Editorial

Is QA investment worth it?

The evidence is familiar – screening the population and preventing ill health and healthcare complications, especially in the young can save billions – but at what personal and economic cost to service providers? Doug Ford and Dick Zoutman in this issue explore quality improvement (QI) success and failure from an employee perspective. Their on-line survey measured QI project time, effort, commitment, reward, benefits and downsides in Canadian acute hospitals. Survey response rates, despite follow-up e-mails, were disappointing, which rings warning bells about QI project commitment and engagement. On the upside, however, data were gathered from 125 acute hospitals, which improves external validity (the extent to which findings can be generalised). Encouragingly, respondents, despite their negativity, felt that QI projects improved patient safety and service quality. Also encouraging were the hospital QI projects' breadth and depth – notably how intractable healthcare problems (such as hospital acquired infections) were being solved. The major downsides included competition between QI project demands and healthcare professionals' clinical duties. That is, worryingly, it is the key stakeholders (nurses and doctors) most affected by these competing demands and, therefore unsurprisingly, are the less committed professionals. Surprisingly, QI education and training programmes were not universally supported. Manager and leader commitment, on the other hand, featured in bucket loads. Clearly, the challenge is to study how best to support and encourage clinicians to become more engaged with QI.

Chinweike Eseonu and colleagues also underline successful QI project structures and processes. They explore QI project drivers and barriers in North America. Although using an unusual theoretical framework and a more triangulated (quantitative and qualitative) approach than Ford and Zoutman, Eseonu *et al.*, unearth similar outcomes. Their respondents also believed that QI projects improved service delivery, but felt aggrieved that insufficient time and resources were provided for CI work and how professionals were expected to deliver QI and clinical goals simultaneously – also the Ford and Zoutman study respondents' biggest gripe. The Eseonu *et al.*, study participants' main grievance, however, unlike Ford and Zoutman, was managerial commitment to and support for QI projects. Both studies share common ground, but it is clear that ventures in different contexts need bespoke approaches if they are to be successful and sustainable.

One scenario possibly worse than maintaining unpopular QI projects is not knowing what quality is like because service provision is unmeasured. Health and social care permutations mean that there always will be services where quality has not been measured or where quality assurance data are too old; so the adage that we should not change anything that has not been measured applies. In this issue, Vigdis Grøndahl and Liv Fagerli measure Norwegian nursing home service quality is some detail – a challenging research and development (R&D) topic owing to residents' questionable mental capacity. Their cluster analysis reveals a significant elderly group who are dissatisfied with many services. Clearly, the inter-relationships between service domains in the negative elderly resident cluster are complex, which presents managers with a challenge. The growing elderly population, most having made significant contributions to their country, with increasing co-morbidities, mean that they are a sector deserving the best care and service monitoring that can be mustered.

It does not matter whether the organisation in which we work is large or small, one irritation is not being able to find a file or document – a problem in hospitals, which is dangerous. Records control, therefore, is paramount and it is little wonder that records departments are being accredited and certificated using ISO standards. Owing to the myriad

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documents involved and the clinical services in which they are used, establishing a fully ISO accredited hospital medical records service is a significant challenge. In this issue, Lina Al-Qatawneh, describes record control structures processes and outcomes in one Jordanian healthcare organisation. The project's breadth and depth may surprise readers. The author's medical records framework could be adopted by other healthcare managers with great effect.

Without data reduction techniques, patient satisfaction research would not be cost effective because respondents are put off by lengthy questionnaires. Consequently, QA researchers have to strike a balance between minimalist patient satisfaction questionnaires, such as the ultimate question: "Would you recommend this hospital to your family and friends?" and the multi-item "what the patient thinks" questionnaire. We publish a data reduction article written by Seyed Omid Khalilifar and colleagues. They use SERVQUAL and sophisticated statistical techniques (DEA) with a weighting system to highlight the factors that influence patient satisfaction. Their Iranian study's outcomes are surprising: hospital services are not meeting patient expectations; and the strongest factor was users' trust-in services. Although the authors are not advocating a minimalist/ultimate question approach, it seems from their work that SERVQUAL's dimensions and minimal questions (but with a new trust-in services questions), seem to offer managers an efficient and effective systematic approach to maintaining customer loyalty.

Healthcare services are complex and the language we used can bewilder patients and family carers (indeed, language is one characteristic that separates novices and experts). Yet, once ties between patient, family and hospital staff are cut at discharge, we expect patients to continue our good work. And, as Jennifer Innis and colleagues explain in this issue, we do not always explain too well what is needed and do not always back our oral explanations with clearly written literature. We should not be surprised, therefore, to see that health literate discharge (i.e. meeting patient and family health literacy needs in preparation for home care) is significantly associated with treatment compliance, outcomes and readmission. However, before the authors could improve discharge processes, they had to take one step back, develop and test a questionnaire that measures discharge literacy processes. Using data reduction techniques, the authors identified five factors impinging on discharge literacy processes. Their next step is to extend the five-factor analysis by including recently discharged patients and their families in the discharge measurement and improvement process. A QA R&D exercise that should not only improve patient and family life quality but also reduce hospital costs if readmission rates are reduced; that is, ensuring that QA activity and investment pays dividends.

If a country's healthcare is divided into service commissioners and service providers, then commissioners will be especially interested in service quality and value for money. However, reading Ruth Boaden and Lisa Rogan's paper in this issue, makes us wonder how the commissioner-provider aircraft ever took off. Their study qualitatively explores relationships between the two "agencies" and unearth too many practical problems to make commissioning structures and processes viable in their current form, although the authors recommend several policy and practice actions to help start commissioning rehabilitation.

Another issue that makes QA R&D unviable is good evidence-based practice recommendations being ignored. We cannot always blame practitioners for failing to adopt best practice; keeping abreast of the changes is a monumental task. Tying evidence practice to continuing education (CE) is one approach that is gaining traction; especially when CE is tied to rewards such as points towards maintaining professional registration. Kamini Vasudev and colleagues in this issue explain academic detailing (AD) – a novel and more intensive CE strategy. Their results are intriguing; although practitioners liked AD, there were no significant changes in their post education practice. Nevertheless, AD has merit and clearly worth developing.

Keith Hurst