LETTERS

We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

PHOTOS.COM

INCIDENT REPORTING

Seeing the picture through "lean thinking"

We have to take hospital safety out of the safety and quality ghetto and beyond strategies such as clinical audit and feedback that embed existing levels of error into baseline best practice outcomes.[1]

For the past three years we have been experimenting with the application of "lean thinking" to care processes across our teaching general hospital.[2] Lean thinking is an approach to improving the sequential processes involved in production of manufactured goods and services of all kinds.

To the lean thinker, error in execution of a process is an absolute waste. No one benefits from it. Once it is acknowledged that errors resulting in an overt patient safety incident occur in one in five hospital admissions, further retrospective error analysis is of limited value. Simply adding another incident report to the existing pile will not change anything.[3] Instead, we prospectively examine and redesign care processes of all kinds to make doing the right thing easier than making errors. A prospective examination of existing processes, to identify potential weaknesses and opportunities to improve, encourages the improvement team to work at the system level rather than the level of individual blame.[4] It also avoids sterile debate about relative risk.

Over three years, we have halved the number of serious safety events that have had to be reported to our insurers, despite a substantial increase in the numbers of patients seeking care in our hospital. At the beginning of our lean thinking journey, our hospital was struggling to contain a deficit. In the last financial year, we were several millions dollars in the black accomplished without measures such as shedding staff.

David I Ben-Tovim director, Redesigning Care and Clinical Epidemiology Units, Flinders Medical Centre, Bedford Park, SA 5042, Australia david.ben-tovim@fmc.sa.gov.au

Competing interests: None declared.

1 Vincent C. Incident reporting and patient safety. *BMJ* 2007;334:51-2. (13 January.)
2 Womack JP, Jones DT. *Lean thinking. Banish waste and create wealth in your corporation*. London: Simon and Schuster, 1996.
3 Sari AB, Sheldon TA, Cracknell A, Turnbull A. Sensitivity of routine system for reporting patient safety incidents in an NHS hospital: retrospective case note review. *BMJ* 2007;334:79-81. (13 January.)
4 King DL, Ben-Tovim DI, Bassham J. Redesigning emergency department patient flows: application of Lean thinking to health care. *Emerg Med Australas* 2006;18:391-7.

PREVENTING FALLS

Falls need tailored management, fractures risk management

Cameron and Kurrle strike a note of frustration in their editorial accompanying the paper on preventive strategies to minimise falls.[1 2] Falls in older people are sensitive to several spheres of influence: the physical status of the individual; the mental state of the individual; the influence of environmental factors; the impact of medication, adverse or beneficial; and acts of violence and abuse.

For an individual a fall is generally a symptom of an underlying problem not an explicit diagnostic sign, and therefore multivariate analysis using falls as the index is unlikely to produce a robust understanding. In an audit of admissions to one district hospital we observed that in medical admissions from care homes falls were quite common but that conditions that predisposed to falls such as infection and poorly managed heart failure were ubiquitous.[3]

Institutional fall rates are probably an unreliable indicator. In reviewing fall data from care homes, occasionally a report of dramatic fall rates is seen and these are often attributable to individual residents with extremely high fall rates but are seldom accompanied by injury. Investigation often reveals that these are not so much accidental episodes related to gravitational forces but acts that reflect "frustration" even "defiance." Falls may, to a degree that needs definition, be accepted as part of the risk taking associated with individual choice and autonomy; to do otherwise invites imposition of a regime of restraint, restricted movement and inevitable increase in dependency.

Fracture or injury rates have greater currency as they are less amenable to interpretation and may indicate that risk is inadequately being managed. Risk in this context may have dimensions amenable to change. Fracture rates may also allow more robust baselines from which new interventions can be assessed efficiently through statistical design.

Clive E Bowman medical director
BUPA Care Service, Leeds LS18 4UP bowmanc@bupa.com

Competing interests: The author is medical director, BUPA Care Homes.

1 Cameron ID, Kurrle S. Preventing falls in elderly people living in hospitals and care homes. *BMJ* 2007;334:53-4. (13 January.)
2 Oliver D, Connelly JB, Victor CR, Shaw FE, Whitehead A, Genc Y, et al. Strategies to prevent falls and fractures in hospitals and care homes and effect of cognitive impairment: systematic review and meta-analyses. *BMJ* 2007;334:82-5. (13 January.)
3 Bowman CE, Elford J, Dovey J, Campbell S, Barrowclough H. Acute hospital admissions from nursing homes: some may be avoidable. *Postgrad Med J* 2001;77:40-2.

Clinical medication review is effective in care homes

Further to the systematic review of Oliver et al on strategies to prevent falls and fractures in hospitals and care homes,[1] evidence from a recent clinical trial by colleagues and myself shows that clinical medication review by a pharmacist of care home residents and their treatment is associated with a substantial and significant ($P<0.0001$) reduction in the number of falls from 1.3 to 0.8 falls per patient in six months (secondary outcome).[2] Since very little else has been shown to reduce the high incidence of falls in care home residents, this evidence is of particular value.

Our intervention also led to an increase in the number of drug changes per subject (2.4 versus 3.1, $P<0.0001$), but no difference in the number of general practitioner consultations, cognitive state, activities of daily living, or the number or cost of prescribed drugs. The reduction in hospitalisations did not reach significance.

Arnold G Zermansky honorary senior research fellow Pharmacy Practice and Medicines Management Group, Healthcare Studies, University of Leeds LS2 9JT zermansky@btinternet.com

Competing interests: None declared.

1 Oliver D, Connelly JB, Victor CR, Shaw FE, Whitehead A, Genc Y, et al. Strategies to prevent falls and fractures in hospitals and care homes and effect of cognitive impairment: systematic review and meta-analysis. *BMJ* 2007;334:82-5. (13 January.)
2 Zermansky AG, Alldred DP, Petty DR, Raynor DK, Freemantle N, Eastaugh J, et al. Clinical medication review by a pharmacist of elderly people living in care homes--randomised controlled trial. *Age Ageing* 2006;35:586-91.

STROKE REHABILITATION

Geratology rehabilitation units are not just for stroke

Young and Forster highlight the benefits of a devoted stroke unit.[1] The advantages of specialised rehabilitation for unselected elderly patients are less widely accepted.

With distinct stroke and general geratology rehabilitation units, we were able to conduct a retrospective study investigating the impact of rehabilitation on functional status of general geratology patients. Case notes of 95 patients were reviewed (31% male, average age 85, average length of stay 52 days). Patients were referred from a variety of specialties (acute general medicine (72%), trauma (11%), non-orthopaedic surgery (5%)) and the reason for initial admission to hospital was categorised as fall or musculoskeletal injury (30%), infection or acute confusional state (29%), other medical problem (31%), or surgical problem (5%).

All patients were assessed and managed by a dedicated team of doctors, nurses, physiotherapists, occupational therapists, pharmacists, speech and language therapists, and dietitians. The average Barthel index on admission to the rehabilitation unit was 9, compared with 12 on discharge; 45% reached a functional capacity allowing discharge straight to their pre-admission home. The positive effect on functional status was significant ($P<0.0001$) and, importantly, independent of the acute diagnosis precipitating admission.

Running a dedicated unit may be expensive, but by avoiding nursing home admission, it has been shown to reduce the overall cost of care.[2]

Anushka Soni clinical fellow in rheumatology, Great Western Hospital, Swindon anushkasoni@doctors.net.uk
Katie Walter senior house officer in geratology
Simon M Ward specialist registrar in geratolgy
Hywel Jones consultant in geratology
Radcliffe Infirmary, Oxford

Competing interests: None declared.

1 Young J, Forster A. Review of stroke rehabilitation. *BMJ* 2007;334:86-90. (13 January.)
2 Phibbs CS, Holty JEC, Goldstein MK, Garber AM, Wang Y, Feussner JR, et al. The effect of geriatrics evaluation and management on nursing home use and health care costs. Results from a randomised trial. *Med Care* 2006;44:91-5.

WARD CRISIS

It's the same in many fields of endeavour

The problem on the wards is the same in many fields of endeavour.[1] As a dentist with over 40 years at the "toothface" I know that most of us do not spend enough time personally helping patients to keep themselves healthy—showing them how to clean their teeth and how to eat sensibly. We would much rather be doing the "advanced treatment"—fixing the teeth that should have been kept healthy in the first place. The simple things we delegate to others.

This is all very well—it takes less time to train a hygienist than a dentist—but because it costs less to see a hygienist than to have a tooth fixed by a dentist both patient and dentist come to believe that the simple care is less important than the complex.

Good leaders in all fields know that you have to make your presence obvious regularly and from time to time get in there and do the simple jobs yourself.

Jim Page dental practitioner and dental tutor Tunbridge Wells TN4 8BG jimpage@bikerider.com

Competing interests: None declared.

1 Teale K. What's wrong with the wards? *BMJ* 2007;334:97. (13 January.)

Team based doctors produce better ward care

Teale points out that poorly managed problems on the ward are well remembered by patients.[1] The converse is also true. In my first posting in foundation year 1, I found myself to be well liked by patients for explaining diagnoses and keeping them updated with their management progress. My team was happy that I knew what was going on with my patients, and I was happy that I felt appreciated.

I have moved from a team based job to a ward based job. Instead of my old ward round, jobs, problems, and review routine, there are three separate ward rounds each day by each of the teams and a consultant ward round six days a week, which means I miss out on many ward rounds because they often overlap and I spend much less time with patients.

This leaves me with a list of disconnected jobs to do for patients I may not have seen. I don't see all of my patients every day, so I don't know them well. I spend very little time with senior house officers or registrars and learn less from them, all of which is detrimental to patient care, my personal learning, and job satisfaction.

For good ward care, you need team based doctors.

S G Ninan FY1 house officer, Leeds General Infirmary, Leeds LS1 3EX sean9n@hotmail.com

Competing interests: None declared.

1 Teale K. What's wrong with the wards? *BMJ* 2007;334:97. (13 January.)

SEX WORKERS' PROTECTION

Sex workers make a valuable contribution to society

The Sexual Freedom Coalition sent an 86 page response to the Home Office *Paying the Price* team and didn't even get an acknowledgement.[1] We argued the case for decriminalisation, promoting the New Zealand model. We pointed out that if this were any other business, the client's health and safety would be a priority, unlike the 11 lines the Home Office devoted to "users."

Sex workers can and do provide invaluable services to clients: obese, disabled, and widowed and people rejected for not being in jobs, good looking, and fit. I recently brought Pru, Sex Worker of the Year in the Erotic Awards, along to speak at the Different Strokes conference, making the point that no stroke survivor should be left to sit without speech or friends during years of recovery. A sex worker, master or mistress of non-verbal communication, should be part of the rehabilitation team. We're a long way off combating the stigma, but between us a little toe is in the door.

Tuppy Owens charity worker,Sexual Freedom Coalition, London N1 3QP tuppyo@gmail.com

Competing interests: None declared.

1 Goodyear MDE, Cusick L. Protection of sex workers. *BMJ* 2007;334:52-3. (13 January.)