Royal United Hospitals Bath
NHS Foundation Trust

Innovation and Quality Improvement

Current Awareness Bulletin

February 2025

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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: 18th February @ 10am, 18th March @ 11am, 10th April @ 12 noon & 9th May @ 2pm

- **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: 19th February @ 12 noon, 13th March @ 10am, 11th April @ 11am & 12th May @ 12 noon

- **Quickfire health literacy – getting your message across**
  30 minutes. Learn about the communication barriers patients may encounter, and ways to ensure they get the most from their care.
  Next sessions: 17th February @ 11am, 4th March @ 12 noon, 2nd April @ 1pm & 15th May @ 2pm

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

Five principles to prioritise in small-scale surgical quality improvement: a qualitative study of the views of surgical improvement leaders.

Ko CY. *BMJ Open Quality* 2025;14(1):e002917.

This study identifies five principles likely to be useful in guiding better surgical QI in frontline settings. These principles can help inform a structured framework to support small-scale surgical improvement efforts.

Read it online at https://bmjopenquality.bmj.com/content/14/1/e002917

Conceptualising Centres of Clinical Excellence: A Scoping Review.

Kandasamy T. *BMJ Open* 2024;14(12):e082704.

Centres of clinical excellence (CoCE) are healthcare facilities that provide excellent healthcare. However, despite their increasing prevalence, it is unclear how CoCE are identified and monitored. This paper explores how CoCE has been described in the literature.
There are inconsistencies in how CoCE are established, identified, monitored and evaluated. Common (but not uniform) features of CoCE are highly skilled staff, high-quality care delivery and optimal patient outcomes.]

Read it online at https://bmjopen.bmj.com/content/14/12/e082704

Forging a more equitable healthy future through policy and partnership: tackling health inequalities through innovation

Health Innovation Network

Tackling health inequalities remains one of the greatest challenges facing the NHS and the wider health sector today. The Covid-19 pandemic exposed how deeply entrenched these disparities are, underscoring the urgent need for innovative and comprehensive approaches to address them. This report argues that advances in digital technologies, data analytics, workforce development, and community partnerships present a unique opportunity to reshape the health system to serve everyone, irrespective of their circumstances. Drawn from a roundtable discussion held in December 2024, the report captures how culturally competent approaches, data-driven insights, and place-based partnerships can create a new blueprint for equitable health services.

Read the report online at https://thehealthinnovationnetwork.co.uk/wp-content/uploads/2025/01/Report-Tackling-Health-Inequalities-Through-Innovation_Jan25.pdf

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1. **Optimizing and Sustaining Clinical Outcomes in 88 US Hospitals Post-Pandemic: A Quality Improvement Initiative**

Authors: Fakih, Mohamad G.;Daragjati, Florian;Sturm, Lisa K.;Miller, Collin;McKenzie, Betsy;Randall, Kelly;Masoudi, Frederick A.;Moxham, Jamie;Ghosh, Subhangi;Raja, Jyothi Karthik;Bollinger, Allison;Garrett-Ray, Stacy;Chadwick, Maureen;Aloia, Thomas and Fogel, Richard

Publication Date: 2025

Journal: Joint Commission Journal on Quality and Patient Safety 51(2), pp. 86–94

Abstract: Background: Optimizing outcomes of hospitalized patients anchors on standardizing processes in medical management, interventions to reduce the risk of decompensation, and prompt intervention when a patient decompensates.; Methods: A quality improvement initiative (optimized sepsis and respiratory compromise management, reducing health care-associated infection and medication risk, swift management of the deteriorating patient, feedback on performance, and accountability) was implemented in a multistate health system. The primary outcome was risk-adjusted in-hospital mortality. Secondary outcomes included health care-associated infections, patient-days with hypoglycemic and severe hyperglycemic episodes, and hospital onset (HO) acute kidney injury (AKI).; Results: A total of 2,015,408 patients were admitted to 88 hospitals over the 36-month study period. Overall mortality improved from the baseline observed/expected (O/E) of 0.97 in 2021 to 0.74 in 2023 (-23.4%; 4,186 fewer deaths, $p < 0.001$). Controlling for baseline (2021) mortality O/E ratios, the mean mortality O/E ratio for 2023 was 0.74 for system and 0.84 for peers, representing a difference of -0.10 ($p < 0.001$, 95% confidence interval CI] 0.12 - -0.07], with 1,807 fewer deaths). The standardized infection ratio declined for central line-associated blood stream infections by 24.8% (0.58; 88 fewer events), catheter-associated urinary tract infections by 30.6% (0.44; 98 fewer events), HO methicillin-resistant Staphylococcus aureus bacteremia by 29.0% (0.72; 67 fewer events), and HO Clostridioides difficile infection by 35.1% (0.36; 311 fewer events) in 2023 compared to 2021. HO AKI episodes dropped by 6.2% (8.6%; 1,725 fewer events), and patient-days with

hypoglycemia and severe hyperglycemia decreased by 5.8% (4.0%; 4,840 fewer events) and 22.8% (5.2%; 30,065 fewer events), respectively.; Conclusion: This systemwide initiative focusing on standardizing processes, feedback on performance, and accountability was associated with sustainable improvements in mortality and a reduction in infectious and safety events.

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2. **PD225 Implementation Of Hospital-Based Health Technology Assessment For Innovative And Expensive Medical Devices In A French Teaching Hospital**

Author: Guerre, Pascale and Huot, Laure

Publication Date: 2025

Publication Details: International Journal of Technology Assessment in Health Care, 40, pp.S179. Cambridge University Press.

ISSN/ISBN: 0266-4623

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3. **Co-producing a safe mobility and falls informatics platform to drive meaningful quality improvement in the hospital setting: a mixed-methods protocol for the insightFall study**

Authors: Lear, Rachael;Averill, Phoebe;Carenzo, Catalina;Tao, Rachel;Glampson, Ben;Leon-Villapalos, Clare;Latchford, Robert and Mayer, Erik

Publication Date: 2025

Journal: BMJ Open 15(2), pp. e082053

Abstract: Introduction: Manual investigation of falls incidents for quality improvement is time-consuming for clinical staff. Routine care delivery generates a large volume of relevant data in disparate systems, yet these data are seldom integrated and transformed into real-time, actionable insights for frontline staff. This protocol describes the co-design and testing of a safe mobility and falls informatics platform for automated, real-time insights to support the learning response to inpatient falls.; Methods: Underpinned by the learning health system model and human-centred design principles, this mixed-methods study will involve (1) collaboration between healthcare professionals, patients, data scientists and researchers to co-design a safe mobility and falls informatics platform; (2) co-production of natural language processing pipelines and integration with a user interface for automated, near-real-time insights and (3) platform usability testing. Platform features (data taxonomy and insights display) will be co-designed during workshops with lay partners and clinical staff. The data to be included in the informatics platform will be curated from electronic health records and incident reports within an existing secure data environment, with appropriate data access approvals and controls. Exploratory analysis of a preliminary static dataset will examine the variety (structured/unstructured), veracity (accuracy/completeness) and value (clinical utility) of the data. Based on these initial insights and further consultation with lay partners and clinical staff, a final data extraction template will be agreed. Natural language processing pipelines will be co-produced, clinically validated and integrated with QlikView. Prototype testing will be

underpinned by the Technology Acceptance Model, comprising a validated survey and think-aloud interviews to inform platform optimisation.; Ethics and Dissemination: This study protocol was approved by the National Institute for Health Research Imperial Biomedical Research Centre Data Access and Prioritisation Committee (Database: iCARE-Research Data Environment; REC reference: 21/SW/0120). Our dissemination plan includes presenting our findings to the National Falls Prevention Coordination Group, publication in peer-reviewed journals, conference presentations and sharing findings with patient groups most affected by falls in hospital.; Competing Interests: Competing interests: None declared. (© Author(s) (or their employer(s)) 2025. Re-use permitted under CC BY. Published by BMJ Group.)

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4. **Influence of Workplace Bullying and Bystander Types on Speaking Up for Patient Safety Among Hospital Nurses: A Cross-Sectional Study**

Authors: Park, Sunghee;Kim, Kyoungja;Kim, Sinhye and Jones, Cheryl B.

Publication Date: 2025

Journal: Journal of Advanced Nursing

Abstract: Aims: To explore the influences of workplace bullying experiences, witnessing workplace bullying and bystander types on Speaking up for patient safety (SUPS) among hospital nurses.; Design: Cross-sectional study.; Methods: A survey was conducted in September 2021 using a structured questionnaire about workplace bullying experiences, witnessing workplace bullying, bystander types, and SUPS. The questionnaire was administered to 200 bedside nurses from two tertiary university hospitals in South Korea.; Results: One hundred and ninety-nine responses were analysed. A hierarchical regression model, incorporating organisational factors, workplace bullying experiences, witnessing workplace bullying, and bystander types explained approximately 44.0% of the variance in nurses' SUPS. Witnessing workplace bullying and the perpetrator-facilitating bystander negatively influenced SUPS, whereas victim-defending bystander had a positive influence on SUPS.; Conclusions: Findings suggest that witnessing workplace bullying and the bystander types of nurses working on patient care units are more impactful on nurses' SUPS than individual experiences of bullying. Notably, the victim-defending and perpetrator-facilitating bystander types were identified as key factors influencing SUPS.; Implications for the Profession: Nurse managers should understand the roles of witnesses and bystanders working on a patient care unit, and how these roles may extend beyond traditional views of perpetrators and victims. Developing strategies to support and effectively manage witnesses and bystanders working on patient care units may promote positive SUPS behaviours among clinical nurses.; Impact: What problem did the study address? Speaking up for patient safety (SUPS) in clinical settings is critical in maintaining and enhancing patient safety. However, a negative work environment, such as one that promotes workplace bullying may hinder nurses' willingness to engage in SUPS. Because many nurses involved in workplace bullying may be witnesses or bystanders rather than direct perpetrators or victims of such situations, this study explored the potential influences of workplace bullying, including the roles of witnesses and bystanders, on SUPS. What were the main findings? SUPS was influenced more by witnessing workplace bullying and specific bystander types, namely victim-defending and perpetrator-facilitating bystanders, than by workplace bullying experiences. Where and on whom will the research have an impact? These findings highlight the importance of addressing

the roles of witnesses and bystanders in workplace bullying. Nurse managers should broaden their focus beyond perpetrators and victims to include the roles and views of all nursing staff within a department. By effectively managing witnesses and bystander types, they can foster an environment that enhances SUPS behaviours among nurses.; Reporting Method: This study adhered to STROBE guidelines.; Patient or Public Contributions: No Patient or Public Contribution. (© 2025 John Wiley & Sons Ltd.)

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5. **Features and effectiveness of electronic audit and feedback for patient safety and quality of care in hospitals: A systematic review**

Authors: Soresi, James;Bertilone, Christina;Banks, Eileen;Marshall, Theresa;Murray, Kevin and Preen, David B.

Publication Date: Jan ,2025

Journal: Health Informatics Journal 31(1), pp. 1–18

Abstract: Background: Increasing digitisation in healthcare is flowing through to quality improvement strategies, like audit and feedback. Objectives: To systematically review electronic audit and feedback (e-A&F) interventions in hospital settings, examining contemporary practices and quantitatively assessing the relationship between features and effectiveness. Methods: We performed a systematic review using a structured search strategy from 2011 to July 2022. Searches yielded a total of 5095 unique publications, with 152 included in a descriptive synthesis, reporting publication characteristics and practices, and 63 in the quantitative synthesis, to evaluate the effect size of intervention features. Results: The search returned publications across characteristics, including countries of origin, feedback topics, target health professionals, and study design types. We also identified an association with effectiveness for all but one of the features examined, with a Cohen's d ranging from above +0.8 (a large positive effect), to −0.67 (a medium negative effect). Socio-technical features related to supportive organisations and the involvement of engaged health professionals were most associated with effective interventions. Conclusion: Key findings have confirmed that a common set of features of e-A&F systems can influence effectiveness. Results provide practitioners with insight into where resources should be focused during the implementation of e-A&F.

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6. **Understanding the informal aspects of medication processes to maintain patient safety in hospitals: a sociotechnical ethnographic study in paediatric units**

Authors: Sutherland, Adam B.;Phipps, Denham L.;Grant, Suzanne;Hughes, Joanne;Tomlin, Stephen and Ashcroft, Darren M.

Publication Date: 2025

Journal: Ergonomics 68(3), pp. 444–458

Abstract: Adverse drug events (ADEs) are common in hospitals, affecting one in six child in-patients. Medication processes are complex systems. This study aimed to explore the work-as-done of medication safety in three English paediatric units using direct observation and

semi-structured interviews. We found that a combination of the physical environment, traditional work systems and team norms were among the systemic barriers to medicines safety. The layout of wards discouraged teamworking and reinforced professional boundaries. Workspaces were inadequate, and interruptions were uncontrollable. A less experienced workforce undertook prescribing and verification while more experienced nurses undertook administration. Guidelines were inadequate, with actors muddling through together. Formal controls against ADEs included checking (of prescriptions and administration) and barcode administration systems, but these did not integrate into workflows. Families played an important part in the safe administration of medication and provision of information about their children but were isolated from other parts of the system.

Sources Used:

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

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