation and technology to improve the delivery of services. The report looks at four clinical areas: diagnostics, orthopaedics, gynaecology, and continence care to assess variation in the quality of services.

Read online at <https://mtg.org.uk/wp-content/uploads/2025/12/A-System-That-Learns-Embedding-Best-Practice-Across-the-NHS.pdf>

### NHS must stop making life 'difficult for innovators'

Digital Health, 01 April 2026

Digital leaders urge the NHS to reduce barriers to scaling health technologies, calling for a braver and more honest approach to supporting innovation adoption.

Read online at <https://www.digitalhealth.net/2026/04/nhs-must-stop-making-life-difficult-for-innovators/>

## Why We Start Late: Uncovering the Reasons for Delayed First Case Start Times (FCST) in Gynecologic Surgery.

Whitmore, G.; Bolt, M.; Tam, J.; Orlando, M. In: Obstetrics & Gynecology; 2026Supplement; v.147. 20S-21S.

[https://journals.lww.com/greenjournal/citation/2026/04001/why\\_we\\_start\\_late\\_\\_uncovering\\_the\\_reasons\\_for.24.aspx](https://journals.lww.com/greenjournal/citation/2026/04001/why_we_start_late__uncovering_the_reasons_for.24.aspx)

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### 1. Nursing-Led Knowledge Translation Strategies to Improve Patient Safety in Hospital Settings: A Scoping Review

**Authors:** Canhete, Jhenyfer Amanda Ciriaco;Muniz, Vânia Ana Silveira;Reiser, Milene Negri;Backman, Chantal;Lanzoni, Gabriela Marcellino de Melo and de Mello, Ana Lúcia,Schaefer Ferreira

**Publication Date:** 2026

**Journal:** Journal of Advanced Nursing

**Abstract:** Aim: To conduct a scoping review of nurse-led Knowledge Translation strategies aimed at promoting and enhancing patient safety in hospital settings.; Design: Scoping review.; Methods: This review followed the Joanna Briggs Institute methodology and was reported according to PRISMA-ScR.; Data Sources: Twelve electronic databases and additional grey literature sources were searched for studies published between 2002 and 2023, with no language restrictions.; Results: From 23,691 records identified, 59 studies were included. The majority (n = 56) employed multifaceted Knowledge Translation strategies, incorporating simulation, audits, digital tools and interprofessional education. The interventions focused on patient safety-related events, including falls, pressure injuries and catheter-associated complications. Nursing leadership emerged as a key component, particularly in team training, developing care protocols and delivering feedback. Outcomes included reductions in adverse events, improved adherence to clinical guidelines and cost savings. Yet, sustaining behaviour changes over time and limited interprofessional and family engagement remained recurrent challenges.; Conclusions: Nurse-led Knowledge Translation strategies were heterogeneous, with increasing use of simulations, technologies and multifaceted approaches. Evidence suggests potential associations with fewer adverse events, improved care quality, individualized planning and cost efficiency. Challenges related to the sustainability of interventions persist. Findings underscore the importance of investing in nursing leadership and capacity-building to strengthen patient safety.; Implications for the Profession And/or Patient Care: Strengthening nurse-led KT capacities may enhance evidence-based care and improve safety outcomes. Investment in leadership and tailored implementation is critical.; Impact: What problem did the study address? The limited synthesis of how nurses lead KT strategies to improve patient safety in hospitals. What were the main findings? Most strategies were multifaceted, context-sensitive and associated with improved care processes and safety indicators. Where and on whom will the research have an impact? Findings are relevant to hospital nurses, nurse educators, managers and health systems seeking to implement evidence-informed safety interventions.; Reporting Method: This scoping review followed the PRISMA-ScR reporting guideline.; Patient or Public Contribution: This study did not include

patient or public involvement in its design, conduct or reporting.; Trial Registration: Open Science Framework (OSF); registration identifier: 10.17605/OSF.IO/K3VJC. (© 2026 The Author(s). Journal of Advanced Nursing published by John Wiley & Sons Ltd.)

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## **2. Assessing Patient Safety Culture in Hospital at Home Services Across Spain Through a National Survey**

**Authors:** Granel, Nina; Sanchez Martos, Eva Angels; Subirana-Casacuberta, Mireia; Watson, Carolina E.; Gomez-Ibáñez, Rebeca and Risco, Ester

**Publication Date:** 2026

**Journal:** Nursing & Health Sciences 28(2), pp. e70337

**Abstract:** Patient Safety Culture (PSC) is key to healthcare quality. While widely studied in hospitals, evidence on PSC in Hospital at Home (HaH)-a growing model delivering hospital-level care at home-remains scarce. This study evaluated PSC among professionals in Spanish public HaH units. A descriptive, cross-sectional survey was conducted using the Spanish-validated Hospital Survey on Patient Safety Culture 2.0. Participants were physicians, nurses, and other HaH professionals with  $\geq 3$  months' experience. A total of 199 responses were analyzed using non-parametric tests. Positive response rates identified strengths ( $\geq 75\%$ ) and improvement areas ( $\leq 50\%$ ). Teamwork Within Units achieved the highest positive responses, indicating strong collaboration, while Staffing and Work Pace scored lowest, reflecting workload concerns. Most rated unit safety as "good" or "very good," though few as "excellent." Nurses reported more favorable perceptions than other professionals. Significant differences appeared in teamwork, communication, and leadership support. Comments highlighted commitment despite workforce shortages and limited institutional recognition. HaH services demonstrate a generally positive PSC. Addressing staffing and workload challenges through stronger institutional support and safety protocols is crucial for sustainable, safe home-based care. (© 2026 The Author(s). Nursing & Health Sciences published by John Wiley & Sons Australia, Ltd.)

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## **3. The relationship between psychological safety, patient safety culture, and work engagement with patient safety outcomes: a cross-sectional study in a Japanese university hospital**

**Authors:** Hata, Takeo; Nitta, Masahiko; Matsuo, Takami; Arai, Kohei; Ueda, Eiichiro; Nishihara, Masami; Ashida, Akira; Neo, Masashi; Katsumata, Takahiro and Hoshiga, Masaaki

**Publication Date:** 2026

**Journal:** BMC Health Services Research

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## **4. When does trust in leader foster innovative work behaviour in public hospitals? Role of employee engagement and high-performance work systems**

**Authors:** Jatoi, Shazia Aman and Channar, Sajjad Hyder

**Publication Date:** 2026

**Journal:** Journal of Health Organization and Management , pp. 1–21

**Abstract:** Purpose: This study examines how trust in leader influences doctors' innovative work behaviour (IWB) in public hospitals, identifying employee engagement as a mediating mechanism and perceived High-Performance Work Systems (HPWS) as a contextual moderator. Drawing on the Social Exchange Theory (SET) and the Ability-Motivation-Opportunity (AMO) framework, the study explains how relational and structural factors jointly shape IWB in public healthcare settings.; Design/methodology/approach: A deductive, quantitative design with a cross-sectional approach was employed. Data were collected through a self-administered survey from 270 doctors working in public hospitals in Sindh, Pakistan. Data were analysed using SmartPLS to assess mediation and moderation effects.; Findings: Trust in leader was positively associated with employee engagement, which in turn predicted IWB, supporting the mediating role of engagement. However, perceived HPWS negatively moderated the engagement-IWB relationship, indicating that higher levels of HPWS weakened the positive effect of engagement on IWB.; Research Limitations/implications: First, the cross-sectional design limits causal inference among trust in leader, employee engagement, HPWS and IWB. Longitudinal or time-lagged research could better capture the dynamic and reciprocal nature of these relationships. Second, the findings are based on public-sector hospitals in Sindh, Pakistan, which may limit generalisability to other institutional or cultural contexts. Future studies could replicate the model across sectors and regions to assess contextual robustness. Third, although a negative moderating effect of HPWS was observed, the study relied on perceived measures and did not directly assess implementation quality or system strength. Multi-level or mixed-method approaches could provide deeper insight into how HR system characteristics shape the engagement-innovation link.; Practical Implications: The findings also carry practical implications for public healthcare administrators. First, building and maintaining trust between leaders and doctors should be prioritised, as relational trust directly and indirectly supports IWB. Leadership development programmes should therefore emphasise credibility, fairness and transparent communication. Second, fostering employee engagement is essential for sustaining innovation. Hospital management can support engagement by recognising contributions, encouraging participation in decision-making and creating opportunities for professional development. Finally, the results suggest that merely establishing formal HR systems may not automatically enhance innovation. Policymakers and HR departments should focus not only on designing HPWS practices but also on ensuring their consistent and credible implementation.; Social Implications: In public healthcare settings, aligning HR practices with professional norms and allowing sufficient autonomy may be critical to ensuring that structural systems support, rather than constrain, innovative behaviour. Collectively, by promoting IWB among doctors, these practices may ultimately contribute to improved healthcare service quality and patient outcomes, thereby generating broader societal benefits.; Originality/value: By integrating the SET and the AMO framework in a moderated mediation model, this study advances the understanding of how trust-based relational mechanisms and perceived formal HR systems interact to influence IWB in public-sector healthcare contexts. (© Emerald Publishing Limited.)

## 5. Hospital-acquired pressure injury prevention: a quality improvement project

**Authors:** Kayum, Charlene K.

**Publication Date:** 2026

**Journal:** Journal of Wound Care 35, pp. xxvii–xxxviii

**Abstract:** The prevention, management and monitoring of pressure injuries (PIs) have become an important quality indicator for healthcare. In an acute care organisation, hospital-acquired pressure injuries (HAPI) remained prevalent, despite the implementation of a structured plan for PI prevention. The gap in practice for January 2021 to March 2021 was a HAPI incidence rate of 6.35% in the acute care unit. The project's purpose was to implement a HAPI prevention bundle and improve nurses' knowledge of prevention measures. The measured outcome was the HAPI incidence rate on the identified unit. This quality improvement project used Lewin's change theory as the framework. The PICOT clinical question was: 'How does implementing a PI prevention bundle and validating the knowledge, skills and attitudes of nurses on a medical surgical/step-down unit result in an improvement in the HAPI rate and improve the knowledge of nurses over eight weeks compared to solely utilising the current PI hospital policy and online PI education tool?' For the eight weeks from October 2021 to November 2021, the pre-implementation HAPI incidence rate was 6.51%. Post-implementation, the HAPI incidence rate decreased by 5.5%, and knowledge scores increased by 13% (average test score pre-implementation was 75.8%). Limitations were nursing shortages due to the COVID-19 pandemic. Recommendations included implementing the intervention bundle and competency assessment in other units over an extended timeframe and with a larger sample of patients.

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## 6. Economic and environmental impact of reducing unnecessary coagulation screen testing on an acute medical unit: a quality improvement project.

**Authors:** Nasher M.;Beveridge N.;Burrows S.;Jones N.;Gurumurthi S.;Sajjad A.;Gurung S.;Griffiths B.;Wong W. and Varia, R.

**Publication Date:** 2026

**Journal:** Postgraduate Medical Journal (pagination), pp. Date of Publication: 11 Feb 2026

**Abstract:** BACKGROUND: Inappropriate coagulation testing contributes to inefficiency, cost, and environmental harm. Baseline audits on our acute medical unit (AMU) showed that one-third of coagulation screen requests lacked a clear clinical indication. AIM: To reduce unnecessary coagulation screens on acute medical services [AMU and Medical Same Day Emergency Care (mSDEC)] by 90% within 12 months, aligned with National Health Service (NHS) Net Zero ambitions and our Trust's Green Plan. METHOD(S): Using the Model for Improvement, we conducted three Plan-Do-Study-Act cycles. Our analogue and digital interventions included revised triage order sets, condition-specific electronic order sets, and a digital decision prompt requiring clinicians to confirm test indication. Data were collected at baseline (January-February 2024) and re-audited after interventions (December 2024). Outcome measures were the proportion of inappropriate tests,

cost savings, staff time, and carbon reduction.

**RESULT(S):** At baseline, 34%-39% of coagulation screens were inappropriate across AMU areas. Postintervention, inappropriate testing reduced to 20% in mSDEC, 10% in AMU 1B, and 15% in AMU 1C. This equates to a projected annual reduction of 44 000 tests, saving 130 000, 367 staff hours, and 3.6 tonnes CO<sub>2</sub>e (equivalent to a 9000-mile car journey). Laboratory workload and plastic waste also fell substantially.

**CONCLUSION(S):** Embedding decision prompts within electronic order systems achieved rapid, sustained reductions in unnecessary testing. This scalable, low-cost intervention aligns clinical practice with sustainability goals and offers a model for reducing unwarranted diagnostics across the NHS. In the face of the climate crisis, aligning practice with environmental goals is both a professional responsibility and an opportunity to improve care, efficiency, and outcomes. Key messages What is already known on this topic Inappropriate coagulation testing is common across NHS acute care, with studies showing over one-third of tests lack a clinical indication. Excess diagnostic testing contributes to financial costs, staff workload, plastic waste, and carbon emissions. Previous quality improvement initiatives have focused mainly on education or guideline dissemination, with variable success. What this study adds Embedding a simple digital decision prompt into electronic order sets significantly reduced inappropriate coagulation screens across an Acute Medical Unit. The intervention was low-cost, rapidly implemented, and co-designed with frontline clinicians to improve uptake and sustainability. Projected impact includes avoidance of 44 000 tests annually, saving ~130 000, 367 staff hours, and 3.6 tonnes CO<sub>2</sub>e, supporting NHS Net Zero targets. This scalable model demonstrates how small digital changes can drive large improvements in clinical quality, efficiency, and sustainability.

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## 7. 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:** 2026

**Journal:** Journal of Patient Safety 22(2), pp. 101–106

**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.

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## **8. Risk Factors and Mitigation Strategies in Radiation Therapy: A Study of Patient Safety Events From 40 Hospitals**

**Authors:** Taylor, Matthew A.; Symington, Scott and Bakhtiari, Mohammad

**Publication Date:** 2026

**Journal:** Patient Safety (2689-0143) 8(2), pp. 1–12

**Abstract:** Background: Radiation therapy is a common lifesaving practice in the treatment of cancer, yet there is the potential for error that may cause patient harm or death. Methods: Using a retrospective mixed-methods design, we studied a two-year period of event reports submitted by hospitals to the Pennsylvania Patient Safety Reporting System (PA-PSRS) database and targeted those reports that described errors in radiation therapy. We analyzed the relation between the following primary variables: event type, whether it reached the patient, phase of radiation therapy when the risk factor originated, and risk factor (i.e., event impetus). Results: Our sample included 245 event reports from 40 hospitals. Among the 245 reports, 60% of the errors reached the patient, 71% of the sample were a wrong dose, and 29% described a delay in treatment. Across all six phases of radiation therapy, 38% of events originated from the treatment planning phase and 40% were from the treatment delivery phase. We identified 23 unique categories of risk factors that acted as the impetus. The most frequently identified were malfunction of hardware/software, wrong contour, absent or wrong accessory, wrong position, and wrong or low-quality images. Conclusions: The present study expanded upon many of the prior radiation therapy studies by exploring the relation among the various combinations of the primary variables. The study highlights the current risks in the practice of radiation therapy and the broad range of conditions in which errors may occur. Online Supplement Appendix S1 provides a list of mitigation strategies aimed at detecting and preventing the risk factors identified in the present study.

## 9. Relationships Between Organizational Innovation Climate, Creative Self-Efficacy, and Innovation Performance: A Cross-Sectional Study in Public Hospitals

**Authors:** Wu, Ruizhe;Feng, Xingmiao;Zhai, Ziyang;Sun, Xinyue;Wang, Zhen;Wang, Zhaoyang and Meng, Kai

**Publication Date:** 2026

**Journal:** Inquiry (00469580) 63, pp. 1–12

**Abstract:** Physicians play a central role in medical innovation, bridging scientific discovery and clinical application. Underpinned by Social Cognitive Theory, this study examines the associations among organizational factors, psychological factors, and physician innovation performance, within the distinct setting of public hospitals. A cross-sectional survey was conducted among 1859 physicians from 22 tertiary municipal hospitals in Beijing. Multilevel structural equation modeling (MSEM) was employed to examine the relationships between organizational-level and individual-level variables. The hospital organizational innovation climate was positively associated with both physicians' creative self-efficacy ( $\beta = .255$ ,  $P < .001$ ) and their innovation performance ( $\beta = .501$ ,  $P < .001$ ). Creative self-efficacy was positively associated with innovation performance ( $\beta = .646$ ,  $P < .001$ ) and partially mediated the climate-performance relationship (indirect effect = 0.217). These results highlight the importance of the hospital innovation climate—integrated with robust resource systems and scientific incentives—as it relates to physicians' creative self-efficacy and their innovation performance in public healthcare institutions.

### Sources Used:

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

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