Kwaliteit kortgesloten. Het beoordelen van de kwaliteit van de zorg op gesloten psychiatrische opnameafdelingen

Nijssen, Y.A.M.

Citation for published version (APA):

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: https://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.
Summary

The attention for the quality of care in the Netherlands has considerably intensified during the past years due to more professionalisation in health care, a more critical attitude of the patients and a relative shortness of resources and facilities. A critical evaluation of the offered care can be considered as a tool to monitor and improve quality of care. In a Dutch law on the quality of care (‘Kwaliteitwet Zorginstellingen’), institutions have to determine the criteria for the quality and to implement a quality assurance system.

This thesis focuses on the quality of care in closed psychiatric admissionwards, a most stressful experience for the admitted patients. Within a restrictive environment they are faced with other patients who are also confused, afraid, lonely, aggressive, depressed or suicidal. Caregivers in their turn are confronted with an increase of re-admissions, threat of suicide and aggressive incidents which, in combination with the need to shorten the length of stay, leads to high working loads. Since the patients are in general in a very disturbed condition and are as soon as possible transferred after recover, it may well be possible that there is insufficient feedback of the patients to their caregivers. Therefore, a specific instrument was needed for the monitoring of quality assurance on closed psychiatric admissionwards.

The main objective of our research project was to develop an instrument to assess the quality of care on closed psychiatric admissionwards to identify bottlenecks. Step by step we outline the objective of our study and summarize the outcomes.

In Chapter 1, the background of the project is presented. Quality in this context is defined as the degree in which the whole of characteristics of a product, process or service meets the fixed or the implied requirements or needs. There are different perspectives on quality (consumers, caregivers, insurers and government), depending on the perspective specific characteristics or quality aspects are considered to be relevant. National initiatives from those perspectives to assure and improve the quality of (mental) health care are described. Specially the changing role of psychiatric patients in the quality of care discussion is highlighted: the expertise of patients in mental health care becomes more legitimate. Two quality models, the European Foundation for Quality Management and the Harmonization model for Quality assessment in Health Care, are presented. Both models give a high priority to the assessment of quality of care by patients and to the patient satisfaction. Scientific research is essential for the development and for the application of assessment instruments and quality indicators.

Mental health care is in a transformation process that aims at a better tuning between demand and offer. Central to the new mental health organization is an improved integration of psychiatric patients in the society, this can be reached by a dispersion of psychiatric hospitals over the country and by ambulatory care. Moreover a psychiatric admission must be prevented and, if inevitable, admission must be as short as possible and less restrictive. Whether these changes mean a quality improvement is not (yet) clear. Criticism particularly concerns the functioning of closed admissionwards. Caregivers are supposed to aim at the reduction of symptoms and disturbing behavior and mainly reach this goal by medication. The patients are not consulted and have insufficient opportunity to talk about their complaints and problems. Little research has been done about the quality of
care on closed psychiatric admissionwards and a reliable instrument to assess the quality is not yet available. Moreover, information about numbers and capacity of closed wards are not available, the same applies to characteristics about organization, patient population, staffing and treatment activities. Based on these data we formulated our research questions.

In Chapter 2 the outcomes are reported of a survey about the state of affairs on closed psychiatric admissionwards in the Netherlands. Next to insight into the number of wards and beds and the occupancy of the beds, an overview is given of the activities and the care objectives of the wards. Other points were: who were the caregivers and for whom do they care. Based on the total number of beds (n=1484), the mean length of stay (one month) and the occupancy of beds (on an average 96%) our conclusion was that annually about one-third (17,500) of the total number of psychiatric admissions is on closed wards. This mainly concerned younger patients with an acute or very serious psychotic disorder or affective disorder. One in every four patients was involuntarily admitted, one half had an earlier admission. There seemed to be a continuum with at one side closed wards aiming at reduction of symptoms by medication and a very short stay on the wards. At the other side there are closed wards where the patients stay longer and can receive various treatment modalities. Bottlenecks we observed were the continuity of care, the therapeutic environment and the facilities on the ward.

Chapter 3 presents an overview of twelve Dutch mental health care instruments, developed in the past ten years, for assessing the quality of care from the patients’ point of view. These instruments met our inclusion criteria: at least in part, psychometrically tested and applied in mental health care. The instruments were evaluated with regard to the source (who is responsible for the design), target group and setting, domains of care and psychometric properties.

The studied instruments focus on specific mental health settings. All but one instrument measure various aspects of care. Relevant for all settings are aspects which refer to the relationship between the patient and the caregiver, such as information, participation and attitude. For acute and ambulatory care settings, aspects such as competence and effectiveness are also important. Clinical settings stress the importance of ward facilities and leisure activities.

Most instruments miss a theoretical basis and relevant psychometric information, and have not (yet) been implemented in the daily practice of mental health care; most instruments have only been applied in the framework of research activities. The design of the instruments differs, therefore adequate comparison between settings is not possible. Conclusion: apart from instruments for specific settings, a generic instrument is needed with adequate psychometric properties and suitable for all mental health settings. Such an instrument will enable caregivers to evaluate the quality of their care compared to other settings, in this way the quality of care can be further improved.

In Chapter 4, qualitative good care on closed psychiatric admissionwards is defined in terms of quality criteria. The Concept Mapping technique was used to verify the views of patients, family members, nurses, psychiatrists, health insurers and medical inspectors about items which they consider important for the quality of care. Guided by this inventory, we established a number of quality-relevant care aspects. Subsequently the participants graded their relevance about these aspects for the quality of care.

The quality of care concept for closed psychiatric admissionwards, based on 97 structured statements, was summarized in two quality dimensions and eleven quality domains.
The observed dimensions made clear that the participants recognize the function of treatment and care on the admissionwards, but also realize that patients have to stay behind closed doors. The latter has serious consequences for the privacy. Additionally, the participants stress the role of a ‘guard function’ of closed wards. The assurance of safety and, if indicated, use of compulsory measures are recognized as relevant aspects. This apart from aspects like information and patient participation which stress the importance of patients’ autonomy.

When comparing this quality of care concept with descriptions of qualitative good care in other psychiatric settings, we conclude that it is feasible to draw up a general definition of quality in mental health care. In all settings certain general aspects seem to be important. However, every setting also emphasizes specific aspects. The divergence in the definitions of quality of care become more apparent if the aspects are tailored to concrete quality criteria. Therefore an empirical study is essential for every setting, i.e. studies which focus on the quality criteria and relevance for the parties involved.

The quality aspects which we assessed for the closed admission ward, are not considered to be equally important. The aspect of ‘safety’ has a relatively high priority whereas the aspect of ‘privacy’ has a relatively low priority. Furthermore, there are differences in priority between caregivers. Patients and family members stress the importance of communication and a respectable attitude. Caregivers in their turn emphasize personal expertise.

We developed a new instrument, because the current instruments for the assessment of quality of care were, apart from the uncertainties about the psychometric qualities, in respect to the content not adequate for closed admission wards or not suitable for this target group. Chapter 5 concerns the applicability, reliability and validity of the instrument, the KWAZOP, to assess the quality of care on closed psychiatric admissionwards. The KWAZOP consists of three parts: one for patients, one for the psychiatrist and one for the nurse. Patients assess the quality of care via an interview, the psychiatrist and nurse each complete a questionnaire. The questions have closed response sets which offer three options.

During a period of six months we interviewed 132 patients upon discharge or referral from closed admission wards of three Dutch psychiatric hospitals. 109 interviews (83%) were reliable. The length of the interview, about half an hour, was acceptable. Psychiatrists returned 97 questionnaires and nurses 99. It took about 5-10 minutes to complete the forms. Based on factor analysis, the patient items (90 items) were grouped in four core subscales: (medical) treatment, nursing care, reliability/safety in contact, privacy/personal freedom; and two facultative subscales, that is use of compulsory measures and family involvement. Similarly, the items of psychiatrists and nurses (13 and 18 items) were grouped in four core subscales, that is continuity of care, treatment plan, nursing plan, and evaluation of admission period. The reliability of the subscales in terms of homogeneity and of the four core subscales of the patients’ part in terms of test-retest reliability were encouraging (Cronbach’s alpha 0.67-0.86; Interclass-correlation 0.97-0.90).

In Chapter 6 the application of the KWAZOP is elaborated. We illustrate that qualitative good and less good aspects of care can be determined and reported to the ward. Subsequently, suggestions for quality improvement can be made. For this purpose, the data of the study described in Chapter 5 were re-analyzed. This re-analysis concerned three psychiatric hospitals: 109 interviews with patients, 97 questionnaires of psychiatrists and 99 questionnaires of nurses.

At first, the subscale scores show per hospital or per ward which aspects have a sufficient score and which ones insufficient. For a sufficient score on the KWAZOP subscale minimal
half of the items needs a maximum score, additionally maximal two or three items, depending on the number of items per scale, may have a minimum score. After correction for differences in patient characteristics, it is possible to determine significant differences in quality of care between wards based on subscale scores.

The patients of the three participating hospitals assessed the subscales (medical) treatment and reliability/safety predominantly as sufficient and scored the use of compulsory measures predominantly as insufficient. On subscale level there were no significant differences in patient scores between the hospitals. However the scale scores of the psychiatrists and nurses differed significantly on the themes: continuity of care, nursing plan and efficiency. The scores on item level showed which items accounted for sufficient or insufficient scale scores. The staff on the wards judged the outcomes realistic and useful.

In Chapter 7, the general discussion, the main results of the study are argued and recommendations are made for further research. The developed instrument, the KWAZOP, is based on an evaluation of existing instruments for the assessment of quality of care and by means of the Concept-Mapping method. Different parties, consumers, caregivers, insurers and government were involved in this study. The first step in the process of validating was factor analysis, followed by grouping of the items in subscales. The reliability of the subscales is encouraging. For daily practice, the KWAZOP is an appropriate instrument to signal shortcomings in care on closed psychiatric admission wards both from the perspective of patients and that of caregivers. Furthermore, it is possible to determine differences in the quality of care between wards. A psychometric study to investigate the responsiveness of the KWAZOP is not (yet) done.

Since the end of 1998 a follow-up study is in progress on 21 closed admission wards, and is funded by the Netherlands Fund Mental Health Care. Application of the KWAZOP on a wider scale not only enables us to investigate the variability in care, but also makes it possible to formulate referential values or quality norms. At the same time we can assess the association between differences in quality assessments and patient characteristics or certain organizational, personnel or clinical characteristics of a ward. With this information on hand the outcomes of the ward can be more properly judged by the caregivers. In practice remains to be seen whether caregivers are actually prepared and able to improve the quality of their care based on the obtained information.