# Quality lines

David P Stevens, *Editor-in-Chief*

## Incident reporting and feedback to improve care systems

Effective incident reporting and feedback systems in healthcare are essential if organizations are to learn from failure. A report in this issue of *QSHC* analyses patterns in the reporting of patient safety incidents from all acute hospitals in England to the NPSA National Reporting and Learning System. Reporting rates increased steadily over the observation period and were correlated with safety culture. A separate report reviews the relevant literature and expertise in healthcare and industry reporting systems to establish a basis for closing the safety feedback loop. Closing the loop involves implementing effective corrective actions in addition to the broad dissemination of information to raise front line safety awareness. Feedback actions to improve clinical systems must be both timely and visible to the reporting community to support the development of a safety-conscious culture within the organization. An accompanying editorial emphasises the need to deliver on the promise of reporting systems for safer healthcare. ***See pages 2, 5 and 77***

## A different paradigm for training safer doctors

A report in this issue advances a proposal that, given current demands of modern healthcare, most doctors-in-training may expose patients to undue harm because they do not have the necessary experience, knowledge and technical skills to work effectively in complex environments with limited resources and supervision. More robust training models may be needed for the new generations of healthcare professionals. The current model of learning by doing or "see one, do one, teach one," may fall short if it does not demand demonstration of competence rather than time served in medical training. Competence-based advancement must become the standard of medical training and be incorporated into current certification processes. This proposal advances a new paradigm for ensuring competency and safety for doctors-in-training that integrates knowledge and competencies. It builds substantially on a culture of patient safety in a simulated environment. ***See page 63***

## Increasing implementation rates of patient safety processes in a teaching hospital intensive care unit

A report of efforts to increase implementation rates of evidence-based interventions in a teaching hospital intensive care unit (ICU) focuses on developing a durable and reproducible intervention model. Team building and team communication, incorporation of prompts in progress notes, development of a value compass for reflection of change unique to ICUs and the use of a data wall to provide real-time feedback all appear to contribute to improving this ICU microsystem. Demonstrable process improvements focused on prophylaxis against venous thrombo-embolic disease, ventilator-associated pneumonia and stress ulcers. This interventional model may offer a method for simplified real-time defect analysis, and adapting Plan-Do-Study-Act (PDSA) to offer more comprehensive microsystem review. ***See page 74***

## A proposal: harness the properties of complex socio-technical systems for safer care

In addition to top-down reorganisation, policy reforms, credentialing and directives to standardise care processes, these authors from Australia and New Zealand suggest improving communication and relationships, enhancing individual decision-making through evidence-based decision support and promoting patients' involvement in their own care are vital for safer care. They suggest that such a bottom-up strategy led by clinicians is needed to balance top-down approaches, and that the natural properties of a complex socio-technical system offers promise for promoting self-regulation in the pursuit of safer, better healthcare. This provocative proposal is offered by *QSHC* in the interest of promoting reflection and comment among our readers. ***See page 37***

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