PATIENT INVENTORY: FROM QUALITY IMPROVEMENT TO SCIENTIFIC JOURNALS

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Introduction Countless quality improvement projects are conducted internationally each year, but only a few of them are translated into scientific literature. This is problematic, as a core element of the improvement model is to map best practices and previous experiences so that new projects do not always have to start from scratch. In this presentation, a quality improvement project is presented, and the Patient Inventory method is introduced, which can be a useful tool for identifying inefficiencies in patient pathways and for implementing targeted quality improvement initiatives.

High-quality treatment and care for patients require appropriate management of patient pathways. However, patient pathways are often challenged by breakdowns in coordination, continuity, and communication between healthcare professionals and across sectors. With the increasing number of people needing treatment, hospital capacity is also challenged, compromising the quality of care and treatment and resulting in inappropriate use of resources. Therefore, it is important to identify inefficiencies in patient pathways so that targeted quality improvement initiatives can be implemented. The Patient Inventory is a useful tool for this purpose.

Methods The Patient Inventory tool is a specialized clinical audit that provides a structured basis for assessing the quality of patient pathways at the department or hospital level and between sectors. The method asks whether patients are treated in the right place, at the right level, at the right time, and with the right pathway.

Results The presentation shows results from a specific quality project based on the Patient Inventory method and how the presenters published the results in a recognized journal. The presenters hope that this method and their experience in publishing their results can inspire others to use the Patient Inventory method to improve patient care and to disseminate their findings in scientific journals.

REFERENCES

IMPROVE BETTER BY SCRUM SPRINT IN HEALTHCARE. AN EVALUATION OF THE 24- HOUR SCRUM SPRINT METHOD

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Introduction The quality policy of the Albert Schweitzer Hospital’s radiology department is geared towards continuous improvement and is based on quality measurement results. The number of improvements of the radiology department is currently low compared to the number of quality measurements, and the throughput time of the improvements is long. The purpose of this quality improvement project was to investigate whether the 24-hour scrum sprint method is an effective method to increase the number of completed improvements, and decrease throughput time in the radiology department.

Methods The 24-hour scrum sprint method is being implemented and evaluated in Albert Schweitzer Hospital’s radiology department (intervention group). The chosen study design is an interrupted time series with a control group. Two outcomes are measured for the effect evaluation. The first outcome measure is the percentage of improvement action completed in 90 days. The ratio is calculated using a negative binomial regression analysis and a logical regression analysis. A process evaluation was also conducted engaging a focus group to evaluate the implementation trajectory and the intervention.

Results Having implemented the 24-hour scrum sprint, 2.5 times as many improvements were completed in the radiology department than before implementation.

With a rate ratio of 2.47 (p<0.001) there is a significant difference. In the control group there was a reduction in the number of improvement actions. This difference is not significant (rate ratio of 0.87; p= 0.82). The percentage of actions completed within 90 days on radiology is 18% before implementation and 65% after implementation. This difference is significant (odds ratio = 8.30 and p<0.001). In the control group there is no significant difference in the post-intervention period compared to the pre-intervention period (odds ratio 0.99; p=0.98). The process evaluation reveals that improvement using the 24-hours scrum sprint method was experienced positively by the participants.

The effect evaluation shows a significant difference in the number of improvement actions and throughput time in the intervention group. The 24-hour scrum sprint method could be an effective method to improve on the radiology department. In order to determine subsequent research is required with a longer follow-up, additional post-intervention measurement moments and a rating of the content and scope of the improvements.

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The existing body of knowledge reveals that the encounter described above can be challenging and overwhelming for both patients and nurses with consequences for nurses’ work environment as well as patient safety. Service users’ experiences of stigma, lack of acknowledgement or neglect from staff, nurses experience uncertainty, lack of skills and knowledge and stress/moral distress, which can contribute to problems regarding recruitment and retention. Mental health service users’ experiences with health care system is crucial because mistrust leads to health avoidance, thus contributing to inequity in health.

Methods I will be presenting the first part of the project focussing on mental health service users experiences with somatic hospitalization for either acute/chronic somatic reasons or psychiatric reasons, the latter e.g. following self-harm or suicide attempt. I carried out eight narrative interviews with service users from all five regions in Denmark. By applying Dialogical Narrative Analysis, which represents a social constructivist approach, I find mental health service users ‘in the borderland’ of patient safety.

Results Their stories reveal that the encounter with somatic staff can have consequences for their safety, since experiencing emotional and psychosocial unintended harm are often internalised, leading to relapse of mental health symptoms, shame and mistrust in the health system. Some even describe that feelings of shame and inferiority can make them self-harm again right after discharge. This not only represents a democratic, ethical, and economical problem but also contributes to inequity in health. The discussion section critically explores and problematizes the conventional understanding and definition of patient safety, emphasising the need of an expansion of the conventional patient safety concept towards a more person-centred, context-sensitive, relational notion of patient safety. What this study adds to the existing body of knowledge is the participatory aspect which enables the development of knowledge through mutual analysis of experiences as well as the empirical material, in collaboration with service users as well as patients.

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Introduction The COVID-19 pandemic has caused a severe worldwide health crisis resulting in a significant decrease in life expectancy in numerous countries. However, Denmark has experienced relatively low mortality rates due to COVID-19, and thus far, there has been no noticeable effect on life expectancy in the country.1

In 2021, the COVID-19 project was launched in Denmark to investigate the secondary consequences of the pandemic on various illnesses.2,3 The study was conducted by the Danish Clinical Quality Program - National Clinical Registries (RKKP) in partnership with medical professionals. The primary goal of the project was to gain insight into how the pandemic affected the following areas: the levels of diagnostic and therapeutic activity for illnesses besides COVID-19, the quality of care for diseases other than COVID-19, social inequality in healthcare, and the lessons learned for managing similar pandemics and catastrophes in the future.

Methods As part of the project, eleven distinct diseases were examined, representing a range of illness types such as acute and chronic ailments, cancer, and psychiatric disorders. These diseases were selected based on their significant and severe nature, which made them more susceptible to being impacted by the pandemic. To gather data, various sources were utilized, including the Danish clinical quality registries, socioeconomic and demographic information from Statistics Denmark, and data on prior illnesses and hospital visits from the Danish National Patient Registry. To analyse the data, the pandemic period and its different phases were compared to the pre-pandemic period.

Results According to the findings of the study, the COVID-19 pandemic did not have a detrimental impact on the overall diagnosis and treatment quality or the general activity levels of the examined disease areas. This suggests that the Danish healthcare system was rather resilient and was capable of preserving its fundamental operations throughout the pandemic. However, the research also indicated that social inequality in healthcare was aggravated during the pandemic, particularly for immigrants, individuals living alone, those with limited education, and low-income groups. In this way, the pandemic has reinforced already known problems with inequality in the Danish healthcare system.4,5 Therefore, the study emphasizes the need to address social disparities in healthcare within the Danish healthcare system and in future public health emergencies.

This project is an example of how the extensive Danish quality databases can be utilized to gain an overview of how crises and catastrophes affect the quality of care provided. It can thus provide valuable information for future emergencies, while also serving as a magnifying glass for potential quality and patient safety challenges that must be addressed even in times between crises.

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