NHS hospital trusts have been busy preparing their annual quality accounts (QAs). These public documents aim to inform professionals and the public alike about the quality and safety of their services, and are part of the national drive to increase transparency of health service providers in England.

Are QAs any better than previous ways of improving the quality and safety of nursing care? A look back over the history of nursing may help to answer that.

Florence Nightingale gave the profession a great start. The shockingly high death rate of young soldiers in hospitals during the Crimean War prompted her to act. Finding that reporting the issue was not enough, she took William Farr’s advice: “We do not want impressions; we want facts.” Six months of figures revealed almost three-quarters of the soldiers had died of illnesses they acquired in hospitals, rather than from their wounds. Her campaign for reform was underpinned by systematic data collection to identify root causes of deaths. Once these had been remedied, mortality from disease dropped sharply.

Over a century later, in 1972, a landmark change was brought about by the Briggs report, which put nursing onto a research-based footing. Since then, practice has become increasingly evidence based, to the undoubted benefit of patients. The lesson from Florence Nightingale was clear – statistics brought about positive changes.

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A strength of QAs is that they are open to scrutiny by local authority overview and scrutiny committees, clinical commissioning groups and Healthwatch groups; they can see the draft QAs, and make comments that are included in the published version. While there is some way to go in achieving the “perfect” QA, evidence is emerging that requests and comments are being taken on board. This is leading to clearer, jargon-free reports, and a change of emphasis from dealing with complaints to encouraging increased reporting by patients, with the aim of fewer and less severe instances of patient harm.

Such improvements reflect well Florence Nightingale’s search for facts not impressions. NT

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HIGHLIGHTS

Exploring the model of advanced nursing practice p20

Preventing secondary fractures p12

Getting enough sun for healthy bones p15

SPOTLIGHT

Peer support aids suicide risk assessment

Assessing whether someone is at risk of committing suicide is a heavy responsibility for a mental health nurse to carry. It is complex and requires considerable skill. And as our expert author explains on page 16, how those who have attempted suicide are interacted with afterwards can make a difference in their recovery and can strengthen their desire to live.

A mental health team in Reading has brought in reflective peer review to support staff in this difficult area. Using this process has helped the team to build on existing skills by learning from each other, leading to a better understanding of risk assessment and more confidence in the process. And it has produced a marked improvement in clinical documentation, which will inevitably benefit staff and patients.

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