Using research evidence and lived experience for better QI & publications

Helen Crisp, Editor-in-Chief, BMJ Open Quality

Amy Price, Patient Editor (Research & Evaluation) BMJ

Speaker biographies

Helen Crisp

- Editor-in-Chief of BMJ Open Quality, strategic consultant, programme developer and trainer for quality improvement in healthcare
- 2009-17 Led Health Foundation, UK grants programme for research into patient safety, quality improvement methods, person-centred care
- Previously 15 years' experience in accreditation, developing standards and assessment processes – adviser on accreditation in Denmark, Portugal, Serbia and Bosnia Herzegovina

@HelenMCrisp

Speaker biographies

Amy Price

- Patient Editor (Research & Evaluation), BMJ
- Senior Research Advisor, Stanford Medicine X | Stanford School of Medicine
- Medical Guidance Analyst EBSCO
- Evidence Based Health Care University of Oxford

Conflicts of interest:

- Both Helen Crisp and Amy Price are paid as editors for BMJ group
- We have no other interests that are connected with this work

Overview of the session

- Using research evidence
  - Where to find it
  - How to sift and sort to get what you need

Improving design and implementation of improvement work
  - Using research to plan and implement your intervention
  - Lived experience to inform improvement work

- How lived experience contributes to improvement research and work
  - Coproduction of research
  - Why coproduction matters

- How you can contribute to better publications on QI
  - Tips for better write-up of improvement work
  - Share lived experience : -practitioners, service users, researchers
  - Wider dissemination of improvement work

Why is publication an important issue for Quality Improvement?

- Using published evidence enables us to learn from other's experience
- Publishing our work can help to spread successful improvement interventions
- Or,
- Prevent wasted effort on reproducing interventions that don't work

Power, policy & politics

- Power of published evidence to persuade
- Policy – published evidence has some influence in forming policy
- Publishing is key to the politics of influence – credibility as leaders and peers

Desert Island QI

You are stranded on a desert Island:

- What would be the ***1 book*** to take with you?
- The ***'luxury item'*** you would most want?
- What aspects of your ***QI experience*** would help you ***to survive***?

2 minutes' individual thinking time

Discuss in small groups

What we think we know

Co-Production PPI | What is It?

Co-production Public and Patient Involvement in healthcare research is the activation of patient and public involvement in which patients and members of the public work with clinicians and researchers to create, redesign and build the research.

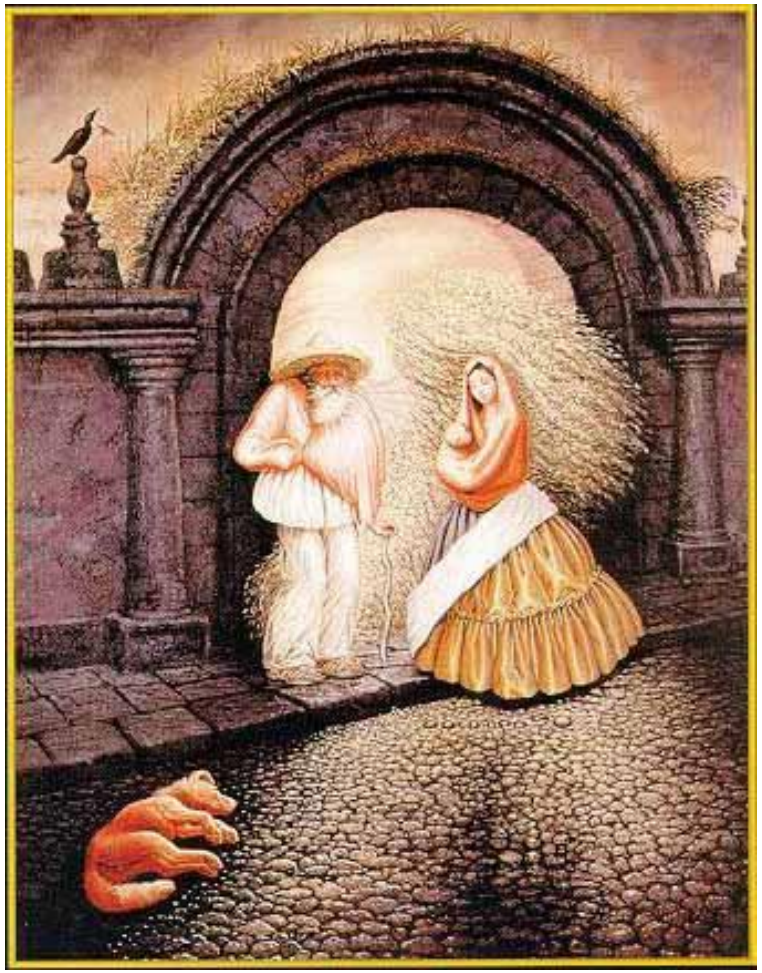
Co-production can also be initiated by the patients and the public as they seek out researchers and clinicians to partner with in research.

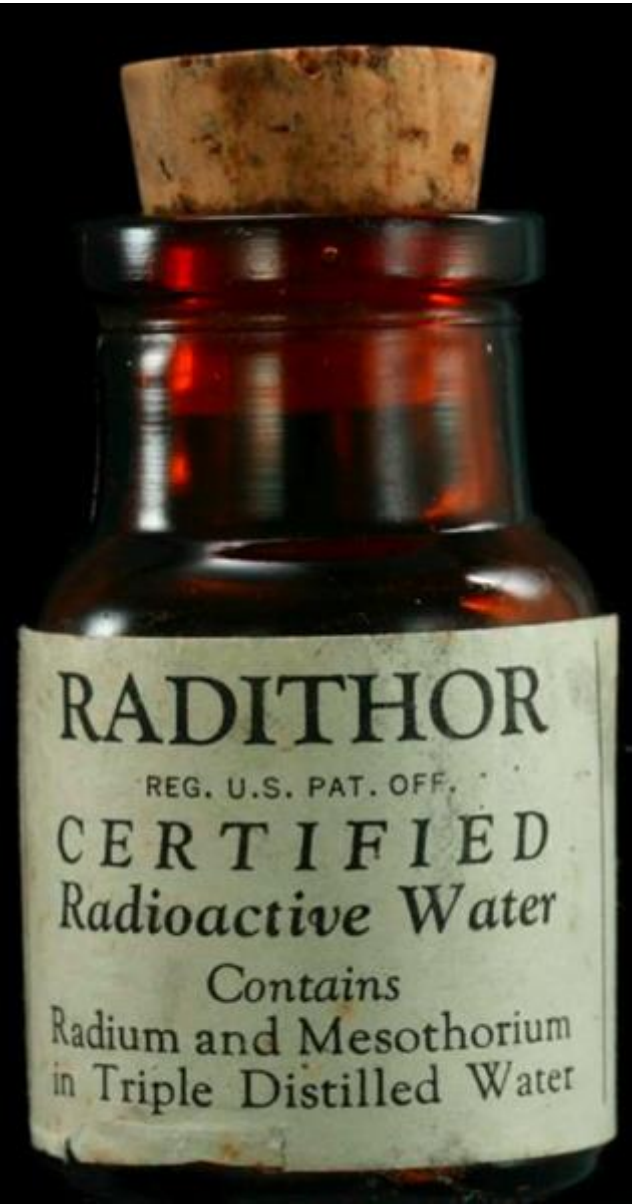
Hole in The Wall

Co-Production Research and How it Works

The Way We See Guides Movement

Good or Evil





"The Radium Water Worked Fine Until His Jaw Came Off *Wall Street Journal* (1928)

The Need

"The first thing we need is a list of those things that make people feel powerless and a set of achievable objects to start removing the barriers to people taking control of the quality improvement health science process" (Dr Andy Biddulph, 2015) .

Benefits of using QI research & Finding the information

Importance of learning from research

- To boost chances of getting desired results
- Use published reports on approaches that have been tried
- Build on previous work that showed good results
- Involve, patients, the public and end-users early in audit and for research
- Learn from interventions demonstrated as ineffective

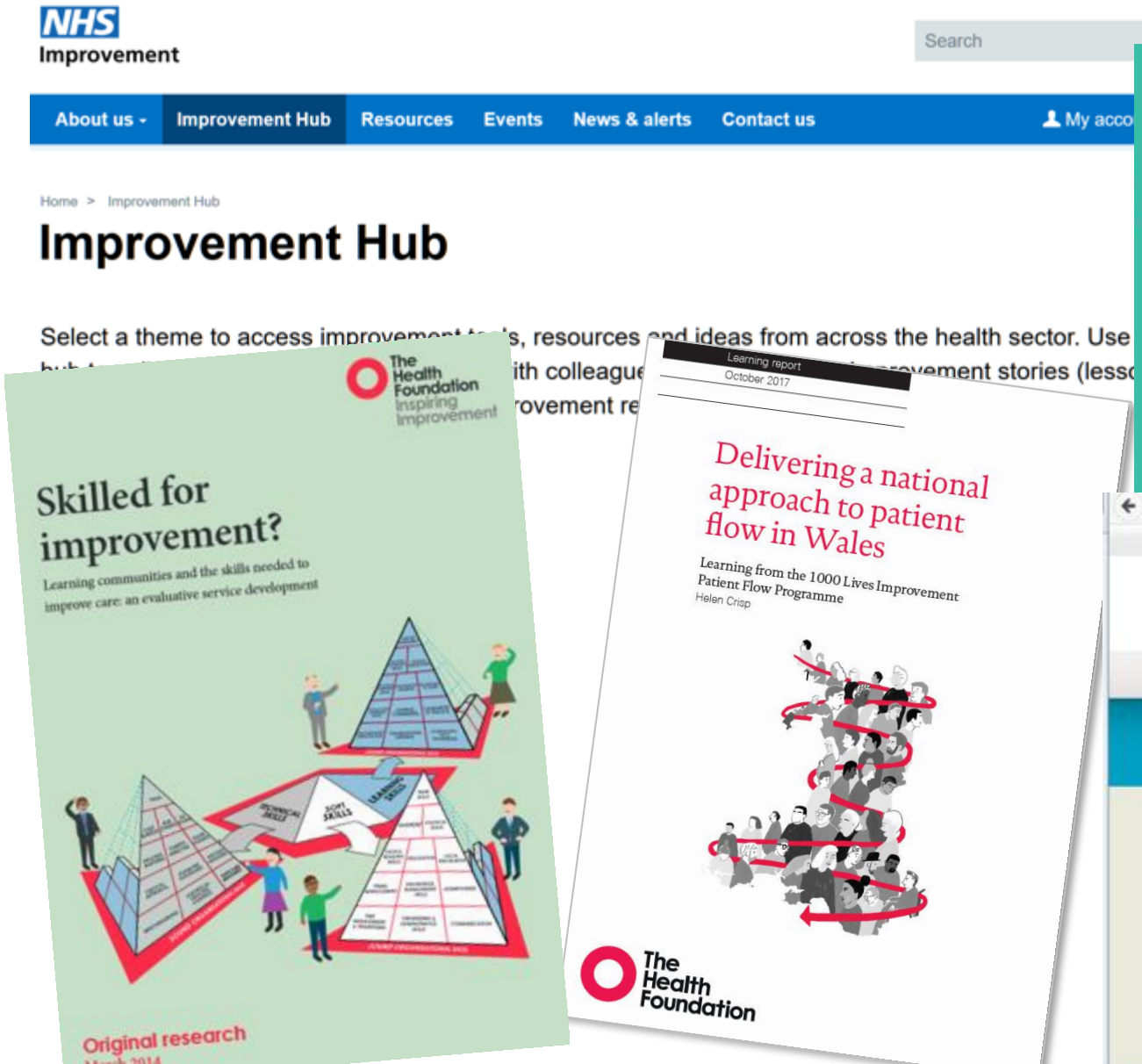
Avoiding wheel reinvention

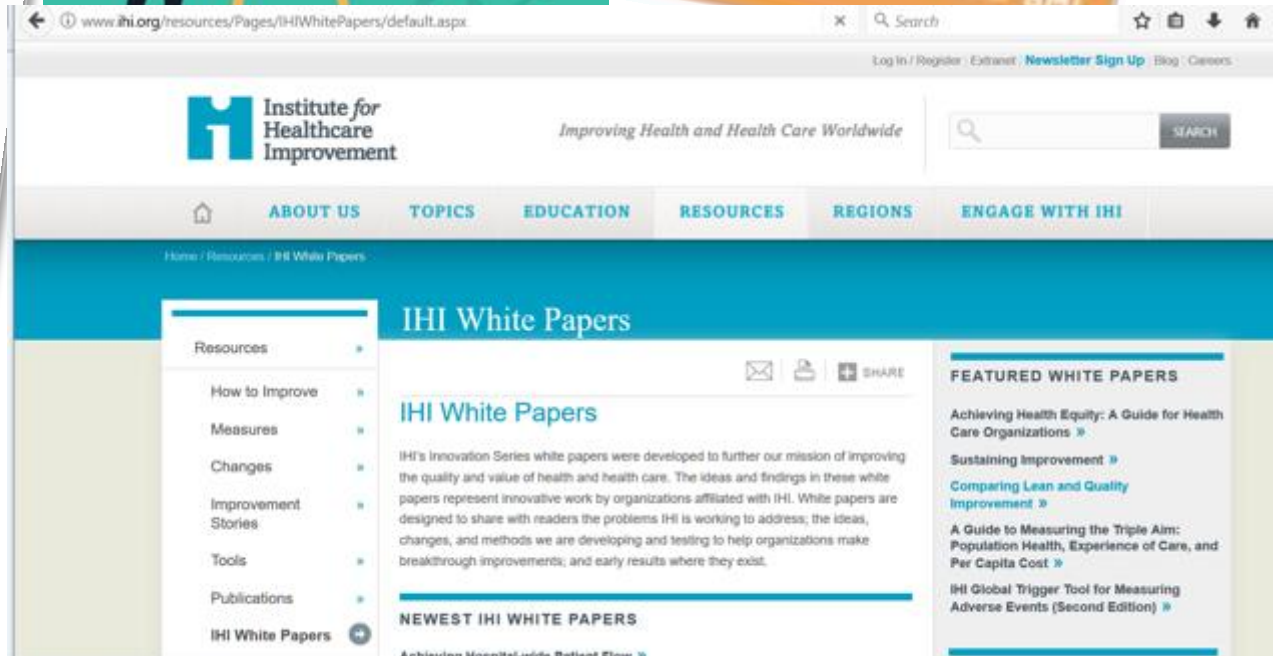
A well known problem in QI work:

- Too much emphasis on local innovation
- Too little considered review of what has been done elsewhere
- Time is wasted on ‘developing from scratch’
- Better to refine and adapt

Horizon scanning

Reports, guidelines, journals, web-sites





Where to find more specific information?

E.g. Improving medicines reconciliation in hospitals

- What approaches have been tried elsewhere?
- What has shown little effect?
- What works?
- Where did it work?
- Is it likely to work for us?

Photo source: Zero waste guide to medication

On-line resources

- NICE Local practice case studies
- BMJ Open Quality
- Health Systems Evidence
- BMJ Quality & Safety
- Range of specialist journals

Photo source: British Skin Foundation

Local practice case studies

A collection of over 500 working examples of quality improvement in health and social care services.

Submit an example

Tell us how you've made improvements in your organisation.

Find a case study

Ideal if you're responsible for making changes to service delivery. Includes examples of:

Adopting a multi-disciplinary approach to improve medicines accuracy in a general surgical ward

Shared learning database

Organisation: Western Health & Social Care Trust

Published date: **January 2017**

Key to the role of a pharmacist, is medicines reconciliation at the interfaces of care (NICE NG5 recommendations 1.3.1, 1.3.2 &1.3.5). This involves aligning pre-admission medications against those prescribed in hospital using at least two sources, including the Electronic Care Record (ECR).

Welcome to BMJ Open Quality, an expanded and rebranded version of BMJ Quality Improvement Reports. The journal is dedicated to publishing high quality, peer reviewed healthcare improvement work. Articles covering original research, local, national and international QI projects, value-based healthcare improvement initiatives and educational improvement work are all considered.

Our website provides a wide range of resources to support you in your quality improvement work such as videos, blogs, podcasts and templates to help you run and write up quality improvement projects.

BMJ Quality Improvement Programme

Improving Medication Reconciliation on the Surgical Wards of a District General Hospital

Erika Hughes, Paul Hegarty, Andrew Mahon

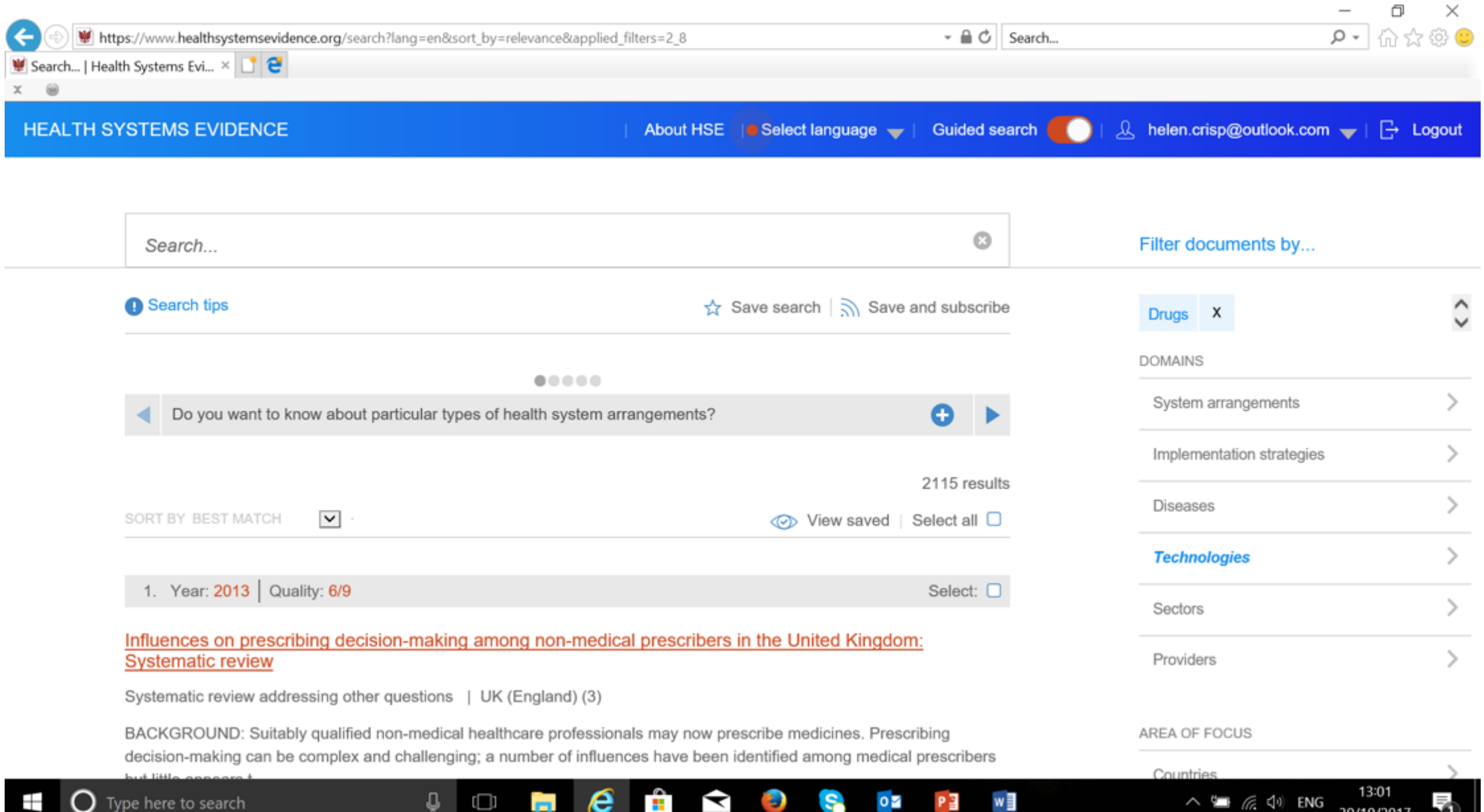
Correspondence to

Erika Hughes , Erika.Hughes@setrust.hscni.net

Abstract

During a routine audit it was noted that the surgical wards were consistently underperforming in their rate of medicines reconciliation in comparison to other specialities. The process of medication reconciliation is usually performed by junior doctors during the admission process and can be a complex task which is usually undertaken in the midst of several other jobs. The aim of this project was to review this process and identify methods of improving patient safety. This led to the design of a surgical admissions proforma which incorporated a 'medications on admission' section, to be used for reconciliation. Over a six month period from its introduction into a pilot ward it was noted to improve medication reconciliation from 60% to 85%. The benefits were

Health Systems Evidence - Canada



Hospital-based medication reconciliation practices: A systematic review

USER-FRIENDLY SUMMARY
Database of Review of Effects

SCIENTIFIC ABSTRACT
PubMed
Publisher

FULL-TEXT REPORT
Full-text report (free)

CITATION
Mueller SK, Sponsler KC, Kripalani S, Schnipper JL. Hospital-based medication reconciliation practices: A systematic review. Archives of Internal Medicine. 2012;172 (14):e1-e14.

TYPE OF DOCUMENT
Systematic review of effects

LAST YEAR LITERATURE SEARCHED
2012

QUALITY RATING
5/10 (AMSTAR rating from McMaster Health Forum)

COUNTRIES IN WHICH STUDIES (INCLUDED IN THE SYNTHESIS) WERE CONDUCTED
Australia(2); Belgium(1); Canada(2); Denmark(1); Netherlands(1); New Zealand(1); Sweden(4); United Kingdom (Northern Ireland)(1); United Kingdom (Scotland)(1); United States(12)

Australia: [illegible] Vasileff HM, et al.

Back to results

Benefits of using published studies

- Learn from others' experience
- Not starting from scratch - many published reports include:
  - Questionnaires used
  - Forms developed
  - Checklist elements
- Benchmark your results against reported findings
- Counters the question when introducing a change:

  "What's the evidence for this?"

Small group discussions

- How have you used research evidence in the past?
  - To decide on areas for improvement?
  - To decide what approach to take?
- What sources have you used to find evidence?
- How else might you search for relevant research evidence?

Feedback on current approaches to research evidence for QI work:

Improving design and implementation of improvement

Why is it so hard to answer the question: *Does quality improvement improve quality?*

Royal College of Physicians | Future Healthcare Journal

A journal of the Royal College of Physicians

Does quality improvement improve quality?

Mary Dixon-Woods, RAND professor of health services research[A] and Graham P Martin, professor of health organisation and policy[B]

+ Author Affiliations

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ABSTRACT

Although quality improvement (QI) is frequently advocated as a way of addressing the problems with healthcare, evidence of its effectiveness has remained very mixed. The reasons for this are varied but the growing literature highlights particular challenges. Fidelity in the application of QI methods is often variable. QI work is often pursued through time-limited, small-scale projects, led by professionals who may lack the expertise, power or resources to instigate the changes required. There is insufficient attention to rigorous evaluation of improvement and to sharing the lessons of successes and failures. Too many QI interventions are seen as 'magic bullets' that will produce improvement in any situation, regardless of context. Too much improvement work is undertaken in isolation at a local level, failing to pool resources and develop collective solutions, and introducing new hazards in the process. This article considers these challenges and proposes four key ways in which QI might itself be improved.

KEYWORDS

evaluation | healthcare organisation | hospitals | patient safety | quality improvement

« Previous | Next Article »
Table of Contents

This Article

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Future Hosp J October 1, 2016 vol. 3 no. 3 191-194

» Abstract
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The trouble with projects:

- ‘Apart’ from day to day work of the service
- Time limited – the ‘evaporation effect’
- Staff can ignore it “Nothing to do with me”
- May promise too much - leading to disillusionment
- Project teams – on to the next thing

Healthcare quality improvement

No silver bullets

- Improving quality of care is complex and progress is typically a series of small steps rather than giant leaps forward
- Interventions often take considerable time to demonstrate impact
- Even the most successful efforts will face obstacles and setbacks along the way
- Local context is crucial in understanding that interventions which ‘worked’ in one place are rarely easy to replicate in others
- Rather than searching for magic-bullet solutions, we need to develop the processes, systems and cultures to support the delivery of high-quality care on a continuous basis

What to change?

- Something that is recognised as ‘an issue’
- Links to the concerns of service users
- An issue that aligns with organisational priorities

Target agreed improvement issues

Do staff agree there is a problem to fix?

“I don’t recognise that in my practice”

“The data are wrong”

“We’ve already changed the way we work”

“Our patients have not complained”

Target agreed improvement issues

Do staff agree there is a problem to fix?

"I don't recognise that in my practice"

"The data are wrong"

"We've already changed the way we work"

"Our patients have not complained"

Highlight areas to target with:

- Hard data
  - Locally produced and validated
  - or from respected source
- Well-evidenced examples of the possible
- Patient survey information
- Discuss what you think the issue is

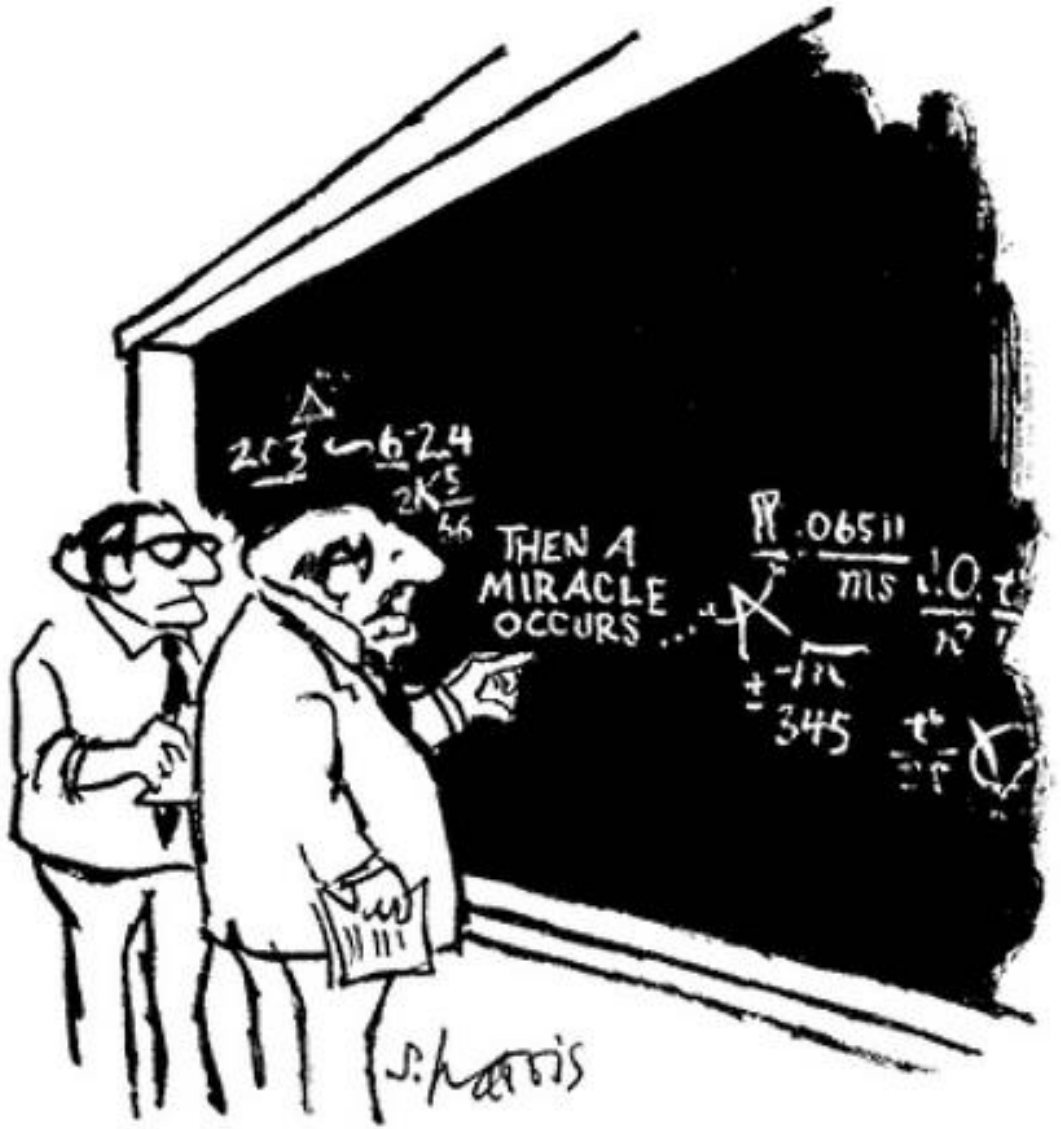
Is the improvement linked to service user concerns?

- What does complaints data tell you about where to focus?
- Using service user feedback:
  - Routine surveys
  - Suggestion ‘box’ or online equivalent
- Go out and ask before making further plans!

Alignment with organisational priorities

- Can you point to a heading in the strategy document?
- Are you focussed on an issue that matters to the Board?
- Will your manager give this priority and support?
- Again, does it matter to patients?

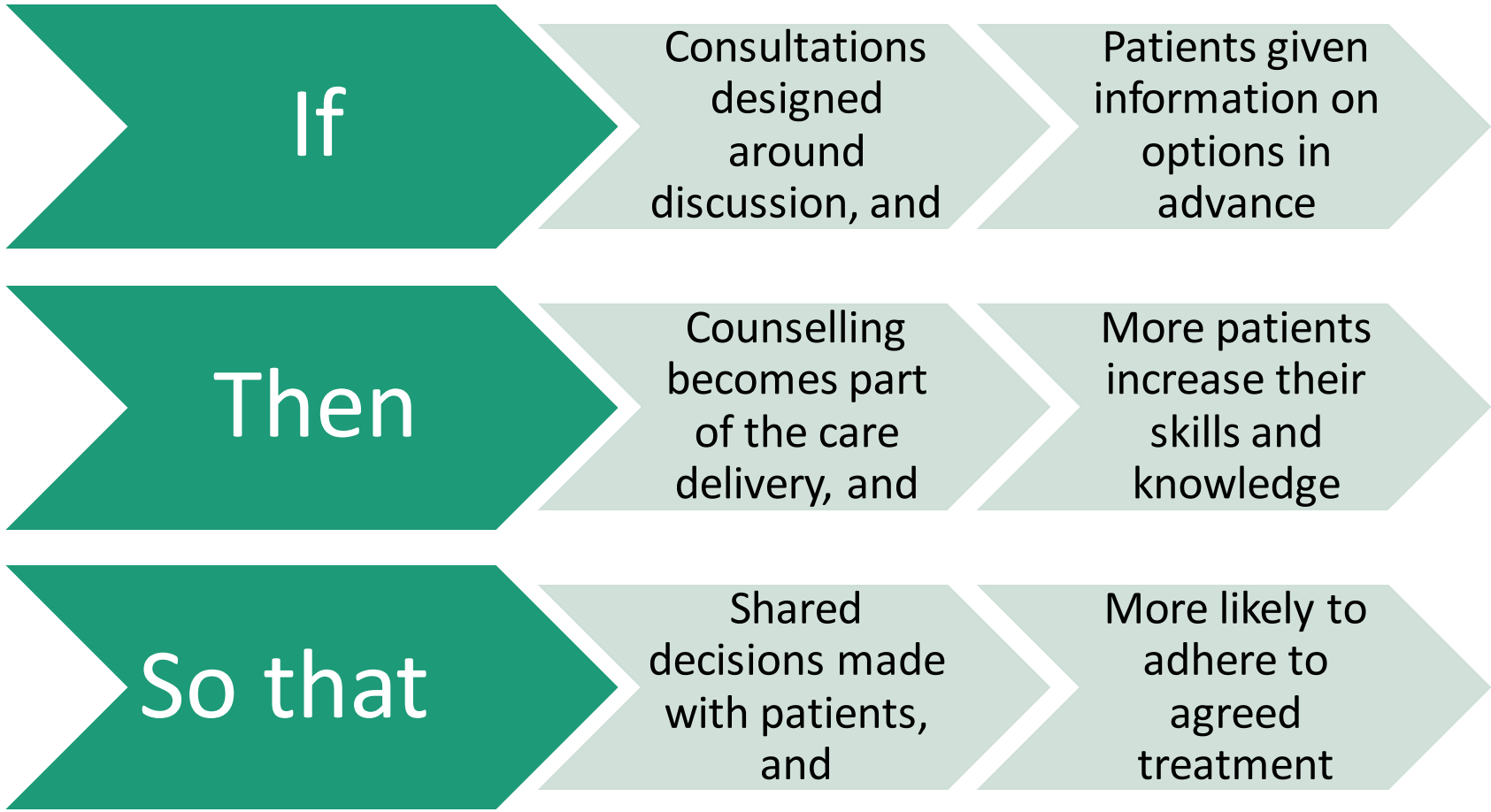
How do you expect it to work?



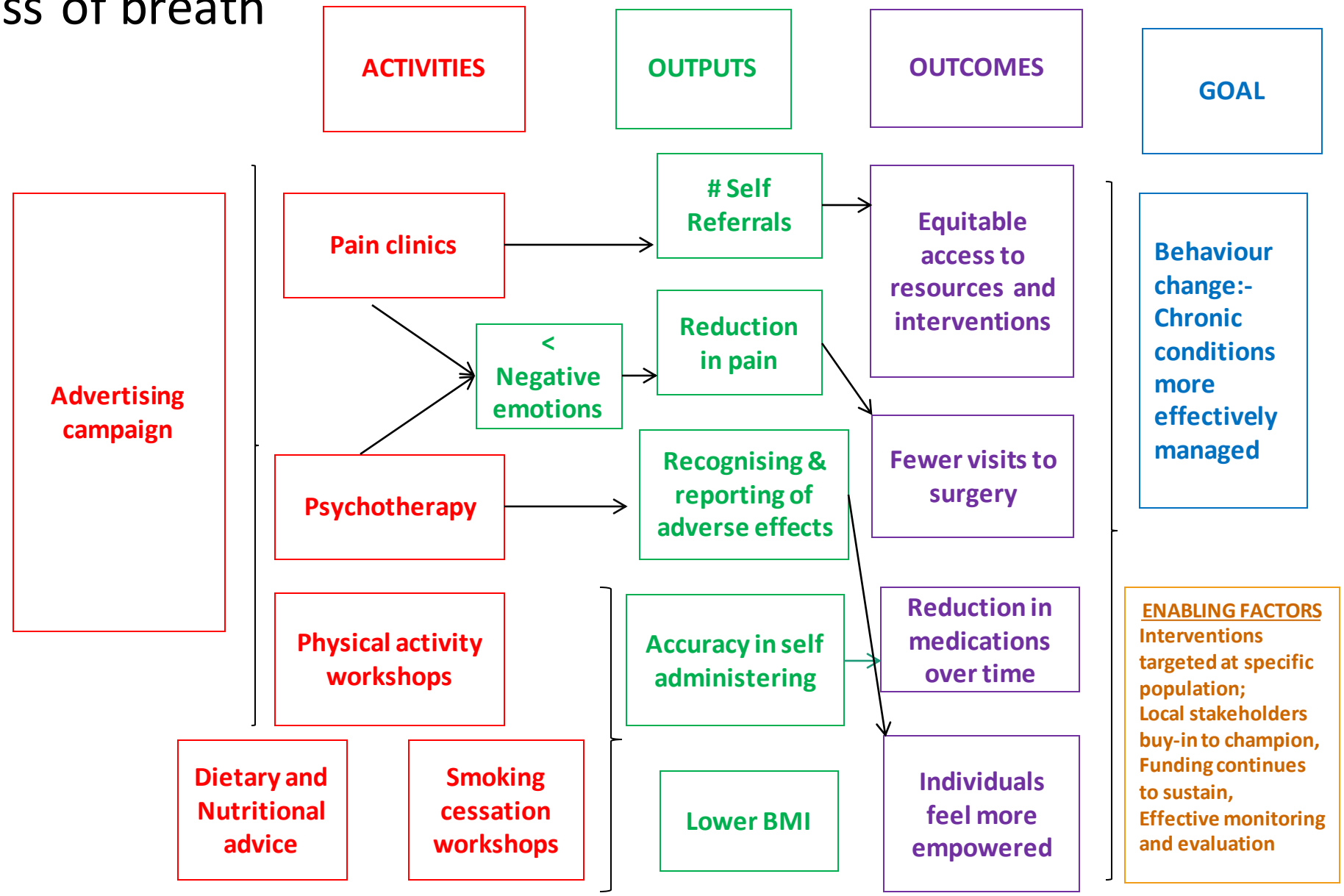
"I think you should be more explicit here in step two"

Cartoon credit: Sidney Harris

Being more explicit at step 2: A simple theory of change



THEORY OF CHANGE : Managing chronic conditions; pain, fatigue, shortness of breath



BMJ Quality & Safety, January 2015

OPEN ACCESS

Demystifying theory and its use in improvement

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ABSTRACT

The role and value of theory in improvement work in healthcare has been seriously underrecognised. We join others in proposing that more informed use of theory can strengthen improvement programmes and facilitate the evaluation of their effectiveness. Many professionals, including improvement practitioners, are unfortunately mystified—and alienated—by theory, which discourages them from using it in their work. In an effort to demystify theory we make the point in this paper that, far from being discretionary or superfluous, theory ('reason-giving'), both informal and formal, is intimately woven into virtually all human endeavour. We explore the special characteristics of grand, mid-range and programme theory; consider the consequences of misusing theory or failing to use it; review the process of developing and applying programme theory; examine some emerging criteria of 'good' theory; and emphasise the value, as well as the challenge, of combining informal experience-based theory with formal, publicly developed theory. We conclude that although informal theory is always at work in improvement, practitioners are often not aware of it or do not make it explicit. The germane issue for improvement practitioners, therefore, is not *whether they use* theory but *whether they make explicit* the particular theory or theories, informal and formal, they actually use.

advantage of informal and formal theory in planning and executing improvement efforts.[3] It is of course possible to achieve high levels of quality and safety on the basis of intuition derived from experience alone, with little evident help from formal theory. The few successful examples that exist do not, however, help to build a science. In this article, we join others in arguing that the explicit application of theory could shorten the time needed to develop improvement interventions, optimise their design, identify conditions of context necessary for their success, and enhance learning from those efforts.[4–9] The need for more effective use of formal theory in improvement is increasingly pressing, because personal intuition is often biased, distorted and limited in scope[10] and the application of formal theory enables the maximum exploitation of learning and accumulation of knowledge, and promotes the transfer of learning from one project, one context, one challenge, to the next. We are concerned in this article with demystifying the nature of theory and making clear its many and various roles in carrying out and evaluating improvement, not with the place of theory in the vast (and often contentious) body of literature on the philosophy of science.

Theory of change

- The value of theory to underpin improvement is under-recognised
- Practitioners not aware, or don't make explicit
- Personal intuition is often biased, distorted and limited in scope
- A theory of change enables rapid 'course corrections'

Plan for success:

CONSULT PUBLISHED EVIDENCE

CONVINCE PEOPLE IT'S THE RIGHT APPROACH

GET STAFF & SERVICE USERS ENGAGED

COMMUNICATE, EDUCATE AND TRAIN

DEMONSTRATE PROGRESS WITH DATA

Managing and reflecting on implementation

- Think about who needs to be involved
  - How to involve patients/ carers?
- Where does the intervention fit in the patient pathway?
  - Consider ‘upstream’ and ‘downstream’ implications
- Monitor changes and adjustments made as you go along
  - Very difficult to capture these with authenticity later
- Check your measures are appropriate and that data is available
  - Do not omit the baseline data step – can never be re-captured
  - Get expert help early-on with statistics and data analysis

Getting the best from QI work

- Link to organisational strategy and priorities
- Use your measurement results to make a business case for continuation:
  - Improved process
  - Cost saving
  - Greater user satisfaction
- Plan for integration from the outset
- Get the bureaucracy in place:
  - Protocols
  - revised job descriptions
  - Referral route etc
- Don’t promise quick results

Involving patients/service users and carers

- Going beyond feedback and complaints data
- Still a rarity!
- Mental health further ahead than hospital services

Photo: PenCLAHRC- NIHR

Engagement and involvement

- From the start – not as an ‘add-on’
- Don’t have one person as a token representative – aim to get a group of people involved
- Ensure there is time and resource for briefing and training
- Include as full team members – not just for quarterly report meetings
- Work with skills and interests:
  - Interviewing other service users
  - Developing and testing patient information materials
  - Designing project webpage
  - Patient ‘diary’ to record experience of service innovation e.g. online consultation

Exercise: Involving patients the 'Understanding our medicines' improvement project

Greenborough Healthcare want to improve the effective use of medicines across their integrated health service. From routine patient surveys they know that many people feel they don't know enough about the medicines they are taking. Not all patients have their medications reviewed and anecdotal evidence suggests that some medications on repeat prescription are not taken used.

The project aims to:

1. Collect data from people taking multiple medications
2. Develop a simple medication information and record book for patients
3. Improve the system for regular individual medication review
4. Reduce unwarranted repeat prescriptions

How would you recruit service users to get involved with the project?

In what ways could service users contribute to the project?

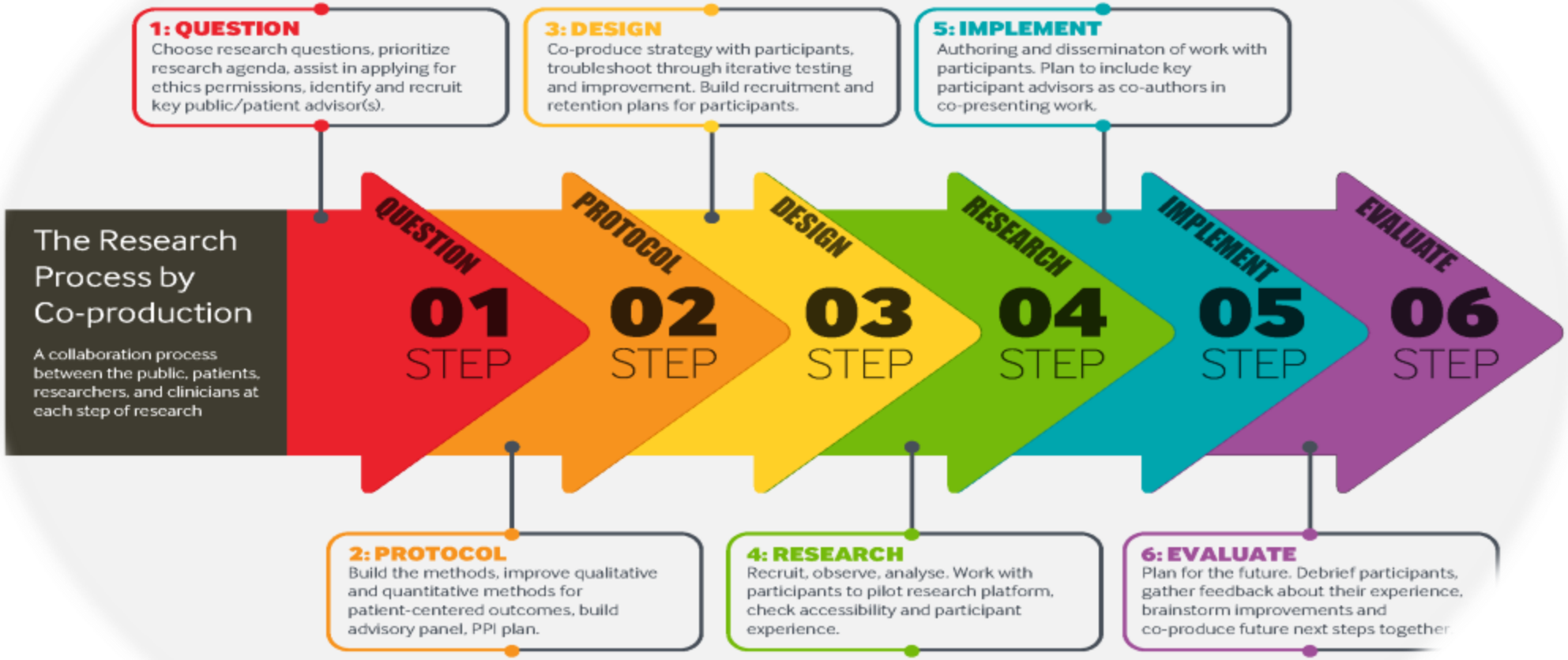
What training do you think they would need?

Would the Researchers need training to work with them?

What benefits might they bring to the improvement team?

Feedback on involving patients/service users in the ‘Understanding our medications’ project:

Coproduction in QI Research

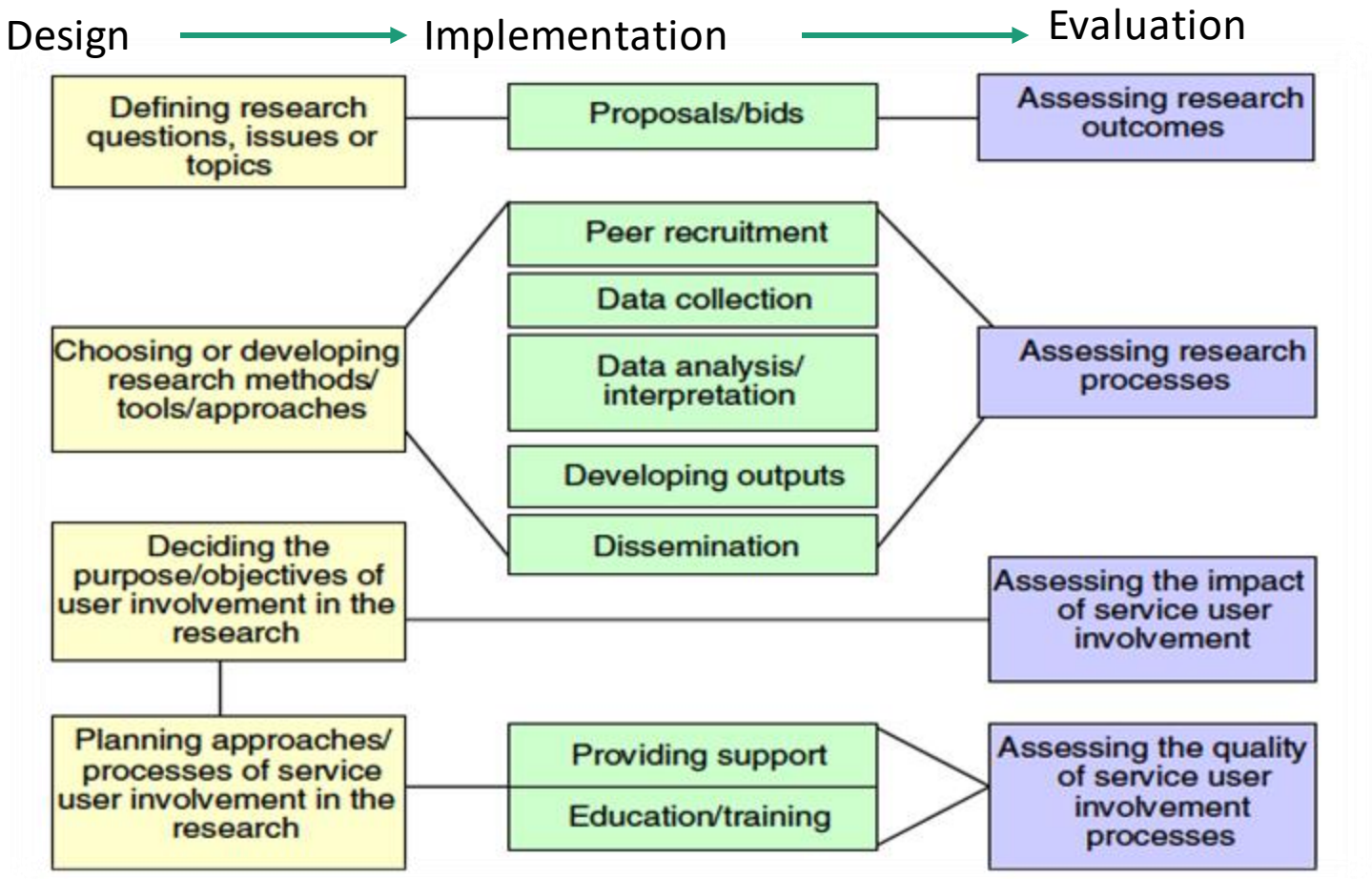

1: QUESTION
Choose research questions, prioritize research agenda, assist in applying for ethics permissions, identify and recruit key public/patient advisor(s).
3: DESIGN
Co-produce strategy with participants, troubleshoot through iterative testing and improvement. Build recruitment and retention plans for participants.
5: IMPLEMENT
Authoring and disseminaton of work with participants. Plan to include key participant advisors as co-authors in co-presenting work.
The Research Process by Co-production
A collaboration process between the public, patients, researchers, and clinicians at each step of research
QUESTION 01 STEP
PROTOCOL 02 STEP
DESIGN 03 STEP
RESEARCH 04 STEP
IMPLEMENT 05 STEP
EVALUATE 06 STEP
2: PROTOCOL
Build the methods, improve qualitative and quantitative methods for patient-centered outcomes, build advisory panel, PPI plan.
4: RESEARCH
Recruit, observe, analyse. Work with participants to pilot research platform, check accessibility and participant experience.
6: EVALUATE
Plan for the future. Debrief participants, gather feedback about their experience, brainstorm improvements and co-produce future next steps together

Why Co-Production Matters| Effectiveness and Safety

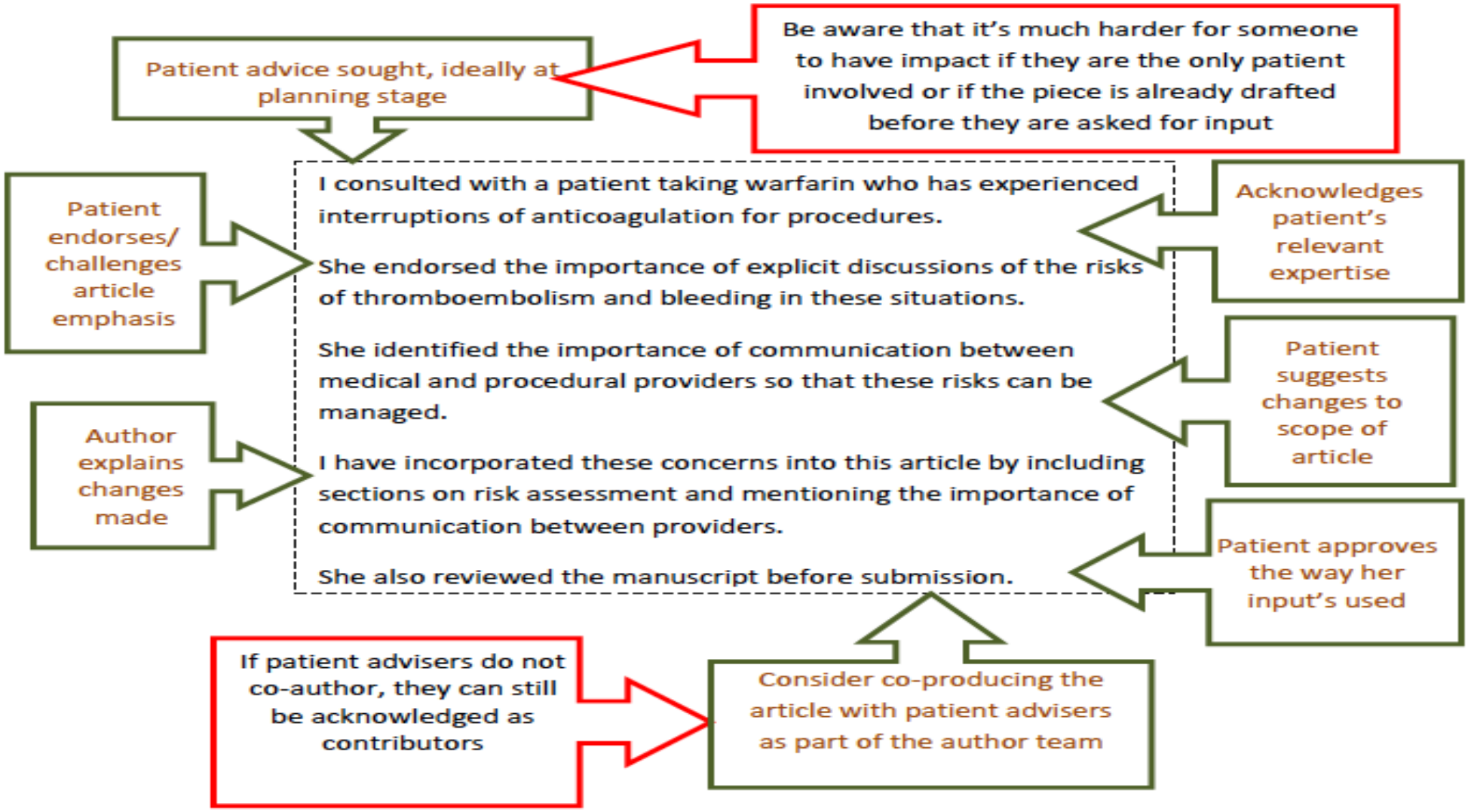
- Co-Production has the potential to improve the quality safety and relevance of health research
- One of the most important stages of the research process is for members of the public to be involved in is research design in order to maximize research influence and impact

Choose one from Each Column

E Smith et al J International Journal of Nursing Studies 45 (2008)298-311



What Co-Production Might Look Like



Used by Permission Dr. Rosamund Snow | The BMJ

Questions and discussion

Break

Re-cap:
What we have covered so far

- Using research evidence
  - Where to find it
  - How to sift and sort to get what you need

Improving design and implementation of improvement work

  - Using research to plan and implement your intervention
  - Lived experience to inform improvement work

- How lived experience contributes to improvement research and work
  - Coproduction of research
  - Why coproduction matters

Next session

- How you can contribute to better publications on QI
  - Tips for better write-up of improvement work
  - Incorporating lived experience : -practitioners, service users, researchers
- Exercise on how to improve QI write-up
- Thinking about wider dissemination of improvement work

Sharing the learning

Recognition and celebration

- Recognise contributions and effort
- Do remind people where you've come from
- Let all the team know when a target has been achieved
- Blow your own trumpet:
  - Poster in department
  - Write-up for newsletter
  - Publication of your work

Helping to build the evidence base

Better reporting of improvement work:

- Helps to spread successful improvement interventions
- Prevents wasted effort on repeating interventions that don't work
- Includes reporting of patient and public involvement in co-production

Reporting bias

Papers tend to get written up when the improvement is ‘successful’

We can also learn a lot from what didn’t work

Content bias

Reports over-focus on results:

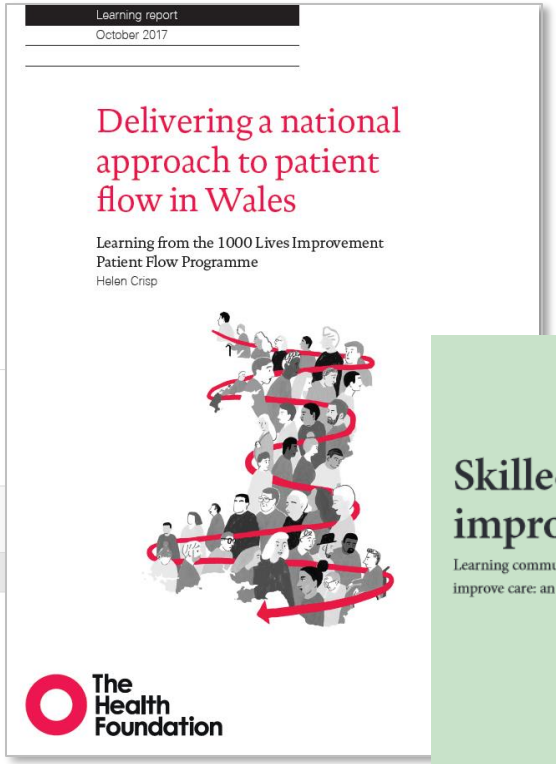
“We achieved 14% reduction of X!”

Little information on methods and the experience of implementation:

“How we planned and adapted what we did to achieve 14% reduction of X”

Learning when objectives not fully achieved

We can learn a lot from what is not so successful



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How collaborative are quality improvement collaboratives: a qualitative study in stroke care

Pam Carter, Piotr Ozieranski, Sarah McNicol, Maxine Power and Mary Dixon-Woods

Implementation Science 2014 9:32 | https://doi.org/10.1186/1748-5908-9-32

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Open Peer Review reports

BMJ Quality & Safety, March 2015

OPEN ACCESS

How to study improvement interventions: a brief overview of possible study types

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ABSTRACT

Improvement (defined broadly as purposive efforts to secure positive change) has become an increasingly important activity and field of inquiry within healthcare. This article offers an overview of possible methods for the study of improvement interventions. The choice of available designs is wide, but debates continue about how far improvement efforts can be simultaneously practical (aimed at producing change) and scientific (aimed at producing new knowledge), and whether the distinction between the practical and the scientific is a real and useful one. Quality improvement projects tend to be applied and, in some senses, self-evaluating. They are not necessarily directed at generating new knowledge, but reports of such projects if well conducted and cautious in their inferences may be of considerable value. They can be distinguished heuristically from research studies, which are motivated by and set out explicitly to test a hypothesis, or otherwise generate new knowledge, and from formal evaluations of improvement projects. We discuss variants of trial designs, quasi-experimental designs, systematic reviews, programme evaluations, process evaluations, qualitative

increasingly important focus of activity within healthcare.[1] How improvement interventions can best be studied, however, has remained contested; as with most new fields, many of the key terms, concepts and techniques currently escape consensus. In a rapidly evolving field, and with the task of designing, testing, implementing and evaluating quality improvement interventions, as well as producing generalisable knowledge growing in complexity,[2] it is helpful to characterise the kinds of study designs that can be used to study improvement interventions. This is the task to which this paper is directed; it is intended to offer an introductory overview and bibliography, particularly for those new to the field. It is based on a narrative literature review[3] using English language articles selected through a systematic search strategy (box 1) and reflection based on our experience in the field.

STUDYING IMPROVEMENT IN HEALTHCARE

We begin by noting that a significant

Reporting to facilitate spread

Improvement reports need to provide enough detail:

- to convey credibly that something worked
- to give insight on the action needed to replicate the results in another setting

Credibility and replication

- Too often improvement reports lack important details about key components of intervention and institutional context
  - ***Readers can't know if it's worth trying in their setting***
- No information is given on barriers or problems to implementation
  - ***No improvement effort works immediately - this absence decreases credibility***

A typical QI report

Introduction

Hospital falls affect thousands of elderly patients each year.

Hospital staff do not risk assess or implement controls consistently.

We implemented a multi-faceted strategy:

- Staff education
- Clinical champions
- Empowering patients and carers to raise concerns

Methods

Briefly stated design, data collection strategy and main outcomes, plus some mention of PDSA

Results

We reduced inpatient falls by 27%

Discussion

Patient and carer empowerment can be effective

There’s quite a lot missing here

Introduction

- Hospital falls affect thousands of elderly patients each year
- Hospital staff do not risk assess or implement controls consistently
- We implemented a multi-faceted strategy:
    - Staff education
    - Clinical champions
    - Empowering patients and carers to raise concerns

No connection between the introduction material

and

specific features of the intervention

A better approach

Introduction

Commonly identified problems which can lead to hospital inpatient falls include A, B, and C

Staff education, clinical champions, and empowering patients **address** A, B, and C

by doing X, Y, and Z

This introduction makes clear what factors can influence numbers of hospital inpatient falls

And, it makes explicit why the intervention includes these ingredients

This "theory for the intervention" will pay off in writing the report and interpreting the results

Is it clear what you did?

- **'PDSA' needs context to make sense!**
- **Simply saying; 'We carried out three PDSA cycles' is not informative.**
- **What did the 'study' of what you had 'done' reveal and how did you 'act' as a result?**

Methods

Briefly stated design, data collection strategy and main outcomes, plus some mention of PDSA

Results

We reduced falls by 27%

Discussion

Patient and carer empowerment can be effective

A better approach

Method

After the first round of staff education we reviewed the delivery mechanism and feedback from participants, using PDSA methodology. It was reported that timing of training sessions was an issue in getting staff attendance, so the next sessions were planned with ward managers.

Participants wanted more visual material to illustrate key points - these were designed with staff and used in subsequent sessions.

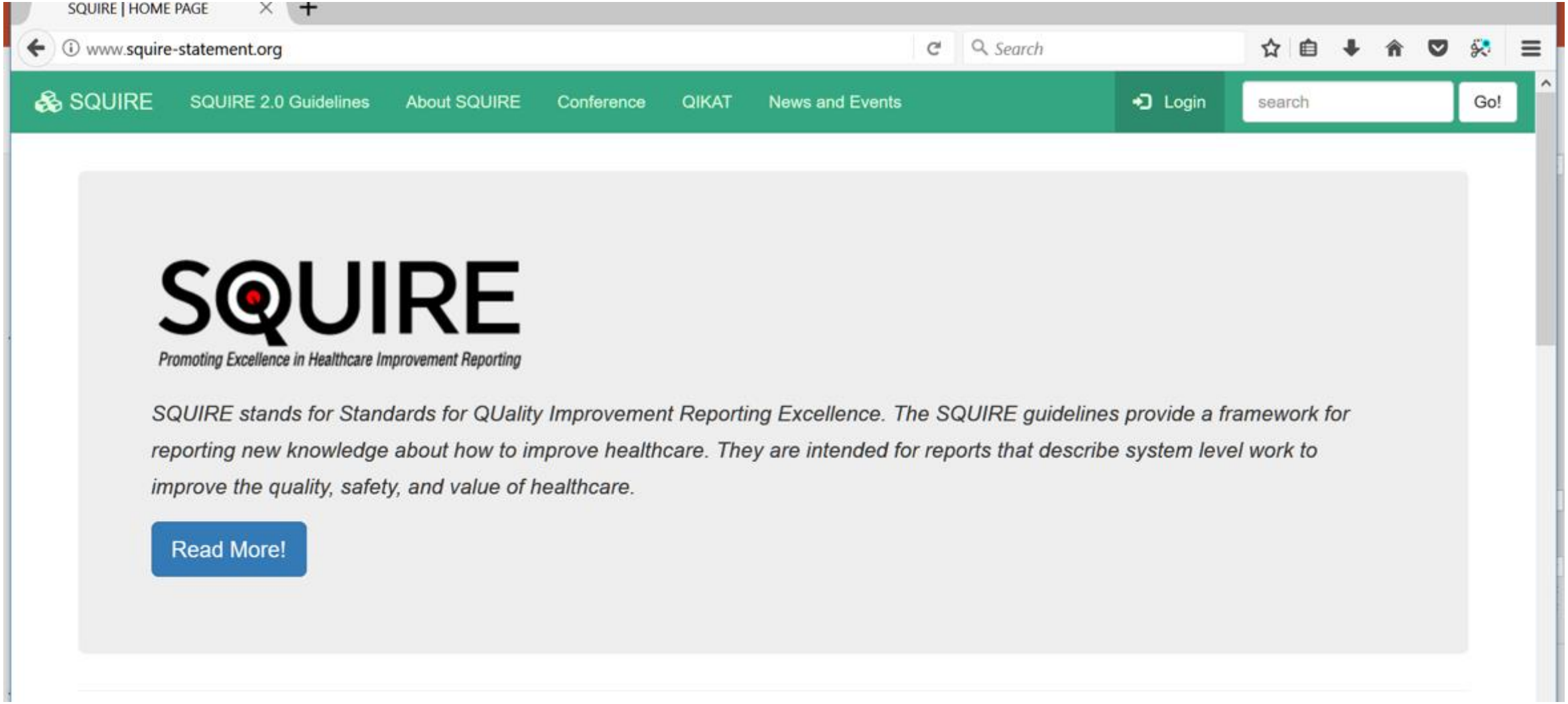
This provides more detail which makes the report credible

Others are likely to have the same issues and could avoid making the same mistakes

Sharing and learning more

- Reports on improvement work need not only **results** but also:
- how the initiative was designed
- the setting where it was implemented
- detail on the core components
- measures and data used to measure the change
- challenges overcome along the way
- how they were overcome
- what the team would do differently in the future

Help is at hand



Revised Standards for Quality Improvement Reporting Excellence

SQUIRE 2.0

Notes to Authors

- The SQUIRE guidelines provide a framework for reporting new knowledge about how to improve healthcare.
- The SQUIRE guidelines are intended for reports that describe system level work to improve the quality, safety, and value of healthcare, and used methods to establish that observed outcomes were due to the intervention(s).
- A range of approaches exists for improving healthcare. SQUIRE may be adapted for reporting any of these.
- Authors should consider every SQUIRE item, but it may be inappropriate or unnecessary to include every SQUIRE element in a particular manuscript.
- The SQUIRE Glossary contains definitions of many of the key words in SQUIRE.
- The Explanation and Elaboration document provides specific examples of well-written SQUIRE items, and an in-depth explanation of each item.
- Please cite SQUIRE when it is used to write a manuscript.

Title and Abstract

1. Title	Indicate that the manuscript concerns an initiative to improve healthcare (broadly defined to include the quality, safety, effectiveness, patient-centeredness, timeliness, cost, efficiency, and equity of healthcare)

SQUIRE 2.0

NOTES TO AUTHORS

TITLE AND ABSTRACT

INTRODUCTION

METHODS

RESULTS

DISCUSSION

OTHER INFORMATION

SHORTCUTS

SQUIRE 2.0 E&E

SQUIRE 2.0 PDF

SQUIRE Guidelines

Based around four fundamental questions:

Why did you start?

What did you do?

What did you find?

What does it mean?

Format of the SQUIRE guidelines

Introduction	Methods	Results	Discussion
• ***Why did you start?*** • Problem definition • Available knowledge • Rationale • Aims	• ***What did you do?*** • Context • Intervention • **Study of the intervention** • Measures • Analysis • Ethical considerations	• ***What did you find?*** • Evolution & modification • Data for process measure and outcomes • Missing data • Unintended consequences	***What does it mean?*** • Summary • Interpretation • Limitations • Conclusions

Reporting Co-production in Quality Improvement

Where

- The PPI statement should appear at the end of the Methods section

What

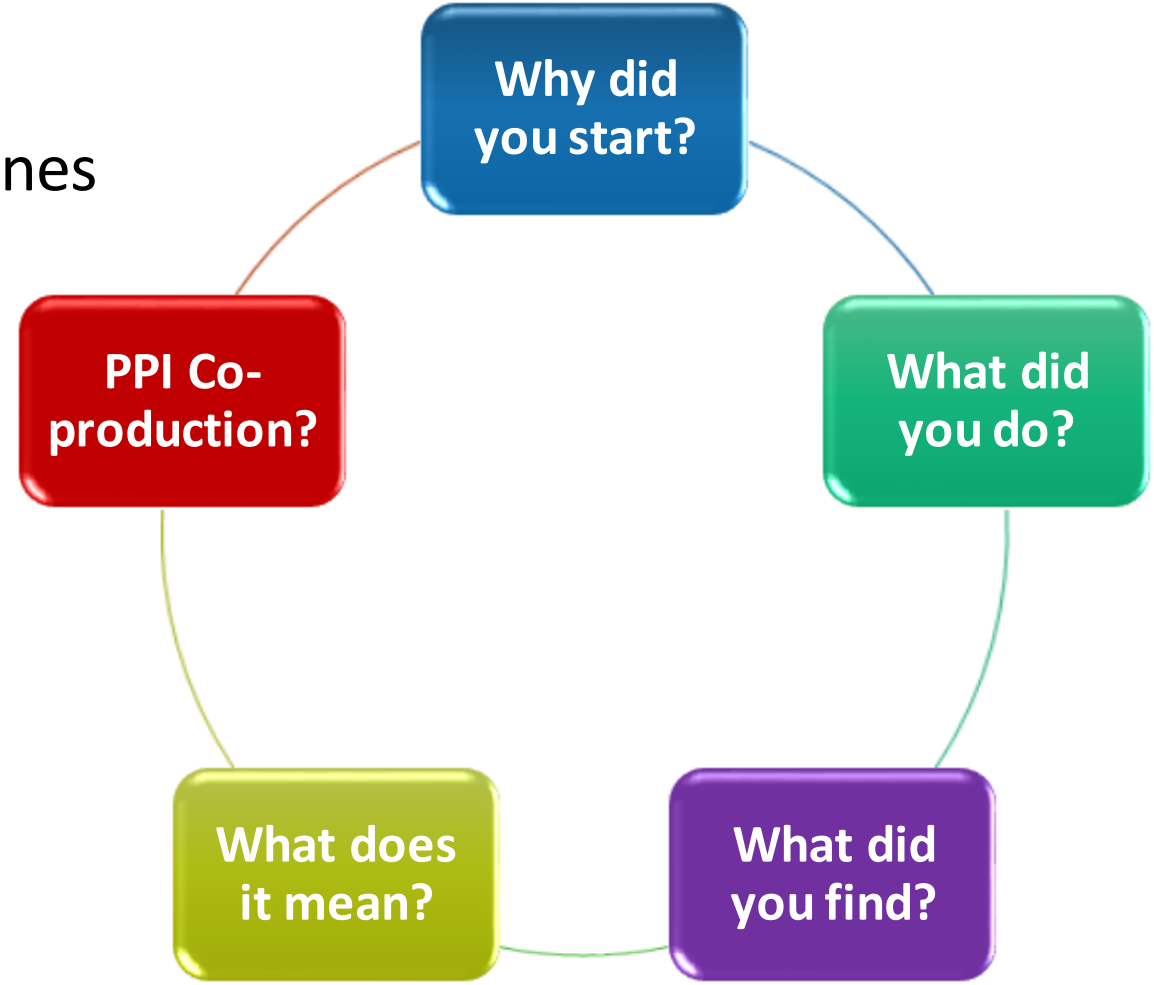
- How was the development of the research informed by public or patients' priorities, experience, and preferences?

When

- How did you involve patients in the design of this study?
- How will the results be disseminated to study participants?

Collaborative Paper Review with Five Questions

- Hint: Use the Squire reporting guidelines
- Include what you have learned
- Review it together
- It is ok not to agree
- Keep it constructive
- Stay positive but clear
- Report it back to us



Feedback from editing exercise:

Starting to write-up improvement

Keep an improvement **journal**

- Capture information as you go along
- Record project adjustments

Think about **data** at the outset

Consider **context** of the intervention

Read before you write:

- Articles on improvement methods
- Quality Improvement reports
- Studies of similar work

Involve others

- Include patient and carer feedback whenever possible
- Perspectives from across the improvement team
- Views on the impact across departments/ care sectors

BMJ Journals now require a statement on patient involvement

Work on your abstract

- It's what reviewers read first – many 'reject' decisions are made on this basis
- Don't rush it - review and fine tune
- Ensure all key information is included
- Make it interesting!

Writing tips

- Use the guidelines!
- Don’t leave it until the end
- Keep an improvement diary
- Data first, middle and last
- Involve the team

It always takes longer than you think it will!

Where to publish?

PROBLEM:

Most improvement reports are not considered to meet the ‘scientific’ criteria for peer reviewed medical Journals

QI reports are not ‘new discovery’

Quality improvement is unashamedly NOT chemistry

Picture credit: http://comofuncionaque.com/

Pros and cons of academic publication

- Gives the work credibility
- Prestigious – career enhancing
- May be read by influential people in the field
- The study of improvement provides useful knowledge for improvement practice

- May not be widely read, or read by your target audiences
- Improvement work does not ‘fit’ with medical research journals
- Improvement research uses different study methods and data analysis

Qual v Quant - the debate continues:

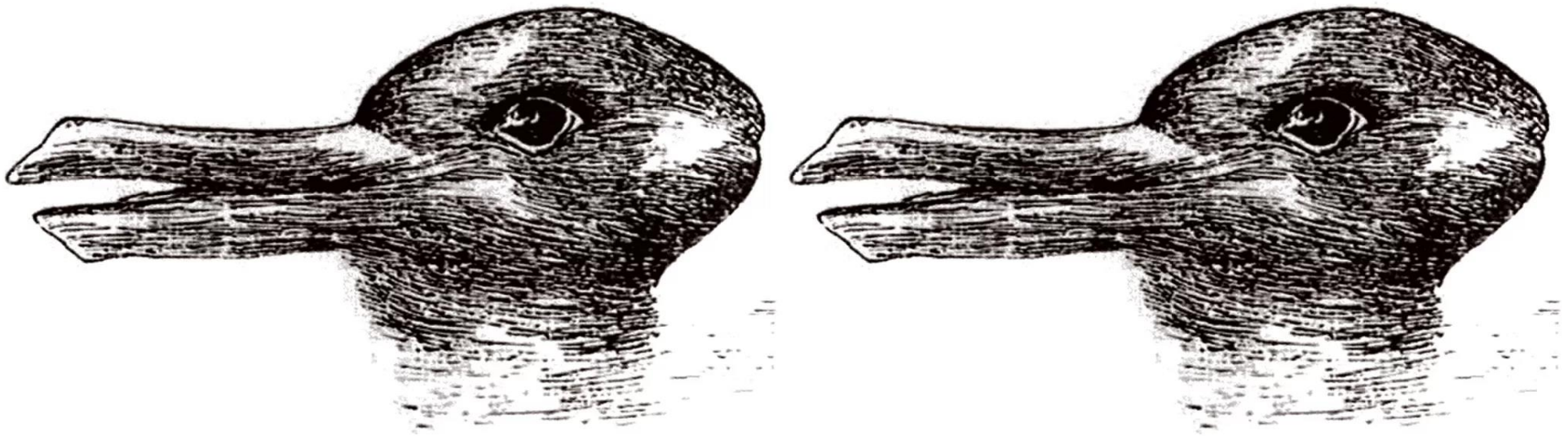
Excerpt from rejection letter tweeted by McGill Qualitative Health Research Group (@MQHRG), 30 September 2015

Thank you for sending us your paper. We read it with interest but I am sorry to say that qualitative studies are an extremely low priority for *The BMJ*. Our research shows that they are not as widely accessed, downloaded, or cited as other research.

An open letter to The BMJ editors on qualitative research

BMJ 2016; 352 doi: https://doi.org/10.1136/bmj.i563 (Published 10 February 2016)

Finding Perspective | Not so Easy



Seeing the Hearing

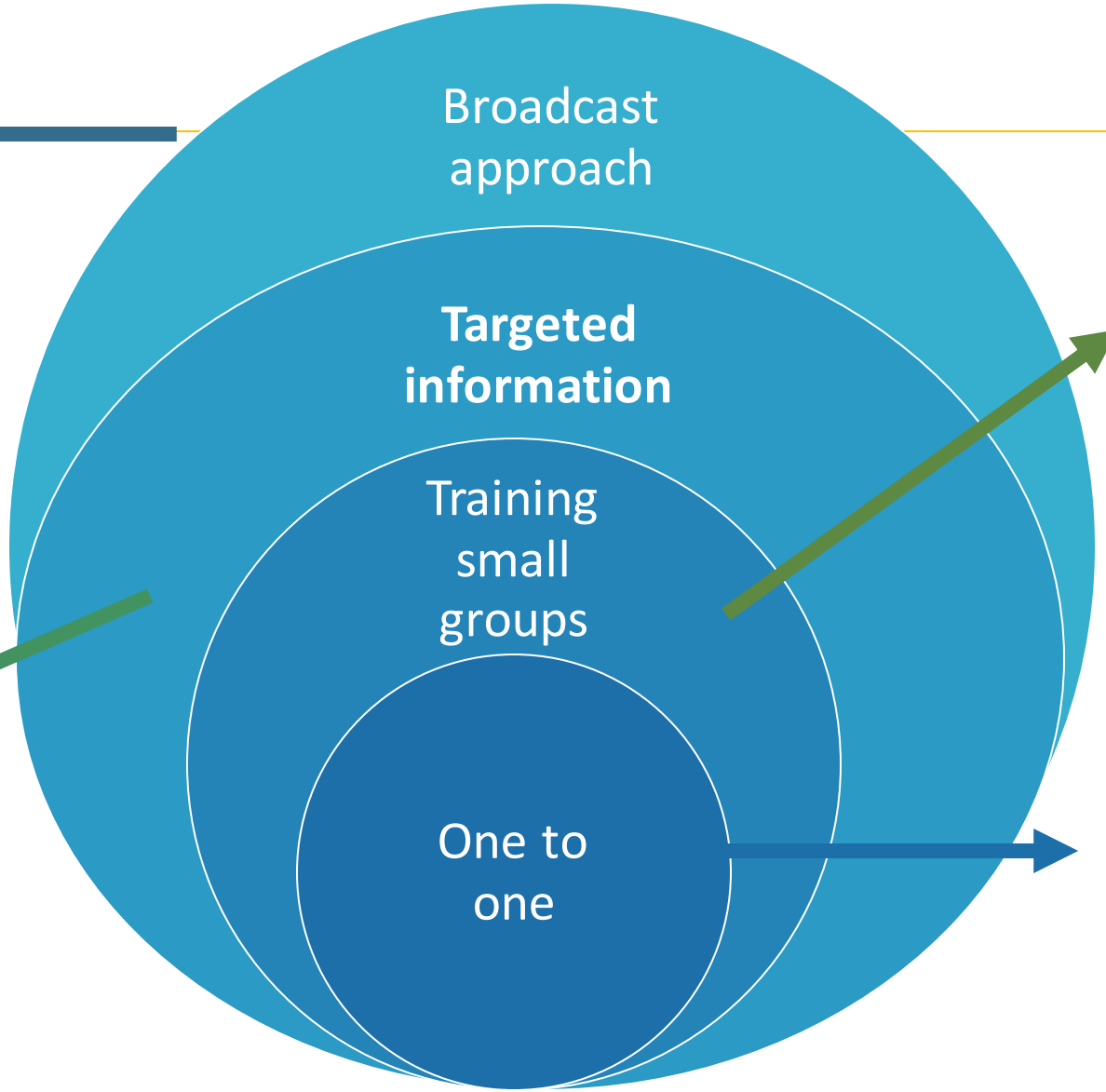
What did The BMJ Really Say?

Assumption is the greatest enemy of collaboration

Co-production is hard because it is moving beyond what you assume and listening to hear

Wider dissemination of QI work

Matching effort to influence



Methods
- Items in newspapers, TV, radio
- Twitter
- Linked-In posts

Methods
- Train the trainer
- Implementation toolkit
- On-line learning resources
- Clinical communities

Methods
- Academic journals
- Articles in professional media
- Conference presentations
- Dedicated website

Methods
- Professional education visits
- Supervised implementation
- Mentoring

Spreading the word

Peer influence is key to getting messages heard

Identify who you want to reach:

- Where are they?
- What do they read?
- What social media do they use?

Conferences & seminars

- See where your work fits best
- Tweak to reflect conference themes
- Engage with the audience's interests
- Tell your story

Don’t dismiss the conference poster!

- Valuable opportunity to share your work
- Needs strong visual appeal
- Put time and resource into design
- Hone the text and limit to key messages
- Be there at breaks to talk about the work

Photo source: Centres for Disease Control and Prevention, USA

‘Best Practice’ Awards – what the judges look for:

- Clear ***results***
- Tangible ***benefits*** for patients (and staff)
- Something a bit different – ***originality***
- Understanding ***what was done and how***

Visual, audio and on-line media

- Blogs
- Videos
- Podcasts
- Webinars

Your outputs

Webinar

Blog

Improvement report

Places needing relevant content

Q Community

Patient/condition charity

BMJ Open quality

Using social media

Social media is a great way to attract attention to your work

- Tweet about up-coming presentations and link to on-line articles
- Linked-In can be used in the same way as twitter or to do mini-blogs
- Facebook works well if you want to interact with a group
- Instagram will work for you if you can capture essential points in photos

Table discussions

- What changes could you make to better disseminate your improvement work?
- What resources have you got now?
- What else is needed?
  - expertise, get more people involved etc.

- What would you hope to achieve through wider dissemination?

Feedback: What will you do differently to disseminate your QI work?

Focus on key messages

- The thing you improved
- Why it’s important
- How patients (& staff) benefited
- What you did
- The challenges overcome

Questions and discussion

Conclusions

Much QI work is not optimal, due to:

- Insufficient regard for the already available evidence
- Not taking account of patient/service user & carer viewpoints and
- Not involving them in improvement and research efforts

As practitioners in the field we can do more to:

- Use the evidence and build the evidence
- Involve patients, service users and carers at every stage

- Thank you to the authors for permission to use the patient feedback paper

Thank you!

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References and resources

‘Does Quality Improvement Improve Quality?’
Mary Dixon-Woods, Graham Martin. Future Hospital Journal, 2016, Vol 3, No 3: 191–4 , Royal College of Physicians, London UK

‘Demystifying theory and its use in improvement’
Frank Davidoff, Mary Dixon-Woods, Laura Leviton, Susan Michie. BMJ Quality and Safety, January 2015

‘Skilled for improvement?’
John Gabbay, Andree Le May, Conn Connell, Jonathan H Klein. Health Foundation, London UK, March 2014

‘Delivering a national approach to patient flow in Wales’
Helen Crisp. Health Foundation, London UK, September 2017

‘How collaborative are quality improvement collaboratives: a qualitative study in stroke care’
Pam Carter, Piotr Ozieranski, Sarah McNicol, Maxine Power and Mary Dixon-Woods. Implementation Science, March 2014

‘How to study improvement: a brief overview of possible study types’
Margareth Crisóstomo Portela, Peter J Pronovost, Thomas Woodcock, Pam Carter, Mary Dixon-Woods. BMJ Quality and Safety, March 2015

SQUIRE Guidelines: http://www.squire-statement.org/
NICE Local case studies https://www.nice.org.uk/localPractice/collection
BMJ Open Quality https://bmjopenquality.bmj.com/
Health Systems Evidence https://www.healthsystemsevidence.org/?lang=en