

A proposed classification for quality improvement interventions

An iterative process to develop a classification framework of quality improvement interventions (QIIs) enlisted the opinions of 27 quality improvement experts in the USA. The participants were selected from among health services and public health researchers who represented the Agency for Healthcare Quality and Research, the Centers for Disease Control, The Veterans Administration, The National Institutes for Health and the Robert Wood Johnson Foundation. The classification framework was based on a heterogeneous convenience sample of 80 selected reports. It divided articles into: 1) empirical reports of development and testing of QIIs (divided further into sub-categories of development of QIIs; history, documentation or description of QIIs; and success, effectiveness and impact of QIIs); 2) QI stories, theories or frameworks; 3) literature syntheses or meta-analyses and 4) development and testing of QII-related tools. This report provides a valuable classification for broader discussion from among various national, scholarly and methodological perspectives. *See pages 394 and 403*

The challenges of reducing wrong site surgery

Efforts to reduce wrong site surgery have employed a wide range of strategies and have met with mixed results. This issue of *QSHC* contains two such reports. A systematic improvement initiative that employed audit and feedback in a Swiss teaching hospital produced improved compliance with a defined set of 11 audit criteria over one year of study. A second report of an interview-based, before-after study in a sample of 11 NHS hospitals in England and Wales evaluated the impact of a 2005 national safety alert by the National Patient Safety Agency. Results in three specialities (ophthalmology, orthopaedics and urology) showed inconsistent compliance with the National Patient Safety Agency recommendations. Although surgeons' self-reported practice



suggested substantial change, interspeciality differences remained. Taken together, the reports suggest that systematic improvement efforts and early testing of safety alerts may facilitate more sustainable changes in practice. An accompanying commentary offers additional observations on the challenges of eliminating wrong site surgery. *See pages 396, 409 and 455*

An analysis of falls during a 12-month period in English and Welsh hospitals

Falls are generally the most frequent patient safety incident and are associated with potentially devastating outcomes for patients. This report describes the analysis of over 200 000 reports of falls from 472 healthcare organisations in England and Wales. Average rates were 4.8 falls/1000 bed days in acute hospitals, 2.1/1000 bed days in mental health units and 8.4/1000 bed days in community hospitals. Diurnal patterns showed a peak at late morning. After adjustments for bed occupancy, both age and male gender were associated with increased falls. Ninety-five percent of falls resulted in no or minimal harm. Falls that resulted in severe harm included 530 fractured neck of femur. Studies such

as this lay systematic groundwork for improving falls prevention efforts. *See page 425*

Different outcomes using the Chronic Care Model for osteoarthritis in different demographic groups

The Chronic Care Model has achieved widespread acceptance as a template for proactive and patient-centred care. Many studies, particularly in patients with diabetes, have shown a positive impact on process and outcome indicators. The Patient Assessment of Chronic Illness Care (PACIC-5A) was used to assess care provided among patients with osteoarthritis. In 1021 patients from 75 primary care practices that employed the Chronic Care Model in Germany, younger and better educated patients achieved higher scores on the PACIC-5A. It is unclear whether this reflects differences in physician behaviour towards different patient groups, different demands among patient groups or special circumstances that occur in persons with osteoarthritis. Further research is needed to confirm and/or better explain this finding. *See page 443*