Quality Improvement Update: January 2019, Issue 1

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Quality Improvement for Managers and Senior Executives

Articles

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Freely available online

A systematic mixed studies review on Organizational Participatory Research: towards operational guidance.
Bush PL. *BMC Health Services Research* 2018;18(1):992.
Organizational Participatory Research (OPR) seeks organizational learning and/or practice improvement. Previous systematic literature reviews described some OPR processes and outcomes, but the link between these processes and outcomes is unknown. We sought to identify and sequence the key processes of OPR taking place with and within healthcare organizations and the main outcomes to which they contribute, and to define ideal-types of OPR.
Freely available online

Developing a hospital-wide quality and safety dashboard: a qualitative research study.
Weggelaar-Jansen AMJWM. *BMJ Quality & Safety* 2018;27(12):1000-1007.
Conclusion: The literature on dashboards addresses the technical and content aspects of dashboards, but overlooks the organisational development process. This study shows how technical and organisational aspects are relevant in development processes.
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Effects of a multifaceted medication reconciliation quality improvement intervention on patient safety: final results of the MARQUIS study
Schnipper JL. *BMJ Quality & Safety* 2018;27(12):954-964.
Conclusions: Mentored implementation of a multifaceted medication reconciliation quality improvement (QI) initiative was associated with a reduction in total, but not potentially harmful, medication discrepancies. The effect of electronic health record (EHR) implementation on medication discrepancies warrants further study.
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Investigating the association of alerts from a national mortality surveillance system with subsequent hospital mortality in England: an interrupted time series analysis
Cecil E. *BMJ Quality & Safety* 2018;27(12):965-973.
Conclusions: Our results suggest an association between an alert notification and a reduction in the risk of mortality, although with less lag time than expected. It is difficult to determine any causal association. A proportion of alerts may be triggered by random variation alone and subsequent falls could simply reflect regression to the mean...
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Medication reconciliation: ineffective or hard to implement? Editorial
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...The challenges of implementing medication reconciliation in the MARQUIS study resonate with other published implementation reports.7–9 Despite these challenges, there were some encouraging signals. Of the four sites that implemented interventions, three observed reductions in potentially harmful discrepancies, consistent with many prior studies of medication reconciliation...
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Mortality alerts, actions taken and declining mortality: true effect or regression to the mean? Editorial
Marang-van de Mheen PJ. *BMJ Quality & Safety* 2018;27(12):950-953.
...After the Bristol inquiry in 2001 in the UK, research showed that given the available data Bristol could have been detected as an outlier and that it was not simply a matter of the low volume of cases.2 3 Had the cumulative excess mortality been monitored using these routinely collected data, then an alarm could have given for Bristol after the publication of the 1991 Cardiac Surgical Register and could have saved children's lives...
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National hospital mortality surveillance system: a descriptive analysis.
Cecil E. *BMJ Quality & Safety* 2018;27(12):965 - 973.
Conclusion: The mortality surveillance system has generated a large number of alerts since 2007. Quality of care problems were found in 69% of alerts with CQC investigations, and one in four trusts reported that failings in care may have an impact on patient outcomes. Identifying whether mortality alerts are the most efficient means to highlight areas of substandard care will require further investigation.
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Quality and safety of in-hospital care for acute medical patients at weekends: a qualitative study.
Sutton E. *BMC Health Services Research* 2018;18(1):1015.
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Poor health literacy is associated with greater decision conflict in patients undergoing elective surgical procedures. Strategies should be implemented to minimize decision conflict in poor health literacy patients undergoing elective surgical procedures.
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Transforming concepts in patient safety: a progress report. Narrative Review
Gandhi TK. *BMJ Quality & Safety* 2018;27(12):1019-1026.
Conclusion: The five transforming concepts were meant to highlight important gaps in safety and to serve as new directions to accelerate progress in patient safety. These concepts are overlapping and synergistic, with common themes including the need for leaders who can build a safety culture to create the right environment to advance these concepts, for clear and meaningful measurement, and for research to advance understanding and improvement capability in these areas.
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Transitional care interventions reduce unplanned hospital readmissions in high-risk older adults.
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This study aims to evaluate the comparative effectiveness of transitional care interventions on unplanned hospital readmissions within 28 days, 12 weeks and 24 weeks following hospital discharge. Multifaceted transitional care interventions across hospital and community settings are beneficial, with lower hospital readmission rates observed in those receiving more transitional intervention components, although only in first 12 weeks.
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Reports

Blueprint for Complex Care.
Institute for Healthcare Improvement; 2018.
http://www.ihi.org/resources/Pages/Publications/Blueprint-for-Complex-Care.aspx
Across the US, pioneering health care organizations are testing promising new models of care for individuals with complex medical, behavioral, and social needs. Many of these activities occur in isolation, however, with little opportunity for innovators to learn from each other and advance best practices collectively. The Blueprint provides a strategic plan to support these innovations and accelerate opportunities to improve care for individuals with complex health and social needs.
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Chief Medical Officer annual report 2018: better health within reach
Department of Health and Social Care; 2018.
https://www.gov.uk/government/publications/chief-medical-officer-annual-report-2018-better-health-within-reach
Professor Dame Sally Davies's report is independent of government and is aimed at government, regulators and healthcare professionals. The report says that there are reasons to be optimistic but greater effort to improve the health environment is required – it should be easier to take the healthy option. There are 4 sections: health as the nation's primary asset; the health environment; using emerging technologies to improve health; effective planning for the future.

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NHS Improvement; 2018.
https://engage.improvement.nhs.uk/policy-strategy-and-delivery-management/patient-safety-strategy/
This consultation outlines NHS-wide proposals to ensure improved patient safety. The proposals include a commitment for some of the most important types of avoidable harm to patients to be halved over the next five years in areas such as medication errors and never events, alongside developing a 'just culture' for the NHS where frontline staff are supported to speak up when errors occur. The consultation is open for responses until 15 February 2019.
Freely available online

Emergency readmissions: What's changed one year on?
Healthwatch; 2018.
https://www.healthwatch.co.uk/report/2018-11-14/emergency-readmissions-whats-changed-one-year
New research indicates spike in emergency readmissions to hospital over the last year. Our report calls on NHS to fix the data gaps to help understand why.
Freely available online

Framework for Effective Board Governance of Health System Quality.
Institute for Healthcare Improvement; 2018.
http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Effective-Board-Governance-Health-System-Quality.aspx
The IHI Lucian Leape Institute's research scan on board governance of health system quality, evaluation of governance education in quality, and expert interviews made it clear that board members, and those who support them, desire a clear and consistent framework to guide governance of all dimensions of quality beyond safety, including identification of the core processes and necessary activities for effective governance of quality.
Freely available online

NICE recommendations: charging and appeal panels
Department of Health and Social Care; 2018.
https://www.gov.uk/government/consultations/nice-recommendations-charging-and-appeal-panels
The Government consulted on proposed changes to legislation to allow the National Institute for Health and Care Excellence (NICE) to charge companies for making technology appraisal and highly specialised technology recommendations relating to their products. They also consulted on changes to the regulations to allow NICE to recruit appeal panel members from the healthcare system in the UK. The consultation response has been published.
Freely available online

Opening the door to change: NHS safety culture and the need for transformation.
Care Quality Commission (CQC); 2018.
https://www.cqc.org.uk/publications/themed-work/opening-door-change
The report found that too many people are being injured or suffering unnecessary harm because NHS staff are not supported by sufficient training, and because the complexity of the current patient safety system makes it difficult for staff to ensure that safety is an integral part of everything they do.

Freely available online

Snowed under? Understanding the effects of winter on the NHS.
Nuffield Trust; 2018.
https://www.nuffieldtrust.org.uk/resource/snowed-under-understanding-the-effects-of-winter-on-the-nhs
The decline in performance over winter is a long-term trend, and the same pressures exist in the system this year as in previous years. There has been no real let-up in underlying workforce challenges, and demographic trends have continued. Services are supporting a higher proportion of older, frailer patients with long-term conditions, and improved survival of patients from earlier emergency admissions is estimated to account for around a third of the increases in emergency admissions.
Freely available online

Staff engagement and its relationship to patient outcomes: common themes.
NHS Employers; 2018.
https://www.nhsemployers.org/case-studies-and-resources/2018/11/staff-engagement-links-to-patient-experience-common-themes
This document, written by the Institute for Employment Studies (IES), pulls together common themes found in four case studies focusing on staff engagement actions at high performing trusts in the north east of England.
Freely available online

Ways of integrating care that better coordinate services may benefit patients.
NIHR Dissemination Centre; 2018.
https://discover.dc.nihr.ac.uk/content/signal-000693/integrating-care-to-coordinate-services-better-may-benefit-patients
NIHR Signal. This NIHR-funded review looked at the international literature to understand how new care models may affect patients, providers and systems. New integrated care models can increase patient satisfaction, perceived quality of care and improve access to services. It is less clear whether there may be effects on hospital admissions, appointments or healthcare costs. Strong leadership and patient engagement are among factors influencing successful implementation.
Freely available online

Winter is coming: Confidence in the NHS's ability to deliver safe care this winter.
NHS Confederation; 2018.
https://www.nhsconfed.org/resources/2018/12/winter-is-coming
NHS Confederation sent out a short survey to Accident and Emergency Board chairs, drawn largely from acute trusts and CCGs, as well as Ambulance Trust chief executives between November and December. Respondents were asked how confident they were in their local NHS's ability to deliver safe care this winter. In total, more than a third (35%) of all respondents were either not very confident (29.6%) or not at all confident (5%) in the ability of their local NHS to deliver safe care this winter.
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Websites and E-Learning

Learning from Deaths e-learning programme
https://www.e-lfh.org.uk/programmes/learning-from-deaths

The national "Learning from Deaths" framework has led to a requirement for training in mortality governance, handling investigations, and embedding safety culture. This e-learning programme, developed by Health Education England, helps organisations enable a change in culture whereby all learning opportunities are taken. It covers: culture and learning from deaths; engaging with families and carers; case record investigations; Trust Boards and the role of Non-Executive Directors.
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Freely available online

Advancing practice in dietitians' communication and nutrition counselling skills: a workplace education program.
Notaras S. *Journal of Human Nutrition and Dietetics* 2018;31(6):725-733.
To our knowledge, this is the first dietitian-specific workplace education program of its type to address essential skills for better communication with patients. Ongoing workplace support, such as peer observation, is recommended to assist with skill development and sustainability
Available within the Royal Free Hospital Library using an Explore Access Point or by emailing cees@ucl.ac.uk.

Models of Peer Support to Remediate Post-Intensive Care Syndrome: A Report Developed by the Society of Critical Care Medicine Thrive International Peer Support Collaborative.
McPeake J. *Critical Care Medicine* 2019;47(1):e21-e27.
Patients and caregivers can experience a range of physical, psychologic, and cognitive problems following critical care discharge. The use of peer support has been proposed as an innovative support mechanism.
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Previous studies have looked at National Early Warning Score performance in predicting in-hospital deterioration and death, but data are lacking with respect to patient outcomes following implementation of National Early Warning Score. We sought to determine the effectiveness of National Early Warning Score implementation on predicting and preventing patient deterioration in a clinical setting.
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Freely available online

Comparative performance reports in anaesthesia: impact on clinical outcomes and acceptability to clinicians.
Collyer T. *BMJ Open Quality* 2018;7(3):doi.org/10.1136/bmjoq-2018-000338.
Since April 2010 postoperative data have been analysed and individual comparative performance reports distributed to anaesthetists. Data analysis showed that there have been significant improvements in the odds of all outcomes (including unexpected admissions) other than vomiting. A survey found that the process was acceptable with 100% of consultant respondents agreeing that performance reports prompted reflective practice and that this process had the potential to improve patient care.
Freely available online

Developing tools to enhance the use of systematic reviews for clinical care in health systems.

Morrow A S. *Evidence-Based Medicine* 2018;23(6):206-9.
The uptake of evidence summaries by health systems can be enhanced by developing tools that provide contextual and implementation information. A dual approach addressing health system representatives as well as clinicians and patients is likely feasible and helpful.
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Do ward round stickers improve surgical ward round? A quality improvement project in a high-volume general surgery department.
Ng J. *BMJ Open Quality* 2018;7(3):doi.org/10.1136/bmjoq-2018-000341.
We designed and implemented user-friendly, clear ward round stickers as an adjunct to surgical ward rounds to evidence standardised care. Baseline performance showed that recording of the checking of drug chart, intravenous fluid chart, analgesia, antiemetic, enoxaparin, thromboembolic deterrents ranged from 0% to 6%. With the introduction of ward round stickers there was noticeable improvement from baseline in all items.
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Risk Factors for 1-Year Mortality and Hospital Utilization Patterns in Critical Care Survivors: A Retrospective, Observational, Population-Based Data Linkage Study.
Szakmany T. *Critical Care Medicine* 2019;47(1):15-22.
Clear understanding of the long-term consequences of critical care survivorship is essential. We investigated the care process and individual factors associated with long-term mortality among ICU survivors and explored hospital use in this group.
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Foundation e-learning programme: Professional Capability: 18 - Patient Safety
https://www.e-lfh.org.uk/programmes/foundation-programme
The Foundation e-learning programme has been developed by the Academy of Medical Royal Colleges in partnership with HEE e-LfH and is approved by UKFPO. This module is about safe practice and what to do when things go wrong.
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Foundation e-learning programme: Professional Capability: 20 - Contributes to quality improvement
https://www.e-lfh.org.uk/programmes/foundation-programme
The Foundation e-learning programme has been developed by the Academy of Medical Royal Colleges in partnership with HEE e-LfH and is approved by UKFPO. This module is about audit and evidence based practice. It outlines the study designs used in medical practice. You are provided with a guide to developing a structured research strategy which will help you find journal articles relevant to your clinical questions.
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Conclusions: Mentored implementation of a multifaceted medication reconciliation quality improvement (QI) initiative was associated with a reduction in total, but not potentially harmful, medication discrepancies. The effect of electronic health record (EHR) implementation on medication discrepancies warrants further study.
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Medication reconciliation: ineffective or hard to implement? Editorial
Cecil E. *BMJ Quality & Safety* 2018;27(12):965-973.
...The challenges of implementing medication reconciliation in the MARQUIS study resonate with other published implementation reports.7–9 Despite these challenges, there were some encouraging signals. Of the four sites that implemented interventions, three observed reductions in potentially harmful discrepancies, consistent with many prior studies of medication reconciliation...
Available with an NHS OpenAthens password

Reports

Developing a patient safety strategy for the NHS.
NHS Improvement; 2018.
https://engage.improvement.nhs.uk/policy-strategy-and-delivery-management/patient-safety-strategy/
This consultation outlines NHS-wide proposals to ensure improved patient safety. The proposals include a commitment for some of the most important types of avoidable harm to patients to be halved over the next five years in areas such as medication errors and never events, alongside developing a 'just culture' for the NHS where frontline staff are supported to speak up when errors occur. The consultation is open for responses until 15 February 2019.
Freely available online

Websites and E-Learning

Learning from Deaths e-learning programme
https://www.e-lfh.org.uk/programmes/learning-from-deaths
The national "Learning from Deaths" framework has led to a requirement for training in mortality governance, handling investigations, and embedding safety culture. This e-learning programme, developed by Health Education England, helps organisations enable a change in culture whereby all learning opportunities are taken. It covers: culture and learning from deaths; engaging with families and carers; case record investigations; Trust Boards and the role of Non-Executive Directors.
Freely available online