Royal United Hospitals Bath
NHS Foundation Trust

Innovation and Quality Improvement

Current Awareness Bulletin

September 2026

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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: 29th September @ 2pm and 7th October @ 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: 29th October @ 11am and 6th November @ 12pm

- **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: 13th October @ 3pm and 25th November @ 4pm

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1. **Knowledge and Attitudes Toward Patient Safety Culture Among Nursing Students: Impact of an Interactive Educational Methodology in a Tertiary-level Hospital.**

Authors: CharloBernardos M.;LopezCuartero P.;MonteroMarco J.;AnguasGracia A.;AltarribasBolsa E.;AibarRemon C.;PellejaGuardiola A.M. and HerreroCortina, B.

Publication Date: 2026

Journal: Journal of Patient Safety (pagination), pp. Date of Publication: 11 Se 2026

Abstract: OBJECTIVES: Promoting a culture of patient safety is essential in nursing education to ensure high-quality care and professional accountability. However, the use of practical, interactive approaches, especially during clinical placements, remains underexplored. This study aimed to evaluate the impact of an interactive educational methodology on nursing students' self-reported knowledge and attitudes towards patient safety culture during clinical placements.
METHOD(S): A pre-post quasi-experimental study was conducted among nursing students during clinical placements at a tertiary hospital. The Latino Student Patient Safety Questionnaire was administered before a structured, interactive training program incorporating case-based learning, debates, and gamification, and again after completion of both the training and the 8-week clinical placement. Five dimensions were assessed: openness in communication, proactive attitude toward risk prevention, error awareness, understanding of human factors, and system complexity/interrelationships.
RESULT(S): A total of 543 nursing students participated (84% female; 64% in their final year), of whom 64% completed the follow-up. The baseline mean+/-SD patient safety score was 3.5 (0.4). Proactive attitude and understanding of human factors were rated highest, while error awareness and interdisciplinary relationships scored lowest. No significant change was observed in the overall score (mean difference=0.0; 95% CI: -0.1 to 0.1). Improvements were found in openness in communication (mean difference=0.4; 95% CI: 0.3-0.5) and error awareness (mean difference=0.3; 95% CI: 0.1-0.4).
CONCLUSION(S): Interactive training during clinical placements was associated with limited improvements in self-reported error recognition and openness in communication. Further research is needed to determine whether these effects translate into safer clinical practice.
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2. **Patient safety culture in hospital maternity care: an integrative review of midwives and nurses**

Authors: Hassan, Nor Amal Hazirah;Asnawi, Damia Hazimah;Asri, Amal Amirah;Rahman, Hanif Abdul and Abdul-Mumin, Khadizah

Publication Date: 2026

Journal: British Journal of Midwifery 34(9), pp. 506–518

Abstract: Background/Aims: Safety is a central element of maternity care. Despite global efforts to reduce maternal harm, preventable adverse events can still take place at hospital maternity services. This integrative review consolidates research on midwives' and maternity nurses' perceptions of patient safety culture, identifying key practices, barriers and facilitators in hospital maternity care. Methods: PubMed, Scopus, ProQuest and Google Scholar were searched for studies published between 2014 and 2024 that explored healthcare professionals' experiences with patient safety culture at maternity units. The included studies' findings were analysed and structured according to the seven common patient safety culture dimensions. Results: Nine studies were included. Common assessment tools were the Hospital Survey on Patient Safety Culture, Safety Attitudes Questionnaire and Safety Climate Scale. Teamwork in units was commonly reported as positive. Key challenges included

hierarchical barriers, inadequate managerial support, staff shortages and workload pressures. Conclusions: Midwives perceive teamwork as a strength in patient safety culture, but report systemic gaps in error reporting and leadership support. Implications for practice: Addressing the identified gaps through non-punitive policies, interdisciplinary collaboration and resource allocation could improve safety in maternity care.

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3. **Preventing Hospital-Acquired Pressure Injuries: A Comprehensive Review of Evidence-Based Quality Improvement Initiatives in the Hospital Setting**

Authors: Oliver, Tamara L.;Manning, Olivia and Schoening, Anne

Publication Date: 2026

Journal: Journal of Nursing Care Quality 41(4), pp. 314–320

Abstract: Background Hospital-acquired pressure injuries (HAPIs) remain a costly yet preventable threat to patient safety and quality of care. Evidence-based prevention strategies are essential to reduce incidence and support institutional goals. Objective The purpose of this review was to synthesize evidence-based quality improvement interventions to prevent nondevice-related HAPIs in US hospital settings. Methods Using the Whittemore and Knafl integrative review framework, a systematic search of 4 databases identified studies published between 2015 and 2023. Of 178 records screened, 10 studies met the inclusion criteria. Methodological quality was appraised using the Quality Improvement Minimum Quality Criteria Set. Results Interventions were clustered into 4 categories: turn teams, documentation enhancements, protocol strategies, and interdisciplinary collaborations. Conclusion HAPI prevention requires coordinated, system-level, interprofessional interventions with engaged leadership, and future research should emphasize sustainability, scalability, and fidelity using standardized quality improvement reporting frameworks.

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4. **Effectiveness and Safety of Continuous Quality Improvement and Failure Mode and Effect Analysis for Preventing Adverse Events in Hospitalized Patients: A Systematic Review of Complex Interventions**

Authors: Villate-Soto, Steffany;Muñoz-Loaiza, Juan,D.;Gaitán-Duarte, Hernando;Durán-Mejía, Daniela and Tariba-Forero, Sonia

Publication Date: 2026

Journal: Journal of Patient Safety 22(5), pp. e99–e116

Abstract: Background This study aimed to assess the effectiveness and safety of continuous quality improvement (CQI) and failure mode and effect analysis (FMEA) in preventing adverse events (AEs) in hospitalized patients. Methods This systematic review included randomized controlled trials, quasiexperiments, and time-series studies that used CQI or FMEA in hospital processes and evaluated AEs. Studies published in English, Portuguese, and Spanish from September 2010 to September 2024 were searched in the MEDLINE/PubMed, Embase/Elsevier, CENTRAL, and LILACS databases. Two authors independently applied the study selection criteria and extracted data on methodology, patient population, and the effect

of CQI or FMEA on AEs. We evaluated the risk of bias for before and after (B&A) studies with a control group and time-series studies, critically appraised the quality of B&A studies without a control group, determined causal inference strength for quasiexperiments, and reported quality for CQI studies. Moreover, we presented a narrative synthesis of results along with an assessment of evidence certainty determined using the GRADE approach. The register code at PROSPERO is CRD42021254216. Results Of the 20,433 titles, 107 were subjected to full-text review, and 59 studies were analyzed. Forty-nine studies (83%) used CQI, whereas 10 used FMEA. The most studied category was related to catheters. Although the analyzed studies predominantly reported a reduction in AEs, evidence certainty was very low for 93% of the intervened processes. Conclusions CQI and FMEA studies revealed a potential reduction of AEs in various processes. However, these results should be cautiously applied to clinical practice due to very low evidence certainty. Moreover, further research with improved control of confounding factors is needed.

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5. **Managing integration and disintegration: performance conditions of patient and public involvement to hospitals quality improvement**

Authors: Voz, Bernard;Pétré, Benoît and Orianne, Jean-François

Publication Date: 2026

Journal: Journal of Health Organization & Management 40(9), pp. 228–242

Sources Used:

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

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