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Innovation and Quality Improvement

Current Awareness Bulletin

July 2026

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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: 3rd August @ 1pm and 29th September @ 2pm

- **Simple and painless evidence into practice (BMJ Best Practice and the LKS Hub)**
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- **Quickfire health literacy: communicating with patients more effectively**
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1. **Same day emergency care for low back pain: quality improvement to support emergency flow and reduce unnecessary acute admissions.**

Authors: Dunstan E.;Wood L.;Coffey F.;Feavyour J.;Rashid N.;Salem K. and Hendrick, P.

Publication Date: 2026

Journal: Emergency Medicine Journal (pagination), pp. Date of Publication: 2026

Abstract: Globally, patients with low back pain (LBP) account for 4.4% of all emergency department (ED) attendances, in the UK, 50 000 visits have been reported each month. LBP is reportedly challenging to manage in this setting. Consequently, hospital admission is common despite low numbers of serious pathology. This quality improvement (QI) project aimed to reduce avoidable hospital admissions by implementing and embedding a same day emergency care (SDEC) pathway for LBP over a 2-year period.A 12-bedded area was repurposed as an SDEC unit, staffed by specialist spinal nurses and a senior decision maker (advanced practice physiotherapist or spinal surgical fellow). The service was co-designed with key stakeholders, including spinal leadership, ED representatives, radiology and patients

to form an ED-spinal interface group. The pathway was developed and refined over four plan-do-study-act (PDSA) cycles (2018-2021), supported by regular interface meetings and iterative feedback. Prospective data collection included referral activity, clinical timings, MRI utilisation and patient satisfaction. The project was registered as a QI initiative and did not require formal ethical approval.Between November 2018 and December 2021, the spinal SDEC recorded 3921 referrals. PDSA cycle 1 (pilot) recorded 267 referrals with 82 (31%) admitted and 19 (7%) requiring same day MRI. PDSA cycle 2 (referral expansion) recorded 569 referrals with 177 (31%) admitted and 39 (7%) requiring same day MRI. PDSA cycle 3 (system engagement) recorded 1043 referrals with 119 (11%) admitted and 154 (15%) requiring same day MRI. PDSA cycle 4 (embedding SDEC) recorded 2042 patient referrals with only 8% (n=172) admitted and 224 (11%) requiring same day MRI. Across four improvement cycles, the spinal SDEC demonstrated progressive and sustained reductions in hospital admission without an apparent increase in demand for same day MRI.
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2. **Doll therapy: Innovative treatment for patients with Alzheimer disease to improve patient and staff safety in a hospital setting**

Authors: Jarrell, Logan and Vanhoy, Sherry

Publication Date: 2026

Journal: Nursing 56(8), pp. 56–61

Abstract: Background Patients with Alzheimer disease may display negative neuropsychiatric symptoms that can pose patient safety risks.. Doll therapy is described in the literature as a successful diversional activity for these patients. Purpose This project aimed to provide doll therapy to patients with Alzheimer disease at their facility to reduce neuropsychiatric symptoms, improve patient safety, patient outcomes, and the patient and family experience, and to positively impact the health care team's experience when caring for this patient population. Methods A total of 55 patients with a diagnosis of Alzheimer disease participated in the doll therapy program. Quantitative and qualitative data were collected and analyzed. These included patient's behavior prior to doll therapy and the patient's response to doll therapy. Results Patients experienced a sense of purpose and comfort, as well as decreased risk for falls, physical workplace violence events, and being placed in restraints as a result of doll therapy.

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3. **Parents' Experiences of Patient Safety Incidents During Their Child's Hospitalization: A Qualitative Study.**

Authors: Kim M.Y. and Kim, Y.

Publication Date: 2026

Journal: Journal of Clinical Nursing (pagination), pp. Date of Publication: 09 Jun 2026

Abstract: AIMS: Patient safety incidents involving hospitalized children can have significant impacts on both patients and their families. However, previous research has primarily focused on healthcare professionals' perspectives, and studies exploring parents' experiences of patient safety incidents in paediatric settings remain limited. This study aimed to identify parents' experiences of patient safety incidents during their child's hospitalization. DESIGN: Qualitative study.
METHOD(S): Data were collected through individual interviews conducted between August 15 and December 23, 2023. Participants were seven parents who had experienced patient safety incidents while their children were hospitalized in South Korea. Data were analysed using deductive content analysis.
RESULT(S): Six themes were identified from parents' experiences, which were organized into three theme clusters: 'the indelible pain of patient safety incidents,' 'limitations of the pediatric healthcare system' and 'the need for an integrated management system to strengthen pediatric patient safety.'
CONCLUSION(S): This study highlights the importance of healthcare environments that reflect the unique characteristics of paediatric patients and patient safety strategies based on parental engagement, as revealed by the experiences of parents whose children experienced patient safety incidents. Our findings underscore the need to develop and implement paediatric-centered healthcare services, as well as programs and policies aimed at creating safer care environments for hospitalized children. IMPLICATIONS FOR THE PROFESSION AND PATIENT CARE: Enhancing paediatric patient safety requires family-centered care that actively involves parents and promotes effective communication between healthcare professionals and parents. Additionally, transparent disclosure and support systems following patient safety incidents should be strengthened, and parent-engagement-based patient safety programs should be expanded in clinical practice. REPORTING METHOD: The study adheres to the Consolidated criteria for Reporting Qualitative research (COREQ) guidelines. PATIENT OR PUBLIC CONTRIBUTION: Parents participated as interview respondents.
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4. **Is there an association between patient safety incident reporting and avoidable patient mortality? An analysis of 125 NHS hospitals in England**

Authors: Richardson, Daniel;Barton, Jack Charles;Chatterjee, Abhisekh;Shah, Viraj;Kuri, Ashvin;Norris-Grey, Caitlin and Round, Jonathan

Publication Date: 2026

Journal: British Journal of Healthcare Management 32(7), pp. 1–12

Abstract: Background/Aims: Patient safety incidents are a major source of avoidable morbidity and mortality. National systems, such as the National Reporting and Learning System and the summary hospital-level mortality indicator, aim to improve patient safety in the NHS through the monitoring of incident rates and excess mortality. This study examined the relationship between patient safety incident reporting and hospital-level mortality. Methods: This retrospective cohort study used two large publicly available datasets: quarterly National Reporting and Learning System reports; and summary hospital-level mortality indicator data. Data from the years 2016 and 2021 were analysed. Correlation and multivariate regression

were used to explore associations between degrees and types of harm reported in patient safety incidents and hospital-level mortality, while accounting for hospital size. Results: No association was found between patient safety incident reporting overall, for any year or at any degree of harm or type of harm, with hospital-level mortality. Further analyses accounting for hospital size or proportions of degrees of harm (low vs severe) also revealed no significant relationships. Conclusions: Although patient safety incident reporting is intended to reduce preventable harm, these findings found no association with hospital-level mortality. This may reflect the complexity of measuring safety outcomes. The pattern of patient safety incident reporting highlights the need for open safety cultures and streamlined reporting for recurrent issues. Implications for practice: Efforts to improve patient safety reporting should focus on improving the quality, consistency and utility of reported data. This includes repeatedly reporting recurrent incidents and developing psychologically safe working environments, with open reporting cultures. There is a need for more standardised national reporting guidance.

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5. **Nurse-Reported Patient Safety Incidents in an Italian Teaching Hospital: A 10-Year Retrospective Study of Trends, Contributory Factors, and Implications for Nursing Practice.**

Authors: Sirago G.;Zotti F.;Comparcini D.;Cicolini G.;Dell'Erba A. and Ferorelli, D.

Publication Date: 2026

Journal: Journal of Clinical Nursing (pagination), pp. Date of Publication: 18 Jun 2026

Abstract: AIMS: To examine 10-year trends in nurse-submitted patient safety incident reports and to identify report characteristics associated with perceived preventability, contributory factors, and harm severity in a large Italian teaching hospital. BACKGROUND: Incident-report counts reflect both reporting behaviour and underlying safety events. Because voluntary systems are subject to under-reporting and reporting-culture effects, they are best interpreted as learning signals rather than direct measures of harm. Nurse-specific longitudinal analyses may clarify profession-specific patterns in reporting-system use and highlight priorities for local safety learning. DESIGN: Retrospective observational study reported following the STROBE guideline.
METHOD(S): We analysed all 216 nurse-submitted incident reports recorded between July 2015 and June 2025 using descriptive statistics, negative binomial regression for annual counts, and logistic and ordinal models. Denominator-adjusted reporting-intensity metrics were calculated for 2020-2024 using ordinary admissions, total hospitalisations, and patient-days. Models were interpreted as exploratory because staffing, workload, case-mix, and independent outcome denominators were unavailable.
RESULT(S): Nurse-submitted reports increased over the period. Aggression and violence (44.0%) and falls (15.7%) were the most frequent categories. Most reports described no harm (48.6%) or mild harm (22.7%). Perceived preventability and system-factor attribution increased over time, and denominator-adjusted reporting intensity also rose between 2020 and 2024, suggesting the increase was not explained only by hospital activity volume; true incident incidence could not be inferred.
CONCLUSION(S): The study demonstrates longitudinal changes in nurse reporting patterns, not direct changes in patient harm. Incident-report analytics can inform local safety learning when interpreted cautiously and triangulated with independent indicators. RELEVANCE TO

CLINICAL PRACTICE: Nurse managers may use feedback loops, safety huddles, and action-tracking to convert reports into learning. Violence and falls prevention emerged as nurse-reported priorities, but interventions should be evaluated prospectively.
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6. **Making What Matters Most Matter: A Quality Improvement Project to Ask What Matters Most to Hospitalized Children.**

Authors: Stanford A.;Errico N.;Selvarajan R.;Conrad N.;Awotunde O.;Bashaw H.;Faisal A.;Haver S.;Nour D.;Weber L.;Carter M. and Port, C.

Publication Date: 2026

Journal: Academic Pediatrics , pp. 103376

Abstract: OBJECTIVE: "What Matters Most" (WMM) refers to the core values, preferences, and priorities of an individual regarding their healthcare experience. Limited data exists on WMM to pediatric patients. The aim of this quality improvement (QI) project was to develop an additional tool for providing patient-centered care (PCC) by increasing the percentage of pediatric hospital medicine (PHM) patient encounters in which patients and/or caregivers were asked WMM from 9% to 75% in 5 months.
METHOD(S): Following engagement of appropriate partners, WMM was assessed for eligible children within the first two days of admission. Using the Model for Improvement, this process was optimized through a series of Plan-Do-Study-Act (PDSA) cycles. Measures included the percentage of patients/caregivers asked WMM during admission (process), patient satisfaction and perception of PCC (outcome), and staff perception on time, impact on care, and satisfaction with the process (balancing).
RESULT(S): The percentage of patients/caregivers asked WMM increased from 9% to 57% over the study period and was sustained at 41% 17 months later. The proportion of patients satisfied increased from a median of 78% to 86%, and 90% (n=18) of sampled caregivers felt that being asked WMM positively impacted their child's care. While 94% (n=31) of providers reported spending <5 minutes on asking WMM, only 56% (n=24) were satisfied with the overall WMM process.
CONCLUSION(S): This project successfully increased WMM elicitation and demonstrated a positive trend in patient satisfaction over the corresponding timeframe with minimal additional perceived time burden by providers.
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7. **Patient and Carer Participation in Reporting Patient Safety Incidents During Hospital Admission: A Scoping Review**

Authors: Sullivan, Rebecca;Ramadan, Tanya;Lee, Shu En and O'Halloran, Robyn

Publication Date: 2026

Journal: Journal of Advanced Nursing

Abstract: Background More than one in 10 patients experience harm in hospital, and patients with communication support needs are at higher risk. Patients and their carers are well-placed to provide insights into patient safety incidents that may result in harm, which is essential to improving patient safety in hospitals. Aim To investigate the methods used to elicit reports of patient safety incidents from patients and their carers, the types of incident reported, and if patients with communication support needs have been included in this research to date. Methods A scoping review. Results Overall, 31 studies described a variety of methods to elicit reports of patient safety incidents from patients and carers across 12 adverse event categories. Surveys and interviews were the most common methods and elicited reports of patient safety incidents across all categories. Most research has occurred in surgical and medical wards. Few studies included patients with communication support needs, and accommodations to support their inclusion were rarely reported. Conclusion Patients and carers can use a variety of methods to report a wide range of patient safety incidents related to hospital care. However, vulnerable patients with communication support needs are not routinely included in the research. Future research should include these patients to better understand ways to improve hospital safety for this population. Implications for the Profession And/or Patient Care This study provides researchers and hospital managers with knowledge about methods used to include hospital patients and their carers in reporting patient safety incidents and identifies at-risk patient populations currently excluded from this research. Impact Surveys and interviews are the most common methods to elicit reports of patient safety incidents. However, the low level of inclusion of patients with communication support needs represents a critical gap in research. Addressing this gap is essential to improving patient safety in hospitals. Reporting Method This review followed the Joanna Briggs Institute (JBI) methodology for scoping reviews and results are reported in accordance with PRISMA-ScR. Patient or Public Contribution This scoping review does not directly involve patients or the general public in its design or execution. However, this study forms a part of a wider body of research by the authors exploring in-hospital patient safety incidents for patients with communication support needs. People with lived experience are advising on this broader program of research.

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8. **Structured, Nurse-Led Post-Discharge Follow-Up Calls to Reduce 30-Day Hospital Readmissions: A Quality Improvement Initiative.**

Authors: Wright, M. R.

Publication Date: 2026

Journal: Worldviews on Evidence-Based Nursing 23(3), pp. e70142

Abstract: BACKGROUND: Thirty-day hospital readmissions remain a persistent challenge, undermining patient safety, disrupting care continuity, and straining healthcare system performance. Ineffective discharge education and weak care transitions leave patients vulnerable after hospitalization. Evidence suggests that structured follow-up calls within 24-72 h can reduce preventable readmissions and strengthen care transitions. AIM: This study aimed to evaluate the effectiveness of structured, nurse-led follow-up telephone calls, guided by the AHRQ RED Toolkit, in reducing 30-day hospital readmissions.
METHOD(S): This study was conducted in a 200-bed urban medical center. It was reviewed and classified as a quality improvement initiative with minimal ethical risk and did not require

informed consent. Over a 12-week implementation period, registered nurses used a standardized script to conduct follow-up calls within 24-72 h of discharge. Calls addressed health status, medication use, follow-up appointments, and home support. Pre- and post-intervention readmission data were collected from the electronic health record. Analysis included descriptive statistics and Chi-square testing.
RESULT(S): Among 287 patients who received standard care, 17% were readmitted within 30 days of discharge. In contrast, only 3.5% of 112 patients who received structured follow-up calls were readmitted, representing an absolute reduction of 13% (chi2 = 12.05, p = 0.0005). Patients also reported improved satisfaction and confidence in managing their care. LINKING EVIDENCE TO ACTION: Structured, nurse-led post-discharge follow-up telephone calls within 24-72 h should be integrated into standard discharge workflows to reduce preventable hospital readmissions. Nursing leadership can leverage this low-cost, scalable intervention to strengthen transitional care, improve patient safety, and support value-based care outcomes across diverse healthcare settings.
CONCLUSION(S): Nurse-led post-discharge follow-up calls significantly reduced 30-day readmissions while enhancing patient safety and care transitions. Findings support incorporating structured follow-up calls into standard discharge planning as a cost-effective, evidence-based intervention for broad implementation.
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