# Improving Quality Update: February 2020, Issue 11

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## Contents:

## Articles

**Assessing the safety of electronic health records: a national longitudinal study of medication-related decision support.**
Holmgren AJ. *BMJ Quality & Safety* 2020;29(1):52-59.
Conclusion: Hospital medication order safety performance has improved over time but is far from perfect. The specifics of EHR medication safety implementation and improvement play a key role in realising the benefits of computerising prescribing, as organisations have substantial latitude in terms of what they implement. Intentional quality improvement efforts appear to be a critical part of high safety performance and may indicate the importance of a culture of safety.
*Available with an NHS OpenAthens password*

**Association of registered nurse and nursing support staffing with inpatient hospital mortality.**
Needleman J. *BMJ Quality & Safety* 2020;29(1):10-18.
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. Conclusion: Low RN and nursing support staffing were associated with increased mortality. The results should encourage hospital leadership to assure both adequate RN and nursing support staffing.
*Freely available online*

**Community pharmacy medication review, death and re-admission after hospital discharge: a propensity score-matched cohort study.**
Lapointe-Shaw L. *BMJ Quality & Safety* 2020;29(1):41-51.explorinexploring
Conclusions and relevance: 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.
*Available with an NHS OpenAthens password*

**Conditional Survival With Increasing Duration of ICU Admission: An Observational Study of Three Intensive Care Databases.**
Marshall DC. *Critical Care Medicine* 2020;48(1):91-97.
Prolonged admissions to an ICU are associated with high resource utilization and personal cost to the patient. Previous reports suggest increasing length of stay may be associated with poor outcomes. Conditional survival represents the probability of future survival after a defined period of treatment on an ICU providing a description of how prognosis evolves over time. Our objective was to describe conditional survival as length of ICU stay increased.
*Freely available online*

**Creating consensus-based practice guidelines with 2000 nurses.**
James-Reid S. *British Journal of Nursing* 2019;28(22):S18-S25.
Traditionally, to develop guidelines, a small group of experts examine evidence then agree on a set of statements, which are then published in journals. However, more than 7000 primary care journal articles are published monthly. This study examined

a different way of drawing up practice guidelines, which involved large numbers of nurses from different countries directly in developing then disseminating the guidelines to speed up acceptance and the implementation of best practice.
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**Does Shared Decision Making Actually Occur in the Emergency Department? Looking at It from the Patients' Perspective.**
Schoenfeld EM. *Academic Emergency Medicine* 2019;26(12):1369-1378.
We sought to assess the frequency, content, and quality of shared decision making (SDM) in the emergency department (ED), from patients' perspectives.
*Email rlibrary@ucl.ac.uk for a copy of this article*

**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.**
Robert G. *BMJ Quality & Safety* 2020;29(1):31-40.
The 'Productive Ward: Releasing Time to Care' programme is a quality improvement (QI) intervention introduced in English acute hospitals a decade ago. Conclusions: 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.
*Freely available online*

**Filming for auditing of real-life emergency teams: a systematic review.**
Brogaard L. *BMJ Open Quality* 2019;8:e000588.
This systematic review of 50 observational studies provides insight into the use of video review of resuscitation teams, trauma teams, emergency paediatric teams and emergency obstetric teams. This technical solution is affordable and relatively easy to install; however, legal and ethical issues may be challenging. Investigating the impact of video review, with regards to improved patient care, all five studies were in favour of the use of video review as an educational intervention.
*Freely available online*

**Improving data sharing between acute hospitals in England: an overview of health record system distribution and retrospective observational analysis of inter-hospital transitions of care.**
Warren LR. *BMJ Open* 2019;9:e031637.
Each year, millions of patients in England attend two or more different hospital trusts. Most of the pairs of trusts that commonly share patients do not use the same record systems. This research highlights significant barriers to inter-hospital data sharing and interoperability. Findings from this study can be used to improve electronic health record system coordination and develop targeted approaches to improve interoperability.
*Freely available online*

**Learning from Patient Safety Incidents in the Emergency Department: A Systematic Review**
Amaniyan S. *Journal of Emergency Medicine*

2019;:doi:10.1016/j.jemermed.2019.11.015.
This review enhances our awareness of contributing factors to patient safety incidents within emergency departments and encourages researchers from different disciplines to investigate the causes of practice errors and formulate safety improvement strategies.
*Freely available online*

**Managing risk in hazardous conditions: improvisation is not enough. Viewpoint**
Amalberti R. *BMJ Quality & Safety* 2020;29(1):60-63.
Conclusions: ...We need in parallel to develop and implement prepared strategies for managing risk at times when ordinary standards cannot be met and the safety of patients is compromised. Finally, in making these proposals, we emphasise that we are not accepting defeat or suggesting that a certain level of harm is inevitable. We argue, in contrast, that the recognition of threats hazards and the development of active, practical risk management strategies is the route to safer healthcare.
*Freely available online*

**Nurses matter: more evidence. Editorial**
Aiken LH. *BMJ Quality & Safety* 2020;29(1):1-3.
Empirical evidence from many published studies indicates that better hospital professional registered nurse (RN) staffing is associated with better patient outcomes, including lower mortality and failure to rescue, shorter lengths of stay, fewer readmissions, fewer complications, higher patient satisfaction and more favourable reports from patients and nurses alike related to quality of care and patient safety...
*Freely available online*

**Pathways to independence: towards producing and using trustworthy evidence.**
Moynihan R. *BMJ* 2019;367:l6576.
We argue that endemic financial entanglement is distorting the production and use of healthcare evidence, causing harm to individuals and waste for health systems. Building on the evidence and practical examples cited below, we propose pathways towards financial independence from industry across healthcare decision making. We hope that our proposals will catalyse and inform development of more detailed recommendations for fundamental reform within research, education, and practice.
*Freely available online*

**Realising the potential of health information technology to enhance medication safety. Editorial**
Sheikh A. *BMJ Quality & Safety* 2020;29(1):7-9.
The WHO'S Third Global Safety Challenge, the recent World Health Assembly Resolution on Patient Safety14 and the continuing policy interest in EHRs have combined to provide an unparalleled opportunity to realise the potential of HIT to enhance medication safety. We owe it to our patients to work in a collaborative, coordinated way to achieve the much-needed HIT-enabled leap forward towards the goal of Medication Without Harm.
*Freely available online*

**The emotional labour of quality improvement work in end of life care: a qualitative study of Patient and Family Centred Care (PFCC) in England.**
Boulton R. *BMC Health Services Research* 2019;19(1):923.
This paper reports findings from an implementation study of an evidence-based intervention called Patient and Family Centred Care (PFCC) designed to tap into patient experiences as a basis for improvement. In this study the PFCC intervention was spread to a new service area (end of life care) and delivered at scale in England.
*Freely available online*

**The harms of promoting 'Zero Harm'. Editorial**
Thomas EJ. *BMJ Quality & Safety* 2020;29(1):4-6.
We should be clear about what types of harms can or cannot be prevented and anticipated, work to eliminate those where there is good evidence for preventability by adopting evidence-based practices, improve the ability of everyone responsible for safety to identify risks, conduct better risk analyses to anticipate and reduce unintended harms, measure and celebrate the routine adaptations that prevent harm, and reward organisational learning and improvement.
*Freely available online*

**The Nursing Activities Score Per Nurse Ratio Is Associated With In-Hospital Mortality, Whereas the Patients Per Nurse Ratio Is Not.**
Margadant C. *Critical Care Medicine* 2020;48(1):3-9.
Studies have shown contradicting results on the association of nursing workload and mortality. Most of these studies expressed workload as patients per nurse ratios; however, this does not take into account that some patients require more nursing time than others. Nursing time can be quantified by tools like the Nursing Activities Score. We investigated the association of the Nursing Activities Score per nurse ratio, respectively, the patients per nurse ratio with in-hospital mortality in ICUs.
*Freely available online*

**Unsafe student nurse behaviours: the perspectives of expert clinical nurse educators.**
Monique K. *Nurse Education in Practice* 2019;41:102628.
Clinical evaluation of undergraduate nursing students is one of the most challenging aspects of baccalaureate nursing education, especially for novice clinical instructors. Early identification of unsafe student behaviours is necessary to ensure students obtain adequate support and guidance. The degree to which clinical instructors are certain about what is safe and unsafe varies, and greatly influences their decisions about evaluative processes and which patients to assign to students.
*Available with an NHS OpenAthens password (select NHS England)*

**Use and reporting of experience-based codesign studies in the healthcare setting: a systematic review.**
Green T. *BMJ Quality & Safety* 2020;29(1):64-76.
Experience-based codesign (EBCD) is used predominantly for quality improvement, but has potential to be used for intervention design projects. There is variation in the use of EBCD, with many studies eliminating or modifying some EBCD stages. Moreover, there is no consistency in reporting. In order to evaluate the effect of

modifying EBCD or levels of EBCD fidelity, the outcomes of each EBCD phase should be reported in a consistent manner.
*Available with an NHS OpenAthens password*

**Worthy of the 'global leader' hype, or are we seeing the tip of the iceberg?**
Tingle J. *British Journal of Nursing* 2019;28(22):1492-1493.
The author discusses some recent patient safety crises, litigation claims and a new patient safety publication from NHS Resolution. Unfortunately, it is never too long before a major patient safety crisis hits the NHS and we saw this recently with the Shrewsbury and Telford Hospital NHS Trust maternity scandal.
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## Reports

**Unconventional health and care: five organisations delivering care differently.**
The King's Fund; 2019.
https://www.kingsfund.org.uk/publications/unconventional-health-care
Each of the organisations studied in this long read has found radically different ways of supporting the people in its care. Breathe Arts uses magic to improve children's fine motor skills; Off the Record creates movements for young people with mental health problems to lobby for social change; Hope Citadel intervenes directly to address the underlying social causes of ill health in a deprived community rather than simply handing out medication to address anxiety and depression.
*Freely available online*

**Implementing the Recommendations of the Neonatal Critical Care Transformation Review**
NHS England; 2019.
https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review.pdf
This action plan to implement the recommendations of the Neonatal Critical Care Transformation Review sets out how the NHS will further improve neonatal care with the support of funding set out in the NHS Long Term Plan.
*Freely available online*

**Indicator: Respect and dignity**
Nuffield Trust; 2019.
https://www.nuffieldtrust.org.uk/resource/respect-and-dignity
The Nuffield Trust examine whether patients feel they are treated with respect and dignity. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 made it a statutory requirement that all service users must be treated with dignity and respect. It is also one of the key NHS values that is written in the NHS Constitution.
*Freely available online*

**What are the sticking points? NASSS framework for technology adoption in healthcare.**
The Mental Elf; 2019.

https://www.nationalelfservice.net/treatment/digital-health/nasss-framework-mindtech2019/
Imogen Bell summarises Trish Greenhalgh's paper on her recent NASSS framework (Nonadoption, Abandonment, Scale-up, Spread, and Sustainability), which is aimed at improving the success of digital health interventions in healthcare.
*Freely available online*

## Websites

**E-learning modules: medicines.**
https://www.gov.uk/government/publications/e-learning-modules-medicines-and-medical-devices/e-learning-modules-medicines-and-medical-devices
These MHRA educational modules on medicines have been written for trainees and healthcare professionals responsible for prescribing, supplying or administering medicines. The modules cover clinically-relevant aspects of medicines regulation as well as topics on the risks of commonly-prescribed specific classes of medicines. Updated December 2019.
*Freely available online*