Quality Improvement Bulletin
Number 20, 10th February 2020

Produced by Milton Keynes University Hospital Library

This bulletin collates information from key resources relating to quality improvement published 1st – 31st January 2020. Brief descriptions of subject content are derived from the published abstract or web page to which hyperlinks are provided. In addition to articles published in BMJ Quality & Safety and BMJ Open Quality, journal articles reporting QI studies, QI methods or clinical audit to drive quality improvement with one or more authors affiliated to a UK/NHS organisation are included. These are presented to assist in the aim of continuously improving the quality of care and outcomes for patients; and are arranged under the categories shown below. Click the category name to go directly to that section.

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General

QI Methods / Tools

Clinical audits
HQIP (Health Quality Improvement Partnership) audit reports and clinical audits reported in journal articles are listed by specialty.

NHS Improvement
Making data count
‘Making data count – getting started’ updated
https://improvement.nhs.uk/resources/making-data-count/

Statistical process control (SPC) tool updated
https://improvement.nhs.uk/resources/statistical-process-control-tool/

Structured query language (SQL) for statistical process control: SQL XmR test template

Journal articles

Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics.
https://dx.doi.org/10.1002/lrh2.10209
Learning health systems (LHS) use digital health and care data to improve care, shorten the timeframe of improvement projects, and ensure these are based on real-world data. This paper examines what would be needed to develop LHS in the United Kingdom, considering national policy implications and actions, which local organisations and health systems could take.

A modified Delphi study to identify the features of high quality measurement plans for healthcare improvement projects.
Woodcock, Thomas. BMC medical research methodology, January 14, 2020, 20(1):8
https://dx.doi.org/10.1186/s12874-019-0886-6
This study offers a consensus-based view on the features of a good measurement plan for a QI project in healthcare. There was consensus in five categories of measurement relating to: design, data collection and management, analysis, action, and embedding.

Novel quality improvement method to reduce cost while improving the quality of patient care: retrospective observational study.
Mate, Kedar S. BMJ Quality & Safety, January 23, 2020,
https://dx.doi.org/10.1136/bmjqs-2019-009825
We developed a technical method to assist health systems to reduce operating costs, called continuous value management (CVM). Derived from lean accounting and employing quality improvement (QI) methods, the approach allows for management to reduce or repurpose resources to improve efficiency. The primary outcome measure was the cost per patient admitted to the ward in British pounds (£). CVM methods reduced the cost of care while improving quality. Most of the reduction came by way of reduced bank nursing spend. Work is under way to further test CVM and understand leadership behaviours supporting scale-up.

Use and reporting of experience-based codesign studies in the healthcare setting: a systematic review.
Green, Theresa. BMJ Quality & Safety, January 2020, 29(1):64-76
Experience-based codesign (EBCD) is an approach to health service design that engages patients and healthcare staff in partnership to develop and improve health services or pathways of care. The aim of this systematic review was to examine the use (structure, process and outcomes) and reporting of EBCD in health service improvement activities.

IHI White Paper

Improving Behavioral Health Care in the Emergency Department and Upstream
The paper includes:
- A framework for a better system of care that comprises four key components: Processes, Provider Culture, Patients, and Partnerships
- High-leverage changes and specific change ideas
- Suggested measures
- Practical tips and examples
- Resources and tools


IHI Blog posts

Having Trouble Holding the Gains? Plan for Sustainability
Blog post by Lauren H. Macy (IHI Improvement Advisor)| January 24, 2020

Root Cause Analysis Won’t Work If People Fear It
Blog post by Richard Guthrie| January 16, 2020

Using a System-Wide Approach to Improve Maternal Health
Blog post by Emma Robinson| January 8, 2020

Why a Cookie-Cutter Approach Won’t Work to Improve Patient Flow
Blog post by Karen Murrell| January 9, 2020

Why Improvement Needs Nurturing
Blog post by Kathy Duncan | January 10, 2020
http://www.ihi.org/communities/blogs/why-improvement-needs-nurturing

NHS Improvement

Delayed transfer of care (DTOC) improvement tool (Updated version)
https://improvement.nhs.uk/resources/delayed-transfer-care-dtoc-improvement-tool/

Demand and capacity core model (latest versions (v2.11) of the populated and blank core models)
https://improvement.nhs.uk/resources/demand-and-capacity-core-model/

Introducing criteria-led discharge in an acute medical unit
A case study detailing how criteria-led discharge (CLD) was introduced on an acute medical unit at Tameside General Hospital resulting in increased weekend discharge rates.

Impact of a national quality improvement programme for hospital wards is unclear

This NIHR Signal provides a commentary on the results of a study which investigated ‘The Productive Ward: Releasing time to care™’ quality improvement programme developed by the NHS Institute for Innovation and Improvement (NHSI) and introduced in 2007.

The case for building a Quality Management System (QMS)

QI as one of three elements in a QMS; the other two being Quality Planning and Quality Control

My Improvement Journey: Katja Behrendt

The power of feedback

The start of a conversation: a new framework for improvement in England

Emotionally evocative patients in the emergency department: a mixed methods investigation of providers' reported emotions and implications for patient safety.

Positive and negative emotions can influence clinical decision-making and impact patient safety. Findings underscore the need for (1) education and training initiatives to promote awareness of emotional influences and to consider strategies for managing these influences, and (2) a comprehensive research agenda to facilitate discovery of evidence-based interventions to mitigate emotion-induced patient safety risks.

A process for supporting children's nurses after medication errors.

This article reports on a quality improvement project aimed at improving the process of supporting nurses after medication-related incidents have occurred on a paediatric intensive care unit.
What do emergency department physicians and nurses feel? A qualitative study of emotions, triggers, regulation strategies, and effects on patient care.
Isbell, Linda M. *BMJ Quality & Safety*, January 15, 2020,
[https://dx.doi.org/10.1136/bmjqs-2019-010179](https://dx.doi.org/10.1136/bmjqs-2019-010179)
The role of emotions in patient safety is in its early stages and many opportunities exist for researchers, educators, and clinicians to further address this important issue. Our findings highlight the need for future work to (1) determine whether providers' emotion regulation strategies are effective at mitigating patient safety risk, (2) incorporate emotional intelligence training into healthcare education, and (3) shift the cultural norms in medicine to support meaningful discourse around emotions.

**Hospital teams / communication**

Does team reflexivity impact teamwork and communication in interprofessional hospital-based healthcare teams? A systematic review and narrative synthesis.
McHugh, Siobhan Kathleen. *BMJ Quality & Safety*, January 7, 2020,
[https://dx.doi.org/10.1136/bmjqs-2019-009921](https://dx.doi.org/10.1136/bmjqs-2019-009921)
To systematically review articles that describe the use of team reflexivity in interprofessional hospital-based healthcare teams. ... The reviewed literature suggests that VRE [video-reflexive ethnography] is well placed to provide more locally appropriate solutions to contributory patient safety factors, ranging from individual and social learning to improvements in practices and systems.

Ensuring successful implementation of communication-and-resolution programmes.
Mello, Michelle M. *BMJ Quality & Safety*, January 20, 2020,
[https://dx.doi.org/10.1136/bmjqs-2019-010296](https://dx.doi.org/10.1136/bmjqs-2019-010296)
Communication-and-resolution programmes (CRP) aim to increase transparency surrounding adverse events, improve patient safety and promote reconciliation by proactively meeting injured patients’ needs. ... Although not necessarily causal, several distinctive factors appear to be associated with successful CRP implementation.

**Patient Safety / Patient Experience**

Association of open communication and the emotional and behavioural impact of medical error on patients and families: state-wide cross-sectional survey.
Prentice, Julia C. *BMJ Quality & Safety*, January 20, 2020,
[https://dx.doi.org/10.1136/bmjqs-2019-010367](https://dx.doi.org/10.1136/bmjqs-2019-010367)
Negative emotional impacts from medical error can persist for years. Open communication is associated with reduced emotional impacts and decreased avoidance of doctors/facilities involved in the error. Communication and resolution programmes could facilitate transparent conversations and reduce some of the negative impacts of medical error.

**Other**

Academy of Medical Sciences
Transforming health through innovation: Integrating the NHS and academia
[https://acmedsci.ac.uk/file-download/23932583](https://acmedsci.ac.uk/file-download/23932583)
Quality improvement through research

**Journal articles**

Association of registered nurse and nursing support staffing with inpatient hospital mortality.
https://dx.doi.org/10.1136/bmjqs-2018-009219

The association of nursing staffing with patient outcomes has primarily been studied by comparing high to low staffed hospitals, raising concern other factors may account for observed differences. We examine the association of inpatient mortality with patients' cumulative exposure to shifts with low registered nurse (RN) staffing, low nursing support staffing and high patient turnover.

Approach to making the availability heuristic less available.
Redelmeier, Donald A. *BMJ Quality & Safety*, January 20, 2020,
https://dx.doi.org/10.1136/bmjqs-2020-010831

Best evidence, but does it really change practice?
de Steiger, Richard N. *BMJ Quality & Safety*, January 6, 2020,
https://dx.doi.org/10.1136/bmjqs-2019-010513

Editorial

Design of a state of the art reporting system and process improvement for reporting of high complexity single antigen bead data for transplant patients to the electronic medical record.
Geer, Lupita I. *BMJ Open Quality* 2020;9:e000813
https://dx.doi.org/10.1136/bmjqs-2019-000813

The study demonstrates that high complexity SAB bead data can be efficiently reported EPIC:CareConnect from HistoTrac as discrete data.

Exploring the sustainability of quality improvement interventions in healthcare organisations: a multiple methods study of the 10-year impact of the 'Productive Ward: Releasing Time to Care' programme in English acute hospitals.
https://dx.doi.org/10.1136/bmjqs-2019-009457

As an ongoing QI approach Productive Ward has not been sustained but has informed contemporary organisational QI practices and strategies. Judgements about the long-term sustainability of QI interventions should consider the evolutionary and adaptive nature of change processes.

The harms of promoting 'Zero Harm'.
Thomas, Eric J. *BMJ Quality & Safety*, January 2020, 29(1):4-6
https://dx.doi.org/10.1136/bmjqs-2019-009703

Editorial

'Immunising' physicians against availability bias in diagnostic reasoning: a randomised controlled experiment.
Mamede, Silvia. *BMJ Quality & Safety*, January 27, 2020,
https://dx.doi.org/10.1136/bmjqs-2019-010079

An intervention directed at increasing knowledge of clinical findings that discriminate between similar-looking diseases decreased physicians' susceptibility to availability bias, reducing diagnostic errors, in a simulated setting. Future research needs to examine the degree to which the intervention benefits other disease clusters and performance in clinical practice.

Impact of emergency care centralisation on mortality and efficiency: a retrospective service evaluation.
Price, Christopher. *Emergency medicine journal : EMJ*, January 7, 2020,
https://dx.doi.org/10.1136/emermed-2019-208539

A centralised site providing early specialist care was associated with improved short-term outcomes and efficiency relative to lower volume ED admitting to MAU, particularly for older patients.

Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics.
https://dx.doi.org/10.1002/lrh2.10209

Learning health systems (LHS) use digital health and care data to improve care, shorten the timeframe of
improvement projects, and ensure these are based on real-world data. This paper examines what would be needed to develop LHS in the United Kingdom, considering national policy implications and actions, which local organisations and health systems could take.

Managing risk in hazardous conditions: improvisation is not enough.
https://dx.doi.org/10.1136/bmjqs-2019-009443

Viewpoint

Nurses matter: more evidence.
https://dx.doi.org/10.1136/bmjqs-2019-009732

Editorial

Quality and safety in the literature: January 2020.
https://dx.doi.org/10.1136/bmjqs-2019-010547

Realising the potential of health information technology to enhance medication safety.
https://dx.doi.org/10.1136/bmjqs-2019-010018

Editorial

Time series evaluation of improvement interventions to reduce alarm notifications in a paediatric hospital.
Pater, Colleen M. BMJ Quality & Safety, January 20, 2020,
https://dx.doi.org/10.1136/bmjqs-2019-010368

We used quality improvement (QI) methods to safely decrease non-actionable alarm notifications to bedside providers. ... Plan-Do-Study-Act testing cycles included updating notification technology, establishing alarm logic and modifying bedside workflow processes, including silencing the volume on all bedside monitors.

Specialties

Here we highlight specialty specific publications and journal articles reporting QI studies, QI methods or clinical audit to drive quality improvement. These articles, with one or more authors affiliated to a UK/NHS organisation, have been published recently in journals which are not featured regularly in this bulletin. Please contact the Library for help with accessing the full-text of the articles or to request a literature search in your specialism.

Anaesthetics

Complications related to peri-operative transoesophageal echocardiography - a one-year prospective national audit by the Association of Cardiothoracic Anaesthesia and Critical Care.
https://dx.doi.org/10.1111/anae.14734

Most complications occurred in patients without known risk factors for transoesophageal echocardiography associated gastro-oesophageal injury. We suggest clinicians and departments review their procedural guidelines, especially in relation to probe insertion techniques, together with the information communicated to patients when the risks and benefits of such examinations are discussed.

Preoperative fasting and prevention of pulmonary aspiration in adults: research feast, quality improvement famine.
Hewson, David W. British journal of anaesthesia, January 21, 2020,
https://dx.doi.org/10.1016/j.bja.2019.12.018
Harm-reducing efficacy of long-standing anaesthetic practices to prevent pulmonary aspiration of gastric contents.

Cardiology

The Myocardial Ischaemia National Audit Project (MINAP).
https://dx.doi.org/10.1093/ehjqcco/qcz052
MINAP is the largest single healthcare system heart attack registry, and includes data from hospitalizations with T1 MI in England, Wales, and Northern Ireland. It includes high-resolution data across the patient pathway and is a powerful tool for quality improvement and research.

Dermatology

British Association of Dermatologists (BAD) National Audit on Non-Melanoma Skin Cancer Excision 2016 in collaboration with the Royal College of Pathologists.
https://dx.doi.org/10.1111/ced.14034
Diagnostic accuracy and complete excision rates remain high. Complication rates may be under-reported owing to lack of follow-up. Histopathology reporting has a greater chance of being complete if reports are generated on a field-based platform (synoptic reporting).

ENT

Epistaxis and atorvastatin: is there an association and are clinicians aware? A retrospective audit of 100 patients.
https://dx.doi.org/10.1017/S0141525519002884
A retrospective analysis over 10 months identified 100 individuals who presented to hospital with epistaxis. A questionnaire of 24 ENT registrars was undertaken.

Gastroenterology

HQIP
Acute Bowel Obstruction Report

Journal articles

Ultrasound-Guided Subcostal TAP Block with Depot Steroids in the Management of Chronic Abdominal Pain Secondary to Chronic Pancreatitis: A Three-Year Prospective Audit in 54 Patients.
https://dx.doi.org/10.1093/pm/pnz236
Subcostal transversus abdominis plane block may be an option in the management of abdominal myofascial pain syndrome secondary to chronic pancreatitis. The block is ineffective in producing clinically significant pain relief in
the presence of ongoing pancreatic inflammation.

**Haematology**

**Implementation and Evaluation of a Standardized Non-Vitamin K Oral Anticoagulant (NOAC) Patient Safety Alert Card Across the Northern Region of England.**


https://dx.doi.org/10.1177/2150132719894758

A simple and inexpensive intervention delivered with no formal funding can address this patient safety concern. We have engaged with Clinical Commissioning Groups and secondary care trusts in the region to ensure the legacy of the project. In response to requests from other regions and organizations, the card has been widely shared and implemented across many areas of the United Kingdom.

**Improving preoperative haemoglobin using a quality improvement approach to treat iron deficiency anaemia.**

Sinclair, Rhona Cf. *BMJ open quality*, January 2020, 9(1)

https://dx.doi.org/10.1136/bmjoq-2019-000776

Optimising preoperative haemoglobin (Hb) before elective surgery is recommended by the National Institute of Clinical Excellence. We have used a quality improvement (QI) approach to treat iron deficiency anaemia in patients presenting to the preoperative assessment clinic (PAC) before major elective oesophagogastric surgery. Through a series of three QI cycles, we have treated iron deficiency, improved preoperative haemoglobin (Hb) and reduced the rate of postoperative blood transfusion.

**Quality improvement in vascular access: The role of patient-reported outcome measures.**


https://dx.doi.org/10.1177/1129729819845624

Quality improvement initiatives should be aimed to enhance clinical outcomes, service delivery and quality of life for patients. For patients reliant on haemodialysis, vascular access is a lifeline ... To facilitate the implementation of quality improvement programmes specifically for vascular access requires suitable tools. While existing patient-reported outcome measures may be applicable to vascular access, it is likely that these will require further evaluation, and the development of vascular access-specific patient-reported outcome measures may be required.

**Mental Health**

**HQIP**

National Clinical Audit of Anxiety and Depression: Psychological Therapies Spotlight Report 2019


**NHS England**

National Quality Improvement Taskforce for children and young people’s mental health inpatient services


Taskforce Charter: National Quality Improvement Taskforce for children and young people’s mental health inpatient services

Journal articles

Implementing a quality improvement programme in a locality mental health service.
https://dx.doi.org/10.7748/nm.2020.e1894
This article describes the process of introducing the QI programme in one of the three locality mental health services in the health board. … The authors also reflect on the challenges they experienced in introducing the QI programme and make recommendations for organisations and senior nurses for implementing such programmes effectively.

Microbiology and Virology

Multistate programme to reduce catheter-associated infections in intensive care units with elevated infection rates.
This multistate programme targeted ICUs with elevated catheter infection rates, but yielded no statistically significant reduction in CLABSI, CAUTI or catheter utilisation in the first two of six planned cohorts. Improvements in the interventions based on lessons learnt from these initial cohorts are being applied to subsequent cohorts.

Midwifery

Post-referral delays can compound late referral for some women, exacerbating health inequalities, but should be amenable to provider interventions. Different patterns of pre- and post-referral delay suggest that a tailored approach is needed to address inequalities in access to antenatal care.

Interventions for improving teamwork in intrapartum care: a systematic review of randomised controlled trials.
https://dx.doi.org/10.1136/bmjqs-2019-009689
This systematic review identified and assessed randomised controlled trials (RCTs) of interventions aimed at improving teamwork among interdisciplin ary teams in obstetrical care. … While the evidence is still limited and from low to moderate quality RCTs, simulation-based teamwork interventions appear to improve team performance and patient morbidity in labour and delivery care.

Neonatology

Embedding best transfusion practice and blood management in neonatal intensive care.
https://dx.doi.org/10.1136/bmjog-2019-000694
Neonate-specific baseline transfusion audit showed inconsistent consent, monitoring and documentation processes in neonatal transfusions. Post-targeted education audit showed improvement in these parameters.
Preventing critical failure. Can routinely collected data be repurposed to predict avoidable patient harm? A quantitative descriptive study.
Nowotny, Benjamin Michael. *BMJ Quality & Safety*, January 8, 2020,
https://dx.doi.org/10.1136/bmjqs-2019-010141
While clinical activity data and direct-to-service patient complaints appear to offer promise as potential predictors of health service stress, complaints to regulators and medicolegal activity are less promising as predictors of system failure. Significant changes to how all data are handled would be required to progress such an approach to predicting health service failure.

Nephrology

Quality improvement in vascular access: The role of patient-reported outcome measures.
https://dx.doi.org/10.1177/1129729819845624
Quality improvement initiatives should be aimed to enhance clinical outcomes, service delivery and quality of life for patients. For patients reliant on haemodialysis, vascular access is a lifeline ... To facilitate the implementation of quality improvement programmes specifically for vascular access requires suitable tools. While existing patient-reported outcome measures may be applicable to vascular access, it is likely that these will require further evaluation, and the development of vascular access-specific patient-reported outcome measures may be required.

Neurology

HQIP
Sentinel Stroke National Audit Programme – Sixth Annual Report

Journal articles

Exploring epilepsy attendance at the emergency department and interventions which may reduce unnecessary attendances: A scoping review.
https://dx.doi.org/10.1016/j.seizure.2020.01.012
We conducted a review to identify implementable measures which improve the management of people with epilepsy reducing healthcare costs and their supportive evidence. ... The findings indicate varied reasons for attendance at ED following seizure, including mental health and knowledge of seizure management and lack of education. Implementations of care pathways in ED have been found to reduce admission related costs.

Obstetrics and Gynaecology

CQC
Maternity services survey 2019 (the experiences of women receiving maternity services)
Oncology

HQIP
Lung Cancer Clinical Outcomes Publication 2019

National Bowel Cancer Audit Annual Report 2019

National Lung Cancer Audit Organisational Audit report

National Prostate Cancer Audit Annual Report 2019

Spotlight report on molecular testing in advanced lung cancer

Journal articles

An audit of liquid-based cytology samples reported as high risk HPV and borderline nuclear change in endocervical cells.
The aim of this paper is to assess adherence to NHS cervical screening programme standards, determine the incidence of cases reported as high risk HPV plus borderline nuclear change in endocervical cells, to calculate colposcopic accuracy and assess histological outcomes in this cohort. A retrospective audit of women referred to a colposcopy clinic in one NHS trust from 2016 to 2018. Data relating to histological outcomes, cytological follow-up and demographics were collected.

How well do we manage non-muscle invasive bladder tumors? A UK audit of real-life practices.
Sountoulides, Petros. Urologia, January 21, 2020, :391560319899303
https://dx.doi.org/10.1177/0391560319899303
The aim of this study was to assess the quality of TURBT (transurethral resection of bladder tumor) using surrogate parameters and evaluate adherence to the guidelines regarding the management of bladder tumors. A clinical audit of all new diagnosis of bladder cancer was undertaken from January 2016 to January 2017. A total of 101 new bladder cancer cases were included. Surrogates of TURBT quality including presence of detrusor in the specimen, rate of re-TUR, presence of carcinoma in situ, and 3-month recurrence rates were analyzed. Adherence to guidelines regarding management of non-muscle invasive bladder cancer including time to re-TUR and utilization of single instillation chemotherapy was evaluated.

International development and implementation of a core measurement set for research and audit studies in implant-based breast reconstruction: a study protocol.
Potter, Shelley. BMJ open, January 20, 2020, 10(1):e035505
https://dx.doi.org/10.1136/bmjopen-2019-035505
INTRODUCTION Outcome reporting in research studies of breast reconstruction is inconsistent and lacks standardisation. The results of individual studies therefore cannot be meaningfully compared or combined limiting their value. A core outcome set (COS) has been developed to address these issues and identified 11 key outcomes to be measured and reported in all future research and audit studies in reconstructive breast surgery (RBS).
Paediatrics

A process for supporting children's nurses after medication errors.
Coulson, Sharon. *Nursing children and young people*, January 20, 2020,
https://dx.doi.org/10.7748/ncyp.2020.e1230
This article reports on a quality improvement project aimed at improving the process of supporting nurses after medication-related incidents have occurred on a paediatric intensive care unit.

Testicular Pain Pathway in Children: Investigating Where Missed Torsion Occurs Most Often.
Bastianpillai, Christopher. *Pediatric emergency care*, January 21, 2020,
https://dx.doi.org/10.1097/PEC.0000000000002026
Using quality improvement principles, the pediatric scrotal pain pathway was mapped out, commencing with initial symptom onset and ending with definitive surgical management. We retrospectively reviewed data on all patients between 0 and 18 years of age attending the emergency department at Whipps Cross University Hospital with acute scrotal pain between October 2010 and October 2013.... In the context of our study, late presentation to hospital appears to be the most significant factor leading to orchidectomy. To target this issue, awareness among both children and parents must be improved.

Time series evaluation of improvement interventions to reduce alarm notifications in a paediatric hospital.
Pater, Colleen M. *BMJ Quality & Safety*, January 20, 2020,
https://dx.doi.org/10.1136/bmjqs-2019-010368
The Joint Commission identified inpatient alarm reduction as an opportunity to improve patient safety; enhance patient, family and nursing satisfaction; and optimise workflow. We used quality improvement (QI) methods to safely decrease non-actionable alarm notifications to bedside providers. ... Our aim was to decrease alarm notifications per monitored bed per day by 60%. Plan-Do-Study-Act testing cycles included updating notification technology, establishing alarm logic and modifying bedside workflow processes, including silencing the volume on all bedside monitors. Our secondary outcome measure was nursing satisfaction. ... We successfully reduced alarm notifications while preserving patient safety over a 4-year period in a complex paediatric patient population using technological advances and QI methodology. Continued efforts are needed to further optimise monitor use across paediatric hospital units.

Pharmacology

Assessing the safety of electronic health records: a national longitudinal study of medication-related decision support.
https://dx.doi.org/10.1136/bmjqs-2019-009609
Electronic health records (EHR) can improve safety via computerised physician order entry with clinical decision support, designed in part to alert providers and prevent potential adverse drug events at entry and before they reach the patient. However, early evidence suggested performance at preventing adverse drug events was mixed. ... Intentional quality improvement efforts appear to be a critical part of high safety performance and may indicate the importance of a culture of safety.

Community pharmacy medication review, death and re-admission after hospital discharge: a propensity score-matched cohort study.
https://dx.doi.org/10.1136/bmjqs-2019-009545
Among older adults, receipt of a community pharmacy-based medication reconciliation and adherence review was associated with a small reduced risk of short-term death or re-admission. Due to the possibility of unmeasured confounding, experimental studies are needed to clarify the relationship between postdischarge...
community pharmacy-based medication review and patient outcomes.

Exploring the implications of different approaches to estimate centre-level adherence using objective adherence data in an adult cystic fibrosis centre - a retrospective observational study.
https://dx.doi.org/10.1016/j.jcf.2019.10.008
Different approaches of calculating adherence produced different adherence levels. Adherence levels based only on agreed regimen among adults who readily brought their nebulisers to clinics can over-estimate the effective adherence of CF centres.

How can patient-held lists of medication enhance patient safety? A mixed-methods study with a focus on user experience.
Patients often carry medication lists to mitigate information loss across healthcare settings. We aimed to identify mechanisms by which these lists could be used to support safety, key supporting features, and barriers and facilitators to their use. ... Different tools for recording medicines met different needs. Of 103 tools examined, none met the core needs of all users. A key barrier to use was lack of awareness by patients and carers that healthcare information systems can be fragmented, a key facilitator was encouragement from healthcare professionals.

Improving timely analgesia administration for musculoskeletal pain in the emergency department.
https://dx.doi.org/10.1136/bmjmq-2019-000797
Our aim was to reduce the time-to-analgesia (TTA; time from patient triage to receipt of analgesia) for patients with MSK pain in our ED by 55% (to under 60 min) in 9 months' time (May 2018). ... We obtained weekly data capture for Statistical Process Control (SPC) charts, as well as Mann-Whitney U tests for before-and-after evaluation. We performed wide stakeholder engagement, root cause analyses and created a Pareto Diagram to inform Plan-Do-Study-Act (PDSA) cycles ... Special cause variation was identified on the ED LOS SPC chart with nine values below the midline after the first PDSA. ... We achieved a significant reduction of TTA and an increased use of medical directives through front-line focused improvements.

Quality improvement of intravenous to oral medication conversion using Lean Six Sigma methodologies.
https://dx.doi.org/10.1136/bmjmq-2019-000804
... intravenous to oral medication conversion rate was 76% with missed opportunity for conversion of 37% ... After improvements, the missed opportunity rate for intravenous to oral conversion decreased from 37% (19/51) to 21% (24/113) (p=0.04, two-proportion test), a 43% improvement. The trend in intravenous to oral conversion rate increased from 76% (39/51) to 85% (171/201) and severity adjusted length of stay was reduced ...

Reducing Fluoroquinolone Use and Clostridioides difficile Infections in Community Nursing Homes Through Hospital-Nursing Home Collaboration.
Felsen, Christina B. *Journal of the American Medical Directors Association*, January 2020, 21(1):55-61.e2
https://dx.doi.org/10.1016/j.jamda.2019.11.010
A hospital-NH partnership with a medical director advisory group achieved a significant reduction in total antibiotic and fluoroquinolone use and contributed to a reduction in CDI incidence. This approach offers one way for NHs to gain access to AS [for antibiotic stewardship] expertise and resources and to standardize practices within the local community.

Ultrasound-Guided Subcostal TAP Block with Depot Steroids in the Management of Chronic Abdominal Pain Secondary to Chronic Pancreatitis: A Three-Year Prospective Audit in 54 Patients.
https://dx.doi.org/10.1093/pm/pnz236
Over a three-year period, 54 patients with chronic abdominal pain as a result of pancreatitis were prospectively...
audited at a tertiary care university hospital. Patients were offered bilateral subcostal transversus abdominis plane block with depot steroids as the primary interventional treatment in the pathway. In patients with myofascial pain secondary to chronic pancreatitis, the block was effective in producing clinically significant pain relief at three months (95%, 20/21) and durable pain relief lasting six months (62%, 13/21). In patients with visceral pain, the block produced a transient benefit lasting two to three weeks in one-third (six of 17).

Primary Care

NHS England
CVDPREVENT (Audit)
A “national primary care audit that will automatically extract routinely held GP data covering diagnosis and management of six high risk conditions that cause stroke, heart attack and dementia: atrial fibrillation (AF), high blood pressure, high cholesterol, diabetes, non-diabetic hyperglycaemia and chronic kidney disease.
https://www.england.nhs.uk/ourwork clinical-policy/cvd/cvdprevent/

Journal articles

Conceptualising the Integration of Strategies by Clinical Commissioning Groups in England towards the Antibiotic Prescribing Targets for the Quality Premium Financial Incentive Scheme: A Short Report.
Anyawu, Philip Emeka. Antibiotics (Basel, Switzerland), January 23, 2020, 9(2)
https://dx.doi.org/10.3390/antibiotics9020044
This paper briefly reports the outcome of a workshop exploring the experiences of antimicrobial stewardship (AMS) leads within CCGs in selecting and adopting strategies to help achieve the QP antibiotic targets. ... Our results suggest that national targets, rather than financial incentives are key for engaging stakeholders in quality improvement in antibiotic prescribing.

Radiology

Improving the effectiveness and efficiency of a skin dose investigation protocol in interventional radiology.
https://dx.doi.org/10.1136/bmjmq-2019-000722
The Radiation Protection Department undertook to resolve ... issues by making use of two software packages (openSkin and OpenREM) to automate key processes in the skin dose investigation protocol. The automation was introduced over three distinct Plan-Do-Study-Act cycles. The introduction of openSkin and OpenREM eliminated the possibility of a high skin dose procedure failing to trigger an investigation. The time spent by staff on skin dose investigations was reduced by an estimated 94%.

Respiratory Medicine

Failure to rescue in the era of the lung allocation score: The impact of center volume.
Osho, Asishana A. American journal of surgery, January 18, 2020,
https://dx.doi.org/10.1016/j.amjsurg.2020.01.020
Failure to Rescue (FTR) is a valuable surgical quality improvement metric. The aim of this study is to assess the relationship between center volume and FTR following lung transplantation. ... Higher volume lung transplantation centers have lower rates of failure to rescue.
Practical lessons in implementing frailty assessments for hospitalised patients with COPD.
https://dx.doi.org/10.1136/bmjoq-2019-000782
This pilot project was designed to assess the feasibility of implementing the CFS among hospitalised patients with chronic obstructive pulmonary disease (COPD), to assess the differences in frailty assessments between health providers, and to understand the distribution of frailty among hospitalised patients with COPD.

Rheumatology

CAPTURE-JIA: a consensus-derived core dataset to improve clinical care for children and young people with juvenile idiopathic arthritis.
https://academic.oup.com/rheumatology/article/59/1/137/5523710
Data collected during routine clinic visits are key to driving successful quality improvement in clinical services and enabling integration of research into routine care. The purpose of this study was to develop a standardized core dataset for juvenile idiopathic arthritis (JIA) (termed CAPTURE-JIA), enabling routine clinical collection of research-quality patient data useful to all relevant stakeholder groups ... and including outcomes of relevance to patients/families.

Trauma and Orthopaedics

HQIP
Fracture Liaison Service Database – 2019 Annual Report

Journal articles

Still too noisy - An audit of sleep quality in trauma and orthopaedic patients.
Gulam, Sumeya. International emergency nursing, January 29, 2020,:100812
https://dx.doi.org/10.1016/j.ienj.2019.100812
It is known that patients can face difficulties sleeping in hospitals which impacts on their recovery. An exploratory descriptive design was applied using a clinical audit. As no standardised sleep assessment tool was identified, a sleep audit tool was developed. .... A significant association between poor quality of sleep and patient recovery was identified in this small sample of trauma and orthopaedic patients. The findings suggest that nurses should try to create a suitable sleeping environment to enhance patient recovery. There is a need for a standardised sleep assessment tool and sleep audit tool so that the quality of patients' sleep can be accurately assessed and documented.
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