



Use of quality indicators by obstetric caregivers in the Netherlands: A descriptive study



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ABSTRACT

Objective: To evaluate the use of quality indicators by obstetric caregivers in hospitals in the Netherlands. **Study design:** An anonymous, self-administered survey was conducted in a convenience sample of obstetricians and clinical midwives in Dutch hospitals. Descriptive statistics were used to analyse the data, both for all caregivers and stratified by hospital setting and profession (obstetricians and midwives). Differences between strata were tested at a 5% significance level.

Results: The response rate to the online questionnaire was 61% ($n = 171/279$). Of all respondents 83% were aware of the quality indicators and 63% contributed to their registration. Caregivers received information about the indicators by mail or in meetings according to 64% (internal indicators) and 48% (external indicators) of the respondents. Of the respondents 56% (internal indicators) and 41% (external indicators) stated to use the results of indicators when designing plans to improve the quality of care.

Conclusion: We conclude that obstetric quality indicators are not widely used by obstetricians and midwives in Dutch hospitals to improve quality of care. To improve quality of care and the effective use of quality indicators we suggest to focus first on registering outcome indicators. These indicators should be implemented in quality structures that ensure that action is taken.

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Introduction

Quality assessment has become more important in health care since the Institute of Medicine published the report 'To err is human' [1] followed by 'Crossing the Quality Chasm' [2]. Since then there has been increasing awareness of the importance to define and measure quality of care [3]. Quality assessment tools such as audits, accreditation, patient safety systems and quality indicators have been developed [4,5].

In recent years, quality indicators have gained prominence on national and international agendas for health policy and research. The most widely accepted definition of quality indicators is: 'Measurable elements of practice for which there is evidence or consensus that they reflect quality and hence help change the quality of care provided' [6]. Quality indicators aim to detect suboptimal care and can be used as a tool in the process of quality improvement in health care [7]. Care providers need a feedback loop to learn and improve the quality of care. Measuring, reporting and comparing outcomes are important steps towards improvement of outcomes [8]. This implies that caregivers should use

indicators to improve the quality of care they provide [9]. Requirements for good indicators are that they are acceptable for the care providers, easy to capture and valid to the events and changes they are intended to detect [9–11].

There are two principal uses of indicator systems in the Netherlands: internal and external. Internal indicators are used in a formative mechanism for internal quality improvement. These indicators are developed to be used by clinicians. They can interpret and discuss these indicators to improve the quality of care within their control. External indicators are developed for external accountability, verification (summative mechanism) and external control. Information from these indicators may be useful for patients to compare providers. In addition they are instrumental to management or government to benchmark and to make policies for the improvement of care at the institutional or system level [12].

Worldwide many quality indicators for obstetric care have been developed [9]. Awareness of quality indicators among caregivers is important. In addition, the indicators must be implemented in an active quality system with a feedback loop [8]. In response to the poor ranking of Dutch fetal and neonatal mortality rates in the Euro-Peristat Project in 2004, policy efforts such as audits of perinatal deaths in term babies were instigated. This led, in 2010, to

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a decline in fetal mortality at or after 28 weeks gestation and neonatal mortality after 24 weeks gestation [13]. This is an example of how indicators are used at policy level. However it is not yet clear whether and to what extent quality indicators are used by the care providers in the Netherlands [14]. The aim of this study was to explore the awareness and the use of quality indicators by obstetric caregivers in their quality cycle in hospitals in the Netherlands.

Materials and methods

Sample and data collection

The study group consisted of obstetricians and clinical midwives, who are the professionals responsible for deliveries in Dutch hospitals. In august 2014 an electronic survey was sent to 279 obstetricians and midwives who were registered in the database of the Masterprogram for Physician Assistant clinical midwifery at Rotterdam University (convenience sample). The questionnaire was anonymous and self-administered to protect confidentiality. Non-responders were not identified and no reminders were sent.

Content survey

The full questionnaire is attached as Addendum 1. The survey was constructed according to the quality steps ‘plan-do-study-act’ [15]. This structure is widely accepted in healthcare improvement and the principles underpin the PDSA-cycle for use in a pragmatic healthcare setting [16]. ‘Plan’ refers to the introduction of quality tools in the maternity wards. The participating caregivers were asked about their knowledge of quality tools such as the multidisciplinary perinatal audit to reflect on perinatal morbidity and mortality, client satisfaction measurement and quality indicators (Q7). As we were specifically interested in quality indicators the rest of the survey was about the use of internal and external quality indicators. For the internal indicators we selected the structure indicators implemented by the Dutch Society of Obstetricians and Gynaecology in 2008. For the external indicators we used the indicators as drafted by the Dutch Healthcare Inspectorate [17].

‘Do’ means implementing guidelines into protocols for single individual maternity units. To assess this, the respondents were

asked if they actually implemented the suggested quality tools in their maternity ward for quality improvement (Q7). ‘Study’ is the evaluation of care provided by the caregivers. This step is designed to connect outcomes, guidelines, protocols and indicators. We assessed this step by asking in what way the quality indicators were communicated to the caregivers (Q9, 15).

In the last step, ‘act’, the caregiver is supposed to formulate recommendations for quality improvement. We asked the caregivers if the results of indicators were discussed in their professional group and if improvement plans were based on these results (Q10, 16).

To check if the respondents knew that certain quality tools, for example the presence of a protocol for treatment of acute shock/circulatory shock, are registered as indicators. We listed a selection of indicators set up by the Dutch Society of Obstetricians and Gynaecology. We asked if the structure was present in their department and if it was used as an indicator (Q8). For each step we included questions with a yes or no answer option and finished the questionnaire with an open question: ‘what else do you know or do in this step/example?’ The survey was tested with the help of a small number of midwives and obstetricians.

Statistical analysis

The survey was analysed descriptively, with numerical data presented with median and interquartile ranges (IQR P25–75) and categorical data presented as percentages. Descriptive statistics were presented both overall and stratified by hospital setting and type of caregiver. As it was a convenience sample, summary statistics describing the hospitals and caregivers were also compared to national statistics where available. Differences between strata were tested by Fisher’s exact test or Pearson Chi-Square. We considered a *p*-value < 0.05 as statistically significant. All analyses were done in SPSS Statistics version 22.

Results

Two hundred seventy-nine obstetric caregivers were invited to fill in the questionnaire. The response rate was 61% (*n* = 171), which represents 10% of all obstetric caregivers (clinical midwives (80%) and registered obstetricians (20%) in Dutch hospitals (Table 1). Over 50% of the Dutch hospitals were represented and these hospitals were spread out over the entire country. Eighty three

Table 1
Characteristics of included obstetric caregivers (Q1–6).

Obstetric caregivers	Sample <i>n</i> (%)	Nationwide (2014) <i>n</i> (%)
Respondents	171	1878
Obstetricians	34 (20)	Total number practising in the Netherlands 977 (52)
Midwives	137 (80)	901 (48) [27]
Hospital setting		
Teaching	88 (51)	1159 (62)
Non-teaching	83 (49)	720 (38)
Number of deliveries by	Unknown	
Obstetricians		10%
Midwives		57%
Others		33% ^c
Practice size ^a	Mean 1800 (IQR 1250–2400)	
Number of obstetric caregivers per maternity unit	Mean 22 (IQR 17–26)	
Working experience ^b	Mean 14 (IQR 7–21)	

^a Number of deliveries per year.

^b Number of years.

^c Data from 2010.

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