

# Quality lines

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David P Stevens, *Editor-in-Chief*

## *QSHC* readers' and authors' access to innovation — *Online First* and a new blog

There was a time—just five years ago—when the editors of *QSHC* scrambled to find enough original scholarly papers to fill 80 pages every 2 months. Recently, however, in spite of an ever-higher bar for acceptance, the queue of accepted papers awaiting publication in the print journal has lengthened to an intolerable 18 months. But help is on the way. Authors and readers will be pleased to learn that *QSHC* will now publish accepted papers *Online First*, a BMJ service that makes papers available to readers online immediately after formal acceptance, usually within the 3-weeks time required to proof and post PDF versions. As a result, the queue will be whittled down, and from now on, accepted papers will be posted promptly after making their way through the review process to acceptance. At the same time, a new *QSHC* Editor's Blog will be launched to address current innovations as well as controversies in healthcare improvement and patient safety. These overdue developments should allow *QSHC* authors and readers prompt access the latest in scholarly evidence for the better and safer care that their patients deserve. *See page 2*

## Global evidence for patient safety

This issue of *QSHC* contains two reports of scholarly reviews advanced by the World Alliance for Patient Safety. The Alliance was formed to accelerate worldwide research toward improving patient safety. The first review is an analysis of the broader world's literature on patient safety research. The second reviews the literature on patient safety issues in developing and emerging countries. Major patient safety topics were identified through a consultative and investigative process and were categorised into the framework of structure, process and outcomes of unsafe care. Lead experts examined current evidence and identified major knowledge gaps relating to topics in developing, transitional, and developed nations relating to 23 major patient safety topics. Much of the evidence is from developed nations where prevalence studies demonstrate that

between 3 and 16 percent of hospitalized patients suffer harm from medical care. Data from transitional and developing countries also suggest substantial harm from medical care. It is clear that, while much of the evidence base comes from developed nations, understanding the scope of unsafe care for the rest of the world is a critical component of delivering safe, effective care to all of the world's citizens. Establishing safe healthcare practices, integrating those processes into routine health services delivery, and developing patients' expectations that such processes be present are necessary prerequisites to measuring and monitoring progress toward safe patient care throughout the world. *See pages 42 and 48*

## Improvement and accreditation in Australian healthcare organisations

While accreditation is accepted as a key strategy for healthcare quality improvement in many countries, little is known about how it improves critical performance. For example, what organisational and clinical variables are associated with the achievement of accreditation? A report in this issue of *QSHC* explores these questions, studying accreditation by the Australian Council on Healthcare Standards. Accreditation performance of 19 randomised health care organisations—5% of the Australian acute care health system—was positively related to organisational culture and leadership, but was unrelated to consumer involvement. There was a weakly positive relationship between accreditation performance and clinical performance. These findings suggest that accreditation models need further improvement if they are to more clearly demonstrate how they lead to improved clinical and organisational performance. *See page 14*

## Managers' capacity for quality improvement in Canada

The specific dedication of quality managers to achieving quality improvement (QI) is increasingly considered an essential component for health care organisations that are committed to healthcare improve-

ment and patient safety. A survey of 97 acute care hospitals in Ontario, Canada found this capacity to be underdeveloped. Many hospitals had no manager in charge of QI, and many such managers were new to their position. Nearly all managers were responsible for multiple portfolios, yet many had no support staff for QI activities. These findings were largely consistent regardless of a manager's level of authority or hospital type. Those with Masters level training and greater experience were more involved in strategic planning, data analysis, and communication. To build capacity for healthcare improvement, recommendations included dedicated QI managers, QI training for executives and clinical staff, and proactive implementation of explicit QI strategic plans. On the other hand, this contrasted with respondents' opinions that QI initiatives should be less reactive to accreditation bodies, government, adverse events, or hospital executives or boards. *See page 27*

## The Hospital Standardised Mortality Ratio in Dutch hospitals

The Hospital Standardised Mortality Ratio (HSMR) was used to analyse death rates for Dutch hospitals by comparing their risk-adjusted mortality with the national average. This analysis used routine administrative databases available in the National Registration Files dataset for the years 2005-2007. Diagnostic groups that lead to 80% of hospital deaths were included in the analysis. The study adjusted for a number of case mix factors, including the primary diagnosis, age, sex, urgency of admission, length of stay, comorbidity (Charlson Index), social deprivation, source of referral and month of admission. The ratio of the HSMR of the Dutch hospital with the highest value was 2.3 times the HSMR of the hospital with the lowest value. The authors suggest that overall hospital HSMRs and mortality at individual diagnostic group level can be monitored using statistical process control charts to give an early warning of possible problems with quality of care. The use of routine data in this standardised model may offer a starting point for improvement of Dutch hospital outcomes. *See page 9*