Quality lines

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Transformation of QSHC to BMJ-Q&S

This is the final issue of Quality and Safety in Health Care. In its place BMJ-Quality and Safety will launch in January 2011 as a reformatted monthly journal that reflects the commitment of BMJ to healthcare quality improvement and patient safety. Finding ways to provide care that is better, safer and less costly has never been more imperative. It is vital that there is a scholarly home for critical science and commentary in these fields. BMJ-Q&S will continue to lead in reporting the critical thinking that underpins the best in scholarly healthcare quality improvement and patient safety. Such reporting is vital to the care of patients, those healthcare professionals that provide that care, and the institutions and systems that support their work. (***See page 469***)

Measuring the quality of the doctor-patient relationship in primary care

This two-part review offers a critical perspective on evaluation of the quality of the doctor-patient relationship in primary care. The range of concepts, theoretical models and empirical approaches that have served researchers in capturing this relationship have included objective measures—scales, categories and other objective measures—on the one hand, and qualitative methodologies—psychodynamic, narrative, critical sociology, and actor-network theory—on the other. The authors conclude that a combination of objective measures and reflective practice offers considerable potential for quality improvement in this critically central relationship in primary care. (***See pages 475 and 479***)

WHO Patient Safety Curriculum Guide for education of future doctors

There is considerable innovation in the formal education of future doctors for safer patient care. Nevertheless, QSHC readers may be surprised to learn that patient safety is still a relatively new concept in many health profession schools and universities throughout the world; many medical educators are unfamiliar with the formal safety literature and unsure how to teach it. While students—future doctors and healthcare leaders—are mindful of their responsibilities to practice safe healthcare, their teachers often find it difficult to integrate patient safety concepts and principles into medical curricula. The regrettable result is that many universities are continuing to graduate doctors lacking in the patient safety knowledge, skills and behaviours thought necessary to deliver safe care. In response to this gap the WHO's World Alliance for Patient Safety sponsored the development of a patient safety curriculum relevant to all medical students. The WHO Patient Safety Curriculum Guide for Medical Schools adopts a 'one-stop-shop' approach; it includes a teacher's manual providing a step-by-step guide for teachers new to patient safety learning as well as a comprehensive curriculum on the principal patient safety areas. The Guide is a potentially valuable step. Its critical evaluation will be important as faculties negotiate the educational and political challenges of its implementation. (***See page 542***)

A US study provides more evidence that statewide collaboratives reduce ICU infections

Efforts to improve quality and decrease healthcare costs in intensive care units have focused on reducing central line-associated bloodstream infections (CLABSI) and ventilator-associated pneumonias. The Rhode Island Intensive Care Unit Collaborative is a quality initiative of all ICU care providers in each of the 11 adult acute care hospitals in that state to improve teamwork, nurture a culture of safety and reduce CLABSIs and VAPs. This statewide Collaborative implemented bundles of evidence-based practices that have been shown to deliver improved outcomes by using appropriate checklists. Compliance with elements of the ventilator bundle increased to 78% during the 30-month Collaborative study period. The mean CLABSI rate decreased 74% from 3.73 to 0.97 infections per 1000 catheter days during a study period. The mean ventilator-associated pneumonias rate fell 15% from 3.44 to 2.92 pneumonias per 1000 ventilator days during the same period. Evidence grows for the use of validated improvement techniques to reduce ICU infections. (***See page 555***)

Getting right the language of practice guidelines

Phrases such as "should consider" and "is recommended" (language related to so-called deontic logic) appear frequently in clinical practice guidelines. The effect of such language on readers' sense of obligation to undertake recommended actions is unknown. This report describes how a sample of clinicians, performance measure developers, and guideline developers ranked commonly encountered deontic terms according to the level of obligation they believed guideline authors intended. "Must" conveyed the highest level of obligation, while "may" and "may consider" conveyed the lowest levels of obligation. All other terms conveyed intermediate levels. "Must," "should" and "may" were found to be ideally suited to represent three levels of recommendation strength because they conveyed non-overlapping ranges of obligation. Other terms may be appropriate as long as guideline developers make explicit the connection between deontic terms and their intended level of obligation. Such an approach contributes to standardising guideline language with more predictable influence on clinical care. (***See page 509***)