Quality Lines

SIMULATION BASED TEAMWORK TRAINING

Simulation based teamwork training has significant face validity. This is based on its success in high risk, high stakes organisations such as aviation. However, evidence that it has an impact in medicine is very limited. Simulation and teamwork experts base their support for team training on the prodigious circumstantial evidence that suggests improved performance is likely to benefit patients. So far there has been little evidence to link improvement in team behaviours with positive clinical outcomes. Organisational leaders have been slow to implement simulation based team training in hospitals. This investment must be justified by evidence of programmatic success in clinical error management. A preliminary investigation reported in this issue shows that realistic multiple emergency patient simulations can be conducted and supports the contention that simulation based training is likely to result in improved team behaviours in the actual clinical environment.
See p 417

HOW DO STAKEHOLDER GROUPS VARY IN A DELPHI TECHNIQUE

Mental health is a core part of primary care, but there are few validated quality measures. Consensus expert panel methods are a good way of developing quality measures where evidence is sparse or opinions are diverse. However, little is known about the dynamics of consensus techniques and the factors that influence the judgements and ratings of panels and individual panellists. Campbell and colleagues describe differences in panel ratings on the quality of primary mental health care by patient, carer, professional, and managerial panels within a Delphi procedure. They explore why panels and panellists rated quality indicators differently. There was little disagreement within panel ratings but significant differences between panels. General practitioners and psychiatrists rated more indicators valid than patients and carers. Ratings were influenced by past experience, expectations, definitions of quality of care, and perceived power relationships between stakeholders. Panel composition and clear objectives are crucial when using consensus techniques.
See p 428

TOWARDS PRIMARY CARE FOR NON-SERIOUS 999 CALLERS

With rising demand for immediate care and consistent evidence that some 999 callers do not need to be taken to the accident and emergency (A&E) department for treatment, the ambulance service is under increasing pressure to rethink the way it delivers care to its patients. In this study, protocols were drafted that allowed crew members to leave some patients at home with a referral on to other more appropriate community based services or advice about how to look after the problem themselves. Introduction of the protocols did not affect the proportion of patients conveyed to A&E, but did lengthen the time taken per job. Patients treated by crews trained to use the protocols were satisfied with their care, although some concerns were raised about safety in a minority of cases. These mixed results indicate a complex clinical and service development and the change management implications need to be considered before implemented elsewhere.
See p 435

INTERNATIONAL NETWORK FOR CLINICAL PRACTICE GUIDELINES

Ollenschlaeger and colleagues introduce an international network for clinical practice guidelines. The network was developed from feedback of a survey fielded to organisations worldwide. The Guidelines International Network, or G-I-N, hosts a internet library of over 2000 guidelines and related tools at http://www.g-i-n.net. Annual meetings, working groups, and other collaborative initiatives, along with the website, form the backbone of this innovative new initiative to improve healthcare quality internationally.
See p 455

SURGICAL FIRES

Surgical fires used to be a known and understood risk of surgery in the days when flammable anaesthesia gases were used. The use of these flammable gases in surgery stopped in the late 1970s. Unfortunately, the risk of surgical fire is still present in modern day surgery, but is very poorly appreciated or understood by the doctors and nurses performing surgery. It is estimated that up to 100 surgical fires occur each year in the United States, including several fatalities. Most of these involve flash fires where surgical linens and body hair are easily ignited due to a build up of oxygen under the surgical drapes. Although technical recommendations for prevention of modern day surgical fires have existed for decades, the major problem in getting them put into practice is one of communication between the surgical team members. New initiatives for encouraging better team communication will hopefully garner a renewed sensitivity to preventing this continuing patient safety risk.
See p 467