Quality Lines

CRISIS MANAGEMENT

Notwithstanding best efforts to avoid calamity in health care, crises occur in the course of patients' care. A crisis—the "turning point in the course of a disease at which a decisive change occurs…"—may be mitigated by the development of algorithms that address systematically such events. On ***p 156***, Professors WB Runciman and AF Merry introduce a crisis in clinical care series which is an online manual for the management of crises under anaesthesia. The 25 papers that accompany this article (***pp e1-e25***) were developed by 30 investigators by means of 10 consensus meetings and the intensive analysis of some 4000 incidents.

See p 156 and e1–e25

STRATEGIES TO MITIGATE ADVERSE MEDICATION EVENTS

Adverse medication events continue to bedevil health care in spite of the best efforts to make care safer and more reliable. This issue of *QSHC* features several original articles and a quality improvement report that address strategies to mitigate adverse medication events.

A prospective study of intravenous fluid replacement on three surgical wards at a teaching hospital in Australia identified 124 medication errors (18%) in 687 observations. The observer intervened in nearly half of the errors, perceiving them to be of clinical importance. The authors argue strongly for intravenous infusion control devices and processes for frequent, regular checking of administration rates.

See p 179

A high rate of errors in intravenous drug preparation and administration was found in a retrospective multicentre audit in the United Kingdom, Germany and France. This study highlights the imperative for more systematic procedures in this high risk area of patient care.

See p 190

The evaluation of the implementation of an alert by the National Patient Safety Agency to limit availability of concentrated potassium chloride in hospitals in England and Wales appears on ***p 196***. The swift effectiveness of this intervention was verified and was attributed to strong support by senior management, hospital pharmacists, and by senior nurses and clinicians.

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The quality improvement report by Fertleman *et al* verified in this setting that the presence of a pharmacist as part of the team that makes post-admission ward rounds improved accuracy of drug history documentation, reduced prescribing costs, and decreased potential risks to patients. The salutary outcome of this quality improvement report was the funding by hospital leadership of a permanent full-time pharmacist to participate in daily rounds. The case for the cost benefit of adding the pharmacist to the team was compelling in this instance.

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ADVERSE EVENTS IN THE OUTPATIENT SETTING

A small study of a group of general medical practitioners highlights the complexity of analysis of adverse events in the outpatient setting. This report describes focus group responses by these practitioners to the linking of postgraduate educational arrangements with significant event analysis and peer assessment. This arrangement holds promise of accelerating evaluation of adverse events in the outpatient setting, and highlights the need for more research focused on healthcare reliability and safety in the outpatient setting.

See p 185

IMPROVING NEONATAL CARE

Neonatal intensive care is a high risk, high cost area of clinical care associated with significant levels of morbidity and mortality. How do the public and health care providers know that these vulnerable babies are receiving a satisfactory standard of clinical care? To answer this question, high quality, timely and appropriate information is needed regarding their treatment and outcomes. In 1994, a new regional data collection system, overseen by a multiprofessional steering group, was initiated in Northern Ireland to collect the required data and to support quality improvement and research. This report highlights how demonstrable improvements in the quality of care provided can be achieved through 1) collaboration and openness with colleagues within and between neonatal institutions and 2) adopting a regional approach to the development, monitoring and feedback of agreed performance indicators which are based on sound clinical research and knowledge.

See p 202

CLASSIC PAPER

This issue's classic paper by Classen *et al*, published in *JAMA* nearly a decade before the clarion call of the US National Academy of Sciences Institute of Medicine report on medical errors, demonstrated the high frequency of adverse medication events by employing a computerised alert system. This report advanced knowledge of the frequency of adverse events at a time when the level of concern about reliability in health care was in its early stages. The accompanying commentary calls attention to the ongoing opportunities for improvement and emphasises the need for multiple approaches to identification of adverse medical events.

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