Quality Lines

QSHC'S NEW COVER: A COMMITMENT TO IMPROVEMENT

QSHC has a new front cover. Each issue's cover will feature an institution as its focus. Our purpose is to emphasise again that much of healthcare improvement and safety is about the systems where patients receive their care and where the stories of improvement have their home. This issue's cover displays a photo of BMA House, the home of BMJ Group in London. We at QSHC remind our readers that we too are committed to continuous improvement. We start modestly: we intend to track our editorial processes with greater precision, with the aim of improving the editorial team's timeliness and quality of reviews. In the final analysis, our readers, like our patients, will determine the quality of our work.

THE IMPACT OF NURSING ON HOSPITAL PATIENT MORTALITY: A FOCUSED REVIEW AND RELATED POLICY IMPLICATIONS

This comprehensive literature review indicates that structures and processes of nursing care have a substantial impact on preventable patient deaths. This study identifies evidence to support policies to reduce patient mortality. They include maximising the level of education and training in hospital nursing staff as well as the proportion of board-certified or medical specialist care providers in hospital medical staff, developing and implementing initiatives to strengthen collaborative relationships among nurses and physicians, and establishing and sustaining clinical nursing support systems to enhance patient care.

See p (qc14514) and p (qc17343)

INTERVENTIONS IN PRIMARY CARE TO REDUCE MEDICATION-RELATED ADVERSE EVENTS AND HOSPITAL ADMISSIONS: SYSTEMATIC REVIEW AND META-ANALYSIS

Medication-related adverse events represent a common and preventable cause of harm to patients in primary care. This meta-analysis examines the development of interventions aimed at reducing such harm. These authors searched 14 electronic databases as well as sources of unpublished data. The results showed that pharmacist-led interventions were effective in reducing harm leading to hospital admissions, but restricting analysis to the eight randomised controlled trials failed to demonstrate significant benefit. Pooling the results of studies in the other categories did not demonstrate a significant reduction in preventable drug-related morbidity. New strategies are needed to reduce medication-related harm in primary care settings.

See p (qc12153)

EXPLORING OBSTACLES TO PROPER TIMING OF PROPHYLACTIC ANTIBIOTICS

Available guidelines provide numerous recommendations regarding antibiotic prophylaxis for the prevention of surgical site infections, including one stipulating that antibiotics be administered before surgical incision. However, a review of the literature suggests that this practice is poorly observed. This study examined the factors contributing to this disparity by eliciting the views and perspectives of health care professionals at two large Canadian academic hospitals. It indicates that barriers to proper antibiotic timing centre heavily on conflicts at interpersonal and organizational levels.

See p (qc12534)

THE RELATIONSHIP OF PATIENT COMPLAINTS AND SURGICAL COMPLICATIONS

This retrospective analysis of 16 713 surgical admissions investigated whether an association existed between patient complaints and surgical complications. The relationship was demonstrated and was still significant after accounting for hospital length of stay and patient co-morbidities. Nevertheless, the rate of patient complaints associated with surgical admissions was low, thus demonstrating the limited utility of spontaneously-generated patient complaints as a marker for substandard surgical care. Active institutional efforts at promoting patient reports as well as systematic collection and analysis of patient complaints might prove more useful for identifying safety concerns associated with surgical care.

See p (qc13847)

THE HEALTH CARE FAILURE MODE AND EFFECT ANALYSIS: A USEFUL PROACTIVE RISK ANALYSIS IN A PAEDIATRIC ONCOLOGY WARD

This paper reports experiences with the Health Care Failure Mode and Effect Analysis (HFMEA) in the paediatric oncology inpatient ward of a university hospital in the Netherlands. The team included a parent of a paediatric oncology patient as a member of the HFMEA team. It concludes that HFMEA is a useful proactive method to detect failure modes of a circumscribed healthcare process in the paediatric inpatient setting. The methods and results of this systematic multidisciplinary approach are described in detail so that readers can use them in their own health care setting.

See p (qc14902)