THE RIGOUR OF QUALITY IMPROVEMENT WORK – WHY IT MATTERS, AND WHAT IT LOOKS LIKE

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10.1136/bmjoq-2023-ISS.1

Introduction

Quality improvement has failed to live up to its promise. In theory, the application of a method to solve complex quality issues holds face validity. In practice, however, much of what is termed quality improvement hasn’t demonstrated the results that we would expect to see.

We propose the fundamental aspect of rigour as being critical to the efficacy of quality improvement. Rigour incorporates both design and evaluation – this session will describe the current landscape of QI, and outline how we can ensure effective design and evaluation in our own quality improvement work, to give it the best chance of success. As with any science, the reliability and validity of the knowledge and learning gained from the method of quality improvement are related to the rigour with which we apply it.

We will discuss the main flaws in the design of quality improvement, and propose how we can rectify this through disciplined application of the core components of improvement: Aim, theory of change, execution theory, measurement and communication. We will also dive into the best approach to evaluation, to ensure that we maximise learning and adaptation during the quality improvement process.

Methods

This session will summarise the findings from the literature on the effectiveness of quality improvement, identifying the key factors that relate to success or failure of improvement work to achieve the proposed aim.

We will return back to the fundamental concepts that underpin quality improvement, and draw out the essential element of rigour. We will describe what constitutes rigour in quality improvement, and how we can all strengthen the rigour of our own quality improvement work. We will utilise the five core components of improvement design in order to structure our thinking about rigour.

We will also look at the topic of evaluation, and identify how we can best introduce simple and effective mechanisms to evaluate our quality improvement work in order to learn and adapt through the project, and continually improve our application of the method.

We propose a simple framework to assess the rigour of our quality improvement work, and to ensure that future quality improvement work applies the core components of design, and a structured approach to evaluation, in order to improve the rigour of the scientific method.

Results

REFERENCES

IS INFLUENZ-ER PROGRAM FEASIBLE AND SAFE?

ASSESSMENT OF HOSPITAL STAFF ACCEPTABILITY AND UTILISATION OF A TELEMEDICINE-SUPPORTED EARLY DISCHARGE PROGRAM

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10.1136/bmjoq-2023-ISS.2

Introduction

Timely healthcare is at core of patient safety. However, it is challenged by low hospital workforce capacity coinciding with an increasing demand for healthcare utilization. Re-organization of healthcare services including home-based programs (eg. Hospital-at-Home, Virtual Wards) are proposed as a solution. Remote monitoring via telemedicine is proposed to save travel time for both patients and hospital staff and smart alerts can support timely management. The stakeholder attitude towards virtual healthcare and their utilization of telemedicine is essential to assess as it is the key to successful outcomes for patients.

Influenz-er is a telemedicine-supported early discharge program proposed as an acceptable and safe alternative to a standard hospitalization of patients at the Department of Pulmonary and Infectious Diseases (DPID) at the North Zealand University Hospital, Denmark. Patients enrolled in the program are transferred from hospital to their home to be monitored remotely by hospital staff. A telemedicine platform facilitates health data transfer and alert hospital staff in case of sign of clinical deterioration to support timely management. Thus, the program aims to provide hospital-level safety and quality for patients in their homes.

Methods

We are currently investigating the feasibility of program Influenz-er in terms of patient safety, patient and hospital staff acceptance, and implementation at hospital-department level prior to a full-scale effectiveness trial. One of the research questions is whether Influenz-er program is perceived as acceptable, appropriate, and feasible by hospital staff and whether hospital staff can provide timely care for patients who are monitored remotely from home. Both qualitative and quantitative data were collected.

We applied RE-AIM framework as recommended by the World Health Organization to perform a process evaluation of Influenz-er program as a part of a feasibility study with 19 patients. We focused on the RE-AIM dimensions adoption and implementation. We collected data on the proportion of the DPID staff trained within the Influenz-er program. Short staff survey was performed to assess the initial level of acceptance, perceived appropriateness, and feasibility of the program. The implementation fidelity is currently assessed via analysis of quantitative process data from the telemedicine platform (eg., time to registered action upon an incoming alert) together with qualitative field data collected during observations of how DPID staff delivered the program. Also, data on incidence of adverse events were collected.

Results

Preliminary results show high level of initial adoption and acceptance among DPID staff and no severe adverse events for patients (n=19) enrolled to the program. Interestingly, the quantitative process data imply somewhat low fidelity to timely registration of clinical actions, however the observations of DPID staff reveal safe clinical actions according to the protocol. Thus, the low fidelity numbers probably mirror a bad choice of the quantitative fidelity measure and a current challenge with low workforce capacity and therefore low prioritization of non-clinical administrative tasks such as timely registration on the telemedicine platform for research purposes.

REFERENCES