**Editors**

**QHC to become QSHC . . .**

Delivering safe health care: safety is a patient's right and the obligation of all health professionals*

One fundamental guarantee that we cannot give our patients is that faults and errors in the healthcare system won't harm them. Of course, health care is by its nature risky. Not everyone undergoing surgery for an aortic aneurysm survives. Many interventions carry risks. But these risks are mostly small and usually quantifiable. Ideally, patients understand the possible risks and benefits before choosing to undergo a procedure. For some patients these are difficult decisions. Although healthcare professionals may discuss risks of treatment, they do not speak about risks of harm from the system—or even about such harm when it occurs.

Recent studies in the United States, Australia, and the United Kingdom and reports from the US Institute of Medicine and the UK Department of Health have drawn attention to the chronic “unsafeness” of health systems worldwide. This attention is not new. What is new is that preventable, iatrogenic injuries are being quantified and openly discussed. For example, adverse drug reactions have become a national issue in the United States—studies show that adverse drug events occurred in 6.5% of hospitalisations. These reports have highlighted the tensions between accountability and improvement, the needs of individual patients and benefit to society, and production goals and safety.

Most causes—and solutions—lie in the systems of care and how we work. Healthcare professionals, however, focus energy on individual patients, tackling difficulties in the system as they appear—often as separate problems and not in parallel. Individual care is, of course, crucial but, unless attention is given to the system, our patients are at risk from a faulty service. For example, inadequate handovers can mean that vital information is lost between diaries. For example, adverse drug reactions have become a national issue in the United States—studies show that adverse drug events occurred in 6.5% of hospitalisations.

Not all these disciplines need be given their own space in the curriculum. The ethical imperative dictates that we should support the development of an understanding about safety from the first day of healthcare training. How long, though, should we wait before all medical schools and training programmes include a patient-centred safety curriculum?

Doctors in particular have mostly avoided the question of how safety can become central to their work. Employing an expert will not reduce harm. A general call to embrace safety may influence a few people but will not change systems. Care will be safer when we learn to work as teams and understand the team as a microsystem—a small, focused, organised unit with a set of patients, technologies, and practitioners. Some important changes that health professionals can make may be very “low tech” and seem trivial. How would methicillin resistant *Staphylococcus aureus* survive if all doctors always washed their hands after examining a patient? Removing concentrated potassium chloride from wards would prevent fatal concentrated injections, while designing unique connectors might prevent fatal intrathecal neurotoxic vincristine injection mix-ups. We know these changes will make a difference.

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*This is a version of an editorial which appeared in the BMJ 2001; 323:585–6.
The difficulty lies in implementing what we know. How can we splice safety culture and practice into the genome of health care? Improving safety of patients should be one of the highest priorities of healthcare leaders. Perhaps things are changing. In the UK, the National Patient Safety Agency has just been set up, and in the USA President Bush has increased the budget of the Agency for Healthcare Research and Quality by $150m to promote research on safety of patients.\textsuperscript{12}

Easy access to research on improving safety may help health professionals and managers to make care safer. This journal has included papers on the safety of health care and on clinical risk management in the past. But, to reflect the increasing concern about the endemic “unsafe-ness” of healthcare systems worldwide and the need to find ways to reduce risk and, with that, the incidence of adverse events and harm suffered by patients, the journal will expand and, from March 2002, become Quality and Safety in Health Care. The new journal will also look different. The logo will change; the cover will be grey and green with the contents listed on the inside on the first page; and the layout will be different. We hope that these changes to the format of the journal will make it easier for readers. We will continue to publish as many papers on quality and safety as before, but each issue will include many papers on safe care and safe practice. We invite readers to send us these. Changing attitudes and practices will be hard work. Patients are being placed at unnecessary risk and many are harmed; they expect that we will offer safer care. We believe that safety and quality will be the Holy Grail of medicine in the 21st century.

**Editor, Quality in Health Care**

Center for Patient Safety, Department of Anesthesia and Critical Care, University of Chicago, Chicago, IL 60637, USA

pbarach@airway.uchicago.edu

**FIONA MOSS**

Editor in Chief, Quality in Health Care

fmoss@londononcology.ac.uk


12 Report of the Quality Interagency Coordination Task Force (QuIC) to the President. Doing what counts for patient safety: federal actions to reduce medical errors and their impact. www.quic.org

**Challenges to quality monitoring systems in care homes**

In the UK access to continuing care services is often a gamble and, as consumers of health care, older people have had little choice in where and how these services are provided as the continuing care of many older persons has shifted from the health service to the independent sector. This shift has raised concerns about the quality of care in private nursing homes and has placed the need to determine such quality high on the government’s policy agenda. The traditional quality assurance mechanism has relied on a registration and inspection system whereby local government authorities monitor and review service delivery. However, the processes are often bureaucratic and ineffective. More recently, the Care Standards Act (2000) and the Regulation of Care (Scotland) Act 2001 have set out the new regulatory framework for all care homes in the UK. This will provide national standards of registration and inspection, with increased authority for health and social care agencies to take action when poor quality is suspected or detected.

A registration and inspection system can only ever provide one component of a quality system for the continuing care of older people. Research by Wagner et al\textsuperscript{9} reported in this issue of Quality in Health Care highlights the difficulties in determining the most appropriate mechanism for monitoring quality in care homes, particularly when the emphasis is on “care outcomes”. The authors point out that it is difficult to determine the impact of quality systems on the quality of care of residents and conclude that there needs to be a greater emphasis on the qualitative aspects of care and, in particular, improvement in the measurement of quality of life.

Outcome can be defined as the end result of care, but outcomes do not directly assess quality of performance; they only permit inferences to be made about the quality of the processes of care. The focus on outcomes is not always appropriate in the context of continuing care. In much of healthcare provision a focus on “health gain”—that is, that the intervention results in a gain in health status for the patient—is seen as the most important outcome measure. In this issue of Quality in Health Care Meiland et al\textsuperscript{3} discuss the complexity of measuring outcome in residents of care homes. By assessing the burden on caregivers, the problems of delayed admission to care homes were identified as well as the continuing effect of these problems on the caregiver following admission of the patient. This suggests that measuring outcome with the patient alone only provides one part of the total picture. Outcomes in continuing care for older people should focus on increasing quality of life rather than longevity. Because quality of life is difficult to define and even more difficult to measure, particularly with physically and mentally frail people, outcomes from care inputs cannot always be clearly articulated as highlighted by Meiland et al. Furthermore, the care of older people in continuing care settings is predominantly based on the maintenance of a normal pattern of lifestyle. However, as pointed out by Wagner et al, such individualised patterns of lifestyle are difficult to measure using standardised instruments. This is not to argue that quality measurement in care homes should not focus on hard outcome data, but that it also needs to include subjective interpretation of quality of life and individual desire and
Improving teaching about improving practice

There is increasing evidence that the structured use of the principles and methods of continuous quality improvement (CQI) in healthcare settings will have a positive effect on improving care. Recognition of this in the UK can be seen from frequent references to CQI in Government publications driving the “modernisation agenda”. Government support of centrally funded initiatives such as the National Breakthrough Collaboratives provides additional evidence, although it is not clear whether a common understanding exists of what are its key elements. For example, these should include a focus on improving the way we understand and meet the needs of patients/users; a focus on improving the processes by which their care is delivered; and the application of improvement methodology that enables us to learn as we go. Finally, it is essential that the delivery of care is improved by the interprofessional teams who provide it.

It is still early days and the limited availability of knowledge and expertise in these methods means that improvement projects often have to rely on the use of external facilitators for their successful conclusion. It has been suggested that it is unlikely that success will be achieved without such facilitation, although it is also true to say that such dependency may itself sow the seeds of future failure. Resourcing such facilitation in the long term is not sustainable if we really want to see improvement become a routine part of everyday practice.

We therefore have to consider how to develop the necessary knowledge and skills within health care itself and, in particular, how to help practitioners learn improvement skills alongside their professional and technical skills. In this issue of Quality in Health Care Kyrkjebø et al describe an educational project that addresses this crucial question and, in doing so, they make an important contribution to the work of others in the field.

This work is beginning to integrate understanding about best improvement practice with knowledge of best educational practice. Making them both practice based and relevant to patients and students produces the best improvements and the best learning. Such an aim underlies the project reported by Kyrkjebø and colleagues. They tested out a student experience that was carefully designed to have a patient focus, to link theory and learning in practice, and to introduce students to improvement methods that could make a real difference to the quality of care. Although they were unable to provide a formal interprofessional team experience, the students were able to develop insight into skills needed to work jointly with colleagues.

As the study infers, such learning must go beyond simply learning the mechanics of improvement tools. Stories of successful improvement are inevitably stories of people learning together and, in health care, this means within clinical and other practice based settings. We need to establish creative learning strategies that involve students in real work as a learning medium so that they may leave something behind as well as take something away. They need to develop a personal understanding that, to be continuous improvers, they must be continuous learners. In educational terms this reflects the difference between “deep” and “surface” learning, and reinforces the need for deep learning that develops each student’s self-concept.


B MCCORMACK
Professor of Nursing Research, School of Health Sciences, Jordanstown, UK
b.mccormack@ulster.ac.uk

H MCKENNA
Professor and Head of School of Nursing, School of Health Sciences, Jordanstown, UK
hp.mckenna@ulst.ac.uk
and self-confidence as a lifelong learner if they are to contribute effectively to continuously improving practice. If their learning about improvement does not achieve this, it will soon become a distant although interesting memory as they cope with the stresses and turbulence of everyday work. The use of “active learning” by Kyrkjebø et al is an important attempt to address this need and gives us clues about creating opportunities for practice based learning in mainstream education.

Their work raises many challenges of implementation for both education and service providers. With regard to the former, there is a particular need to develop the interest and skills of the academic staff who must themselves gain experience of facilitating improvement projects in practice. Unless they do so they will never be able to underpin their teaching with the personal feeling that is critical for helping students to learn. With regard to service providers, Kyrkjebø et al express the hope that their students’ experience “will enable them to take part actively in quality improvement when they are qualified”. This is unlikely to happen by chance and raises significant questions about the environments in which students must learn and will have to practise. In particular, practice based learning requires the creation of opportunities for students to participate in work settings where clinical teams are using systematic approaches to improve their care as part of their everyday work. After qualifying, they require opportunities to develop themselves and their improvement skills within routine organisational staff development programmes. Continuous improvement needs to be integral to both educational and healthcare institutions.

The final message that can be taken from the paper by Kyrkjebø et al is perhaps the most profound. Integrating our basic human enjoyment of learning with deep feelings about providing the best possible care for our patients provides an enormously powerful driver for improvement. It creates the demand for health profession educators and service providers to understand that they are part of the same system of care delivery with a shared underlying purpose. Put another way, how can we provide services that continuously improve care and education at the same time?

This requires a sophisticated dialogue between employers and academics that will establish partnerships between healthcare providers and higher education and will provide benefits for learners, providers, and the wider community.

P WILCOCK

E CARR

Institute of Health and Community Studies,
Bournemouth University,
Bournemouth,
Dorset BH1 3LT, UK
PeterWilcock@compuserve.com

Over the past decade it has become a commonplace—almost a definitional truism—to subscribe to the Institute of Medicine’s view that clinical guidelines are (or should be) “systematically developed statements which assist practitioner and patient decisions about appropriate health care”. Guidelines now subserve other functions too: they provide up to date overviews of research evidence, its strengths, weaknesses and scope of application; summarise research findings in a manner which allows derivation of performance indicators and review criteria; and are used to develop pathways of care, reminder prompts, and to help set healthcare priorities. Indeed, one influential researcher notes that, although guidelines may once have been intended “to act as decision aids by patients and practitioners . . . we do not use them in this way. Instead, they are used to modify the clinical behaviours of practitioners and reduce inappropriate variations in care”.

It is conventional wisdom that the development and application of guidelines are especially appropriate in situations where clinicians are uncertain what—if anything—is the most effective way of treating a particular clinical problem and where there exists reliable scientific evidence which, properly interpreted, can offer a sound basis for developing guidance. Reliable interpretation of scientific evidence is dependent on the adoption of formal methods to inform guideline development and encompasses:

- an explicit approach to identifying areas of practice where guidelines could prove helpful;
- convening competent guideline development groups;
- retrieval, assessment, and synthesis of all relevant evidence to the clinical area addressed;
- translation of evidence into clinical recommendations;
- external review of guideline recommendations.

Since guidelines offer explicit recommendations with the definite intent of influencing what clinicians do, their clinical recommendations make claims which range beyond those which can be derived logically from the results of meta-analyses or randomised trials. The clinical scope of level I evidence is generally too narrow to allow clinically useful guidelines to be created from these sources alone, so recommendations require moorings to other evidential findings and information, including expert and consensus
Guidelines, judgement, opinion, and clinical experience

opinion. Guideline formulation thereby steps beyond the
results of particular studies and beyond re-presentations of
published systematic evidence to incorporate processes of
judicious extrapolation, interpretation, and value judg-
ment.7

The paper by Rycroft-Malone8 in this issue of Quality in
Health Care illustrates how guideline developers can bring
rigorous techniques to bear in tackling such tasks. In the
case of an evidence-linked guideline development proc-

ess, she describes the formal means adopted by the Royal
College of Nursing Institute's Quality Improvement
Programme to develop a national guideline on assessment
of risk and prevention of pressure ulcers. Ulcer risk assess-
ment is a complex clinical area in which explicit evidence
relating to a wide range of problems and techniques has
been summarised.9–11 From these summaries, 200 state-
ments relating to a wide range of problems and techniques has
been published systematic evidence to incorporate processes of
judgement, opinion, and clinical experience in their
construction.7

The transparent approach of the Royal College of Nurs-
ing Institute to the development of a national guideline on
assessment of risk and prevention of pressure ulcers goes
some way towards reassuring those who for some time have
warned of the dangers of treating guidelines as pronuncia-
tions which carry oracular authority. Ten years ago, for
example, Tong wrote: “Medical practitioners should regard
the recommendations of consensus development confer-
ces as useful reference tools; not the rulings of
philosopher kings, but the attempt of thoughtful people to
share their knowledge—albeit imperfect—with other
people”.12

Formal techniques for appraising the results and
relevance of scientific studies and of systematic reviews are
now relatively well established in the context of guideline
development.13 The report by Rycroft-Malone offers an
approach which also brings rigour and stringency to the
equally important task of assaying diverse sources of
judgement, expert opinion, and clinical experience in their
construction.

B HURWITZ

Head, Department of Primary Health Care and General Practice,
Centre for Primary Care and Social Medicine,
Faculty of Medicine, Charing Cross Campus,
London W6 8RP, UK
b.hurwitz@ic.ac.uk

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B Hurwitz

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