the project. The principal method of data collection was a semistructured questionnaire covering 21 aspects of continence care and eight key variables identified from the literature judged as being of central importance in continence care.

The presentation of results occupies four chapters, about half of the report. Each question in the questionnaire has two sets of results; comparing pre-test and post-test results in different types of hospitals and comparing the results for experimental and control groups. This makes for an exceedingly comprehensive, although somewhat indigestible, read, to some extent alleviated by a concluding summary, which is regrettable as the results disclose some very worrying issues.

Of 43 criteria identified within the eight key variables, significant improvements were made for 37(82%) between the pre-test and post-test measurements in the experimental nurse group. The authors conclude that the *Clinical Handbook for Continence Care* provided an effective means of clinical updating for nurses. Most of the nurses also reported that they found it useful and user friendly. This is highly relevant, as the handbook recommended by the authors has the potential to improve continence care. Indeed, it is reasonable to conclude that the real success of the project will depend on the extent to which the readership of the handbook exceeds the readership of the research report.

ASSUMPTA RYAN
Lecturer/Practitioner in Nursing

Quality and Safety in Anaesthesia. J Secker Walker, ed (pp 192; £16.95). London: BMJ Publishing Group, 1994. ISBN 0 7279 0828 6.

The emergence of clinical audit is relatively recent, although individual practitioners often set themselves standards against which they repeatedly measure their activity. Books or articles on pure audit may not seem to be of interest to the practising anaesthetist. The relation between audit and quality and safety of care must be made clear, and this book will help. In *Quality and Safety in Anaesthesia* eleven authors write on different aspects of audit to attempt to show that the process of audit has a key role in assuring the maintained success of anaesthesia.

The reader is taken through a brief history of audit in anaesthesia to illustrate how to produce subjects susceptible to detailed audit. Although there are areas of repetition, audit is shown as forming part of the teaching process and having links with resource management. The definition of "anaesthetic quality" is difficult to measure, but the need for an acceptably high quality in medical audit is clearly

shown. Despite the repetition in the earlier chapters it is fortunate that the reader is moved along from descriptions of audit to links with psychology (unsurprisingly, this time in aviation safety) and methods of performing audits within a department.

The later parts of the book drift further from descriptions of pure audit and deal with safety of equipment. The link between a check on equipment safety and safety measurement and that of anaesthetic audit begins to emerge. If equipment safety can be assured and there is safe and adequate monitoring in anaesthesia, then it would be hoped that the quality of anaesthesia would be high. Anaesthetic audit, as described in this book, is thus shown to perform a useful method of assuming quality.

The final chapter of the book describes the management of an anaesthetic department. Recent changes within the NHS make this a difficult subject; however, the role of audit within management is demonstrated. Audit is often poorly perceived by anaesthetists in training, but its role within the overall practice of anaesthesia is shown by this book. It does not claim to lay down standards of audit but clearly shows that, although embryonic audit is an important tool within anaesthesia and has clear links with resource management, it is often seen as the prerogative of hospital management.

MICHAEL R FERGUSON
Consultant Anaesthetist

Interface Between Research and Practice. B Vaughan, M Edwards (pp 45). London: King's Fund Centre, 1995. ISBN 1-85717-084-9.

Patients deserve care and treatment which have been shown by research to be the best that can be given. However, it is a truism that the results from many research studies are not being used to guide practice. This problem is not confined to nursing. Indeed Proctor stated that: "Clinical research is considered by many doctors as erudite and not likely to involve them directly ... most practitioners are so distanced from clinical research."¹ Therefore, carrying out research alone, although praiseworthy, will not improve the quality of patient care; findings must be implemented. The existence of the Cochrane Collaboration Centre, the York Centre for Reviews and Dissemination, and clinical guidelines all testify that concerns exist about the dichotomy between research and practice.

This timely and topical King's Fund report is another valuable resource in how to deal with this dichotomy. It is based on ongoing work within 30 nursing

development units throughout the United Kingdom. Over recent years members of these units have worked hard to include research evidence into clinical interventions. Based on these local initiatives, this report identifies realistic strategies for bridging the research-practice gap. Although, at 45 pages it is more of a booklet than a book, it is well structured, inexpensive, and well written.

Although the six models described all share the common aim of improving the quality of patient care, they differ in the strategies that must be adopted to achieve this aim. These models are interval evaluation within the nursing development unit team; the researcher as part of the nursing development unit team; use of clinical fellows; unified roles; use of external consultants; and use of external researchers. These are not mutually exclusive, and the strengths and weaknesses of each are discussed, as are the resource implications and the transferability of the models to other disciplines.

The attraction of this publication lies in its pragmatism. Having their foundation in clinical practice, the six models offer realistic and adaptable strategies for multidisciplinary or multidisciplinary research projects. This is a comprehensive, yet "user friendly" guide for those professionals who have research based practice as their goal. Furthermore, it should act as a useful discussion document to take forward the proposals within both local and national research and development strategies.

HUGH McKENNA
Lecturer, University of Ulster at Coleraine

1 Proctor SJ. Why clinical research needs medical audit. *Quality in Health Care* 1993;3:1-2.

DIARY

12 July

London: International Developments in Health Policy: Forces Driving Change – will take place at the Royal College of Physicians. This Conference is planned as a sequel to that held at the Royal College of Physicians in 1994 on Health Care – International Comparisons. At this event, the evolving changes in the primary/secondary care interface, new information technology, the involvement of the pharmaceutical industry and the "technology foresight programme" will be some of the main areas covered. Further information from: Conference Office, Royal College of Physicians, 11 St Andrew's Place, Regent's Park, London NW1 4LE (tel 0171 935 1174; fax 0171 487 5218).