# Quality lines

David P Stevens, *Editor-in-Chief*

## Handovers (handoffs) and patient safety: a call for solutions

Four papers in this issue highlight the importance of better communication between shifts of resident trainees in teaching settings. A report from the US describes anew the hazards that accompany poorly communicated handoffs, emphasises the importance of anticipating potential problems and advances recommendations for timeliness and focus on context. A second report challenges academic settings to invite the patient into the process and places an emphasis on professional responsibility—from "not my patient" to "every patient is my patient". A provocative commentary, which is anchored in experience from non-healthcare, high-risk organisations such as nuclear submarines and space missions, advises parsimony, flexibility and emphasis on situation complexity. Finally, an editorial calls for timely implementation of these and other experience-based recommendations to improve handovers in teaching settings.

***See pp 2, 4, 6, 11***

## System changes reduce adverse drug events in the VA system

Root cause analyses (RCAs) of adverse drug events (ADEs) generally are conducted for serious ADEs in the US Veterans Affairs hospital system. A review of the national experience in 2004 showed that the four most common ADEs were wrong dose, wrong patient, wrong medication, and failure to give prescribed medication. Based on the knowledge gained from the RCAs, significantly improved outcomes were associated with the use of alerts and forcing functions in medication order entry as well as improvements in equipment and bedside care. Of note, training and education were negatively correlated with improvement if they were not associated with these system changes.

***See p 37***

## Opportunities for improvement of post-discharge outcomes in surgical patients

A study of 2145 surgical patients in The Netherlands showed that post-discharge adverse outcomes occurred in one-fourth of admissions and resulted in readmission of one-third of these patients. Adverse outcomes in hospital and complex procedures increased the probability for both post-discharge adverse outcomes and readmissions. Infection was the most common post-discharge adverse outcome (39%). These findings suggest an opportunity for prevention by targeting attention to wound treatment by staff and patients, both in hospital and after discharge. Moreover, clear information about their treatment appears to be particularly important when patients had complex surgical procedures and/or adverse outcomes during hospitalisation.

***See p 47***

## Healthcare professionals' traditional perspectives of quality care and patient safety

Two qualitative studies in this issue remind leaders to be mindful of healthcare professionals' traditional perspectives toward quality and safety. In one report, in spite of their previous roles in a successful management-initiated safety project, views of a cohort of US ICU nurses toward safety remained focused on immediate day-to-day care of their patients, for example bed rails, alarms, equipment and medication administration rather than systems issues such as dangers in the physical environment. "Double checking" was their main self-initiated safety task. In a separate study Swiss doctors and nurses viewed quality through the traditional ethos of professionalism in medicine and nursing, where the individual's skills, dedication to the patient, autonomy and responsibility were seen as achieving quality care. Both studies suggest that health system leaders must continue to consider professional culture and adult learning theory in their commitment to changing systems and implementing quality and safety initiatives.

***See pg 25, 31***