Quality Lines

DRAFT PUBLICATION GUIDELINES FOR QUALITY IMPROVEMENT

In this issue of *QSHC,* readers will find new proposed draft guidelines for reporting healthcare improvement research. Medical quality improvement will not reach its full potential unless accurate and transparent reports of improvement work are published, frequently and widely. These authors propose a draft set of publication guidelines designed to help with writing, reviewing, editing, interpreting, and using such reports. The editors of *QSHC* publish this draft with an invitation to authors, reviewers, and editors to contribute their comments regarding the utility of these guidelines.
See p 314, 315, 317, and 319

REDUCING INEQUALITY TO ACCESS

Eight healthcare services in the UK set up action research projects with an explicit objective of reducing inequalities in access. Projects included community based palliative care, general practice asthma care, hospital based cardiology clinics, and termination of pregnancy services. A number of evidence-based changes to service provision were proposed and implemented with variable success. Key elements for successful interventions included: effective local leadership, identification of an intervention which is both evidence-based and locally practicable, and identification of additional resources to support increased activity. A web based ''toolkit'' has been developed to support the identification and implementation of appropriate changes.
See p 336

TOO MANY MEDICATION SAFETY TERMS?

Consistent terminology is essential to describe, quantify, and compare medication safety related events. This study explored three aspects of medication safety nomenclature: the terms, the definitions, and their functional meanings in real life applications. Terms and definitions from medication safety websites were studied. Thirty three of the 160 websites searched yielded 25 different terms and 119 definitions, with ''adverse event'', ''error'', ''near-miss'', ''adverse reaction'', and ''incident'' being the most frequently defined groups of terms. Each of these five groups was found to have two or more functional meanings. This report highlights the need for consensus on standardised medication safety terminology.
See p 358

HIP FRACTURE OPERATIVE DELAY AND QUALITY

Operative delay in hip fracture surgery is used as a process measure of health system performance assessment, but there is conflicting evidence on whether operative delay has an independent effect on outcomes. This analysis of 16 881 operated hip fracture patients from 47 hospitals revealed that the effect varies among providers and thus biases a straightforward interpretation of the results based on data incorporating several providers. This study suggests the true effects of operative delay on mortality are quite small, but there is a clear association between the proportion of late surgery patients and non-optimal treatment. Hence, operative delay appears to work as an effective quality indicator.
See p 371

REPORTING OF ADVERSE SURGICAL OUTCOMES

Most studies rely on retrospective medical record review to identify adverse outcomes. However, this is time consuming and the underlying reasons for choices and actions, each associated with a certain risk, may remain unknown. In The Netherlands, nationwide routine reporting of surgical adverse outcomes started in 1998. As reporting has been part of daily care, all necessary information is available at the time of actual registration and encoding of adverse outcomes.
See p 378

POSTGRADUATE TRAINEES AND ADVERSE EVENTS

Improving patient safety calls for patient safety education to take a prominent place in postgraduate training programmes. A study that involved graduate medical trainees found that attending a patient safety educational programme, implemented via an introductory lecture and six monthly conferences, promoted positive medical event reporting attitude and behaviour. Major barriers to medical event reporting were lack of time, extra paper work, and concern about career and personal reputation.
See p 383