QUALITY/ SAFETY SECTION

Introducing the Journal's Quality/Safety Section

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With this issue, we are launching a Quality/ Safety Section to focus on quality improvement, patient safety topics and methods important to Hospitalists.

The Institute of Medicine captured national and international attention with the book, *To Err is Human*,[1] published in 2000. The authors estimated the annual number of deaths from health care errors in the United States between 44,000 and 98,000 people. The following year, the Institute of Medicine published *Crossing the Quality Chasm*,[2] which articulated the elements of high-quality health care as: safe, timely, equitable, effective, efficient and patient-centered. The authors called health care organizations, professional groups, and payers to action in improving each of these key dimensions.

In *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*,[3] authors Langley et al. presented a Model for Improvement. The first step is to answer the question "What are we trying to accomplish?", or "What problem are we trying to solve?". The second step is measurement: "How will we know that a change is an improvement?". The third step is to define an intervention: "What change can we make that will result in an improvement?". Plan-Do-Study-Act cycles are used to test, refine, add and abandon interventions based on how effectively they move the measure(s) from baseline to desired performance levels. We don't succeed when we implement a change; we succeed when we improve performance.

How do Hospitalists identify and close quality gaps? We must assess our own performance, and the performance of the complex systems within which we operate, and identify where the care we deliver falls short of the best care possible. We can each lead meaningful improvements in the care of our patients, the functions of our teams, and the performance of our hospitals—starting today. Hassles, frustrations, processes that seem harder than they should be, processes that are variable or inconsistent—all of these present opportunities for improvement. At the other end of the spectrum, we have an imperative to improve when a patient is harmed or put at risk by the care that we provide.

How can we prevent that harm, or reduce that risk? The Langley Model for Improvement provides a structured approach for tackling these gaps and problems. The approach is as useful for reducing the number of times in a day your pager goes off as it is for reducing the number of patients with central line associated bloodstream infection.

The Standards for Quality Improvement Reporting Excellence

(SQUIRE) guidelines[4] provide a framework for reporting health care improvements. While our improvements are "local" and shaped by people, culture and context, using the SQUIRE 2.0 framework to document the improvement work facilitates an improvement team's ability to spread and scale up the changes, and accelerate organizational improvement. The SQUIRE guidelines also prepare you to report improvement work outside of your organization, in manuscripts, and in publications. With a deliberate approach, engagement in quality improvement allows you to improve patient care, improve organizational performance, and build an academic portfolio.

What problems are you solving? We welcome your submissions to the Quality/Safety Section.

Notes

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