QUALITY IN HEALTH CARE

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Editorial

The trouble with brain injury

"The trouble with head injury is that it isn't cuddly," to quote Kate Field's article (p 217)[1] and plea for better head injury services. And this is true not only of head injury. Whether due to stroke, multiple sclerosis, or any other cause, cognitive damage which results in personality and behavioural problems creates a nightmare for any family, who have not only lost someone they love but are obliged to take on a stranger in their place – often not a very pleasant stranger at that.

I am sometimes surprised by the uncomplaining acceptance of this burden. Sadly, the commonest reaction among medical colleagues is to heave a sigh of relief and plan an early discharge date. When community care breaks down, as it almost certainly will, there is at least a sporting chance that the patient will be admitted somewhere else.

Effective rehabilitation is cost effective. It can increase independence and reduce care needs, complications, and readmission rates – quite apart from any improvement of quality of life for patient and carer. Computed over a patient's lifetime, the savings in continued care offset many times the cost of rehabilitation. But there is a hitch. Health care pays for the rehabilitation, while the benefit of reduced care costs accrues to the social services. Joint commissioning must be the answer, but is proving very slow in gestation.

Meanwhile, how do we ensure that rehabilitation is effective? Effective management of cognitive and behavioural problems requires the coordinated effort of a specialist multidisciplinary team. Not every patient needs this level of service, but when he or she does it is often hard to persuade purchasers to pay for it. Many purchasers would prefer to develop their own services locally or in the community, but it is very rare for these services to be able to provide the necessary level of skill and experience – there are simply not enough appropriately trained therapists. Whether they work in hospital or community settings, specialist teams take time to build. They cannot be picked off a shelf and returned at a whim. Short term contracts, negotiated year by year, do not allow the stable development of a highly skilled team. The demise of the regional health authorities threatens the existence of specialist brain injury units, many of which have had at least partial top sliced regional funding. Their survival is essential, not only for their specialist skills and experience but also as a focus for the training and research that is vital to the future development of rehabilitation.

Under pressure, short term financial considerations are apt to take precedence over long term planning, but before we opt for any cheap alternatives it is important that we capitalise on existing resources. Maximal cost efficiency demands a critical mass of senior staff and training grades, and this in turn demands a sufficient caseload. Linking outreach or day facilities to existing inpatient services may allow this critical mass to be reached and thus serve the dual purpose of training tomorrow's staff and containing today's costs.

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1 Field K. The game of injury hop-scotch, UK style. *Quality in Health Care* 1994;3:217–20.

Keyword indexing: brief guidance for authors

From 1994 onwards the method of compiling the subject index in *Quality in Health Care* will change, whereby papers will be indexed by a keyword system. Authors of papers are requested to include up to three, occasionally four, keywords (words or phrases identifying the subject) on their manuscript, which will contribute to the compilation of the annual index in the December issue. The subject index will be different, with the title of the paper repeated after each keyword for every entry; cross references will not appear in the subject index. The author index will no longer include the title of the paper and will comprise a list of authors and page numbers only.

Choosing keywords may not seem intrinsically difficult, but there are unforeseen problems. An index should be as consistent as possible, and entries should not be split between, for example, "antenatal care" and "care, antenatal." Whereas some decisions may reasonably be made about the entries that can be predicted, authors will not know what other work is being published in the same volume or under what titles. Therefore, some modifications by the technical editor may be necessary.

General points

Authors should scan their paper for keywords that may not be in the title, use British approved names for drugs rather than proprietary names, and avoid general terms such as clinical, complications, adverse effects, and patient. As the subjects of the journal are "quality" and "health" it would be better to avoid these terms as keywords whenever possible. Retaining accepted phrases and concepts is preferable – for instance, "health district" rather than "district, health". Some shortened forms may be acceptable as keywords – AIDS, HIV, GP, TQM are widely known and understood – but generally the full form of abbreviations should be used.

Within this framework authors are encouraged to consider their choice of keywords carefully to facilitate location of their published work by readers.

READAPT: An Evaluation of Services for People with Learning Disabilities. (Three booklets, two disks; £85 per set, additional sets of booklets £80). Leeds: Nuffield Institute for Health, University of Leeds, 1993. ISBN 1871 977 58 4. (Available from Quality Assurance Unit, Nuffield Institute for Health, 71–75 Clarendon Road, Leeds LS2 9PL (0532 459034).)

READAPT is an instrument which purports to evaluate services for people with learning disabilities and is intended to be used by any provider or purchaser of services to this group. It consists of two scales: the evaluation of care scale, which is used to assess the care of 10 clients and asks an independent observer to ask clients or their advocate about whether a range of aspects of care (plan of care, goals for elimination, goals for recreation, etc) have been provided, and the organisation evaluation scale, which asks the independent observer to find out whether the service has policies and procedures for everything that a good service should have – for example, dealing with client's possessions, confidentiality, information, and staff development. The responses to all questions on the extensive scales are recorded as yes, no, or not applicable. The pack comes with a brief user friendly guide to the scales, a copy of the two scales, and easy to use software (two disks). All the materials are well presented and clear.

To evaluate the instrument we asked five people (from a variety of professional backgrounds) heavily involved in learning disability services to assess the scales' strengths and weaknesses and tell us if they would buy it. All in this small, and perhaps unrepresentative, sample completed the task, but none expressed an interest in using or purchasing the scales. Why is this you might ask?

The brief and easy to read introduction provides the first clue. The scales seem to emerge from nowhere, in that there is no analysis of how the items were derived, what values, principles, and theory guided the choice of items nor an account of the process of the scales' construction. There was no presentation of whether validity had been considered, nor any relevant data. The reliability of the scale was not discussed. The instructions were very simple for both scales, but no guidance was provided about the complications that would almost certainly arise from asking the important, but simplistic, questions. All our assessors thought that the scale had high face validity, in that it covered a good range of significant variables, but that it was somewhat superficial and likely to prove unreliable.

Several other significant weaknesses were evident. The instrument is very institutionally oriented, with its emphasis on policies, procedures, and documentation. Many very good community services would score badly on the scales and yet could still offer a high quality service to clients. Further, there is very little concession to different types and levels of disability and the instrument is disproportionately focused on clients' excesses, deficits, and inappropriateness rather their needs. Finally, certain subscales such as "dignity" seemed to be assessed rather curiously, being determined by whether you had multiple changes of your own clothes and whether you had access to a hairdresser.

Although this review is fairly critical, the scale undoubtedly has its strengths, which include the motivation of the authors, the extensive range of issues covered by the scales, and the comprehensiveness with which they assess services' documentation, policies, and procedures. Unfortunately, in the final analysis, its obvious weaknesses and little documented evidence about its reliability, validity, and usefulness make us unable to recommend READAPT.

TONY LAVENDER
Director, Clinical Psychology Training Scheme
RICHARD PEMBERTON
Consultant Clinical Psychologist

LEARNING TOOLS

Moving to Audit: An Education Package for Nurses, Midwives, and Health Visitors. Centre for Medical Education, Ninewells Hospital and Medical School, Dundee. Distance learning package: £29.00 (course enrolment); £14.00 resource book only (free to practitioners in Scotland). Dundee: University of Dundee, 1994. ISBN 1 871749 42 10 (Available from postgraduate office).

This *Moving to Audit* educational package developed as a distance learning programme at the Centre for Medical Education at the University of Dundee, in collaboration with the Clinical Resource and Audit Group for Scotland.

The package contains a standalone resource book and a set of challenges and audit activities presented in diary format and simulating everyday practice. Registered practitioners at all levels of knowledge and experience of audit are invited to enrol, and on completion of the six challenges and activities a certificate is awarded, with the possibility of future accreditation for prior learning. Individualised feedback is provided by computer, and there is the opportunity to compare and exchange audit experiences with other course participants.

The resource book is lively, interesting, and easy to read. The twelve chapters are divided into three sections: part one describes the concept of audit and how to set up an audit; part two explains data collection and analysis and interpreting results; and the final part looks at continuing the audit cycle. The reader is guided in the text by helpful subheadings and symbols that highlight key areas for reflection or suggestions for further activity. A comprehensive glossary describes key terminology and there is a wide range of references and suggested further reading.

The chapters dealing with data collection; sampling techniques; practical advice in designing audit tools, data storage, analysing data, and interpreting statistics are particularly helpful and should provide a useful reference for those who want to start an audit initiative but who do not have a background in research.

Within the limits of the resource book, the authors have fulfilled their claim to provide "what every nurse, midwife, and health visitor needs to know about professional audit." The excellent resource material could be further developed in the form of a video to brief members of a quality assurance team for classroom tuition. Future development of a computer tutorial to build on the information gained in the course might be an advantage for those interested in learning more about statistics and measurement.

VALERIE OVERTON
Midwife

DIARY

9 March
Nottingham: East Midlands Conference Centre. Case based auditing. A conference of Lincolnshire Medical Audit Advisory Group (MAAG) in conjunction with the Department of Health; Queen's Medical Centre, Nottingham; Vale of Trent Faculty of the Royal College of General Practitioners; Trent Health; and the Eli Lilly National Clinical Audit Centre. The conference is aimed at members of MAAGs and audit facilitators in primary care, researchers in clinical audit, and health service managers. (£25.00 including VAT.) Further details from Ms Barbara Walker, Lincolnshire MAAG, PO Box 206, Cross O'Cliff, Bracebridge Heath, Lincoln LN4 2JE (tel/fax 0522 569874).

30 and 31 March
London: Royal College of Physicians. Continuing medical education in Europe: the way forward through European collaboration. An international conference of plenary sessions and seminar groups with leaders of medical education in Europe. (£293.75 (2 days), £164.50 (1 day) before 31 January 1995; £317.25 (2 days), £176.25 (1 day) after that date, including materials, refreshments, reception (30 March), and VAT.) Further details from Mrs JM Coops, Conference Office, c/o Fellowship of Postgraduate Medicine, 12 Chandos Street, London W1M 9DE (tel 00 44 0171 636 6334; fax 00 44 0171 436 2535).

27 April
London: Royal Society of Medicine. Evaluating clinical audit: past lessons, future directions. A joint conference of the RSM Forum on Quality in Health Care, CASPE Research, and *Quality in Health Care* on the progress and impact of clinical audit in the NHS. (£45, RSM fellows and former members; £85 others, including all materials, lunch, and VAT.) Further details from Miss Lisa Spicer, RSM, 1 Wimpole Street, London W1M 8AE (tel 071 290 2986; fax 071 290 2989.

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The journal would like to thank the following people for their support in acting as referees of submitted papers.

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