Sustainability of healthcare improvements for patients admitted with community-acquired pneumonia: follow-up data from a quality improvement project

Marinus Fally,1,2 Maria Elizabeth Engel Møller,2,3 Jacob Anhøj,4 Britta Tarp,5 Thomas Benfield,3 Pernille Ravn2

BACKGROUND
Community-acquired pneumonia (CAP) is common and associated with high mortality and healthcare expenses.1 As in other diseases, adherence to management recommendations showed to be variable in CAP, due to multiple factors including lack of knowledge, personal beliefs and inefficient healthcare processes.2 3

To increase adherence to management recommendations for CAP in Denmark, we have recently conducted and reported a multicentre quality improvement project.4 Based on data from a baseline period (November 2017–February 2018), we designed interventions to improve management of patients hospitalised with CAP at three centres. A fourth hospital served as control centre. The interventions were applied throughout an 8-month intervention period (March–October 2018), and short-term sustainability of the interventions was assessed in a 4-month early follow-up period (November 2018–February 2019). As CAP incidence in Denmark is highest in the cold season, we chose these months for our studies. The outcome measure in the study was adherence to a CAP bundle, consisting of chest X-ray, lower respiratory tract samples, CURB-65 (confusion, urea, respiratory rate, blood pressure, age ≥65) score5 and antibiotics within 8 hours of admission. Adherence to the bundle increased from 11% at baseline to 41% at early follow-up at the intervention centres, with no improvements at the control centre.4 Due to the interdependence of the bundle elements, we considered

Figure 1 Run chart showing the proportion of patients receiving the CAP care bundle (i.e. chest X-ray, lower respiratory tract samples, CURB-65 score and antibiotics) within 8 hours of admission in the baseline period (November 2017 to February 2018), the early-follow-up period (November 2018 to February 2019) and the late-follow-up period (November 2019 to February 2020). Each dot represents 8–29 cases of CAP. The figure has been produced by the first author using the open source software R (V.3.6.0, R Core Team 2019).
an adherence of 41% to be a success. However, the main limitation of the previous study was the short follow-up right after the intervention period, leaving us with no knowledge about long-term sustainability.4 The missing estimation of sustainability is a common problem in quality improvement studies.6 7 Therefore, we conducted this single-centre follow-up study at Gentofte Hospital, a tertiary university hospital and one of the intervention centres in the previous study.4

METHODS
To assess long-term sustainability of the healthcare improvements, we compared the baseline period with the early follow-up period and a late follow-up period (November 2019–February 2020). Methods of data collection, control and analysis were the same as reported previously.4 As in the previous study, we assessed adherence to the CAP bundle through statistical process control, using run charts.18

RESULTS
At Gentofte Hospital, 170 patients were admitted with CAP in the baseline period, 138 in the early follow-up period and 136 in the late follow-up period. Most interventions designed by our study group throughout the intervention period were continued after October 2018 (table 1). Detailed information about the interventions was published previously.4

On average, the bundle was completed in 17% in the baseline period, 44% in the early follow-up period and 25% in the late follow-up period (figure 1). The decrease was mainly caused by substantial changes in CURB-65 documentation (39% baseline, 75% early follow-up, 52% late follow-up).

DISCUSSION
Adherence to the CAP bundle was considerably higher in the late follow-up period when compared with the baseline period, but lower than in the early follow-up period. As we used the same methods as in the original study, the main limitation of relying on information documented by other healthcare professionals, gathered by an electronic health record audit, still applies.4

Definite reasons for a lack of sustainability after quality improvement initiatives are difficult to establish.6 7 However, we believe that the discontinuation of central interventions has contributed considerably to the decrease in care bundle adherence, those were (1) educational activities, that is, repeated education of healthcare personal every 1–2 months; (2) activities increasing disease awareness, that is, newsletters distributed to staff members on a regular basis; and (3) personal feedback to physicians. These interventions have previously been successfully applied to increase guideline adherence in other healthcare settings.9–13 However, these interventions are also actions that showed not to be able to create sustained system-based improvement, especially when discontinued.14

One other factor potentially leading to a lower degree of guideline adherence can be physician seniority and frequent changes in staff composition. In Denmark, there is a high turnover rate among, especially, early-career physicians (turnover rate approximately 2–4/month at our study centre). Meanwhile, those individuals are often the treating physicians for patients admitted with CAP in the emergency departments. The impact of physician seniority on guideline adherence in CAP has, to our knowledge, not been investigated in the past. However, a study on guideline adherence for the treatment of diabetes found that junior physicians tended to follow
guidelines less than senior physicians. This, combined with a high physician turnover rate, makes a cultural shift and a sustained, high level of guideline adherence a difficult task.

CONCLUSION
Altogether, the results of our study underline that quality improvement is a continuous process, which must (1) include changes in inefficient healthcare processes and (2) interventions that focus on a system change rather than the individual physicians treating patients.

Author affiliations
1 Department of Respiratory Medicine and Infectious Diseases, Copenhagen University Hospital – Bispebjerg and Frederiksberg, Copenhagen, Denmark
2 Department of Internal Medicine, Copenhagen University Hospital – Herlev and Gentofte, Hellerup, Denmark
3 Department of Infectious Diseases, Copenhagen University Hospital – Amager and Hvidovre, Hvidovre, Denmark
4 Centre of Diagnostic Investigation, Copenhagen University Hospital – Rigshospitalet, Copenhagen, Denmark
5 Diagnostic Centre, Silkeborg Regional Hospital, Silkeborg, Denmark

Contributors MF—conceptualisation, methodology, software, formal analysis, investigation, data curation, writing (original draft), visualisation and project administration. MEEM—data curation, validation and writing (review and editing). BT—conceptualisation, methodology, software, formal analysis, investigation, validation, resources, data curation, writing (review and editing) and visualisation. TB—conceptualisation, data curation, validation and writing (review and editing). PR—conceptualisation, data curation, funding and project administration.

Funding This study was funded by the Danish Ministry of Health under grant number 1608969.

Competing interests All authors report a grant from the Danish Ministry of Health for the conduct of this study. PR reports grants from Novartis Healthcare, MSD Denmark, CSL Behring, Takeda Pharma and GlaxoSmithKline Pharma, outside the submitted work. TB reports grants from Novo Nordisk Foundation, grants from Simonsen Foundation, grants and personal fees from GSK, grants and personal fees from Pfizer, personal fees from Boehringer Ingelheim, grants and personal fees from Gilead, personal fees from MSD, grants from Lundbeck Foundation, grants from Kai Hansen Foundation, personal fees from Pentabase, grants from Erik and Susanna Olesen’s Charitable Fund, outside the submitted work.

Patient consent for publication Not required.

Ethics approval The study was a clinical audit study without direct patient contact. Patient consent and ethical approval were, therefore, not required to conduct this study. Local approval was granted by the hospital board. Data for analysis were fully anonymised and handled according to the national regulations of the Danish Data Protection Agency (registration number HGH-2017-039).

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES
1 Welte T, Torres A, Nathwani D. Clinical and economic burden of community-acquired pneumonia among adults in Europe. Thorax 2012;67:71–9.
2 Arts DL, Voncken AG, Medlock S, et al. Reasons for intentional guideline non-observance: a systematic review. Int J Med Inform 2016;89:55–62.
3 Halm EA, Atlas SJ, Borowsky LH, et al. Understanding physician adherence with a pneumonia practice guideline: effects of patient, system, and physician factors. Arch Intern Med 2000;160:98–104.
4 Fally M, von Plessen C, Anhøj J, et al. Improved treatment of community-acquired pneumonia through tailored interventions: results from a controlled, multicentre quality improvement project. PLoS One 2020;15:e0234308.
5 Chalmers JD, Singanayagam A, Akram AR, et al. Severity assessment tools for predicting mortality in hospitalised patients with community-acquired pneumonia. Systematic review and meta-analysis. Thorax 2010;65:878–83.
6 Wiltse Trimmer S, Kimberly J, Cook N, et al. The sustainability of new programs and innovations: a review of the empirical literature and recommendations for future research. Implement Sci 2012;7:17.
7 Martin GP, Weaver S, Currie G, et al. Innovation sustainability in challenging health-care contexts: embedding clinically led change in routine practice. Heal Serv Manag Res 2012;25:190–9.
8 Anhøj J, Wentzel-Larsen T. Sense and sensibility: on the diagnostic value of control chart rules for detection of shifts in time series data. BMC Med Res Methodol 2016;18:100.
9 Hogli JU, Garcia BH, Skjold F, et al. An audit and feedback intervention study increased adherence to antibiotic prescribing guidelines at a Norwegian Hospital. BMC Infect Dis 2016;16:1–11.
10 Fooled F, Huang AM, Nguyen CT, et al. A multicentre stewardship initiative to decrease excessive duration of antibiotic therapy for the treatment of community-acquired pneumonia. J Antimicrob Chemother 2018;73:1402–7.
11 Bond SE, Boutlis CS, Yeo WW, et al. Impact of an antimicrobial stewardship intervention on appropriateness of prescribing for community-acquired pneumonia in an Australian regional hospital. Intern Med J 2017;47:582–5.
12 Avdic E, Cunshinotto LA, Hughes AH, et al. Impact of an antimicrobial stewardship intervention on shortening the duration of therapy for community-acquired pneumonia. Clin Infect Dis 2012;54:1581–7.
13 Engel MF, Postma DF, Hulscher MEJL, et al. Barriers to an early switch from intravenous to oral antibiotic therapy in hospitalised patients with cap. Eur Respir J 2013;41:123–30.
14 VHA National Center for Patient Safety (NCPS). Guide to performing a root cause analysis, 2021.
15 Aljažeri J, Punthakee Z. The impact of resident seniority on guidelines adherence: a commentary on diabetes management in the hospital. Endocr Pract 2017;23:1479–81.