Editorial

Mind the gap: discrepancies at local, national and international levels

In 2012, an 11 year old boy boarded a flight in Manchester airport and flew to Rome, having escaped from his mother's watchful eye in the nearby Wythenshawe shopping centre, close to the airport. He came to no harm and probably had one of the most memorable days of his childhood. There was only one problem; he had neither a ticket nor a boarding card, managed to get through several sets of security checks and even the on-board head count failed to spot the extra traveller on the plane.

This story made the evening news on TV stations and headlines in the national newspapers. Yet every day in our hospitals, patients who are supposed to be checked for identification, are administered dangerous drugs and undergo risky investigations. Celik *et al.* shine a light into the area of patient wristband identification and suggest that failures in this area are linked to medical errors. While the paper does not provide a practical recipe to rectify this problem easily, we have chosen to print it as a wakeup call to one of the WHO patient safety goals.

While patients remain in our care in hospitals we have a duty to look after them in a holistic fashion. While we focus our attentions on the medical interventions to better manage the risks of things going wrong, the more elemental aspects of human caring can receive less attention. In a striking study of the nutritional assessments of patients' intake in hospitals Kawasaki *et al.* identify that the quantification of food intake is more complex and subject to many more external factors than previously considered.

Every action or intervention has inherent built-in risk. Modern healthcare is grappling with the management of that risk and hence we have the WHO patient safety goals. But there are differing perspectives on every story and though we have benefitted significantly from the increased emphasis on managing risks in healthcare, the human condition is such that demand for our inputs will always exceed supply. It sound obvious that patients are counselled every time prescribed medication is dispensed but Ong *et al.* have identified that an express prescription completion service can be considered a reasonable option for many patients. I suppose it is a previously unforeseen benefit of the globalisation of information availability in many societies today.

I hope that the close proximity of the papers by Hennessy and Fry, Huotari *et al.* and Al-Hyari *et al.* provides you, the reader with some thought provoking messages on the management of quality cultures in your institution. Each paper harbours a nugget of learning for the support and rollout of initiatives in organisations but unlike the wonderful children's story of *Goldilocks and the Three Bears*, one solution is not suit all scenarios.

Variation in the utilisation of healthcare by the elderly in seven countries is the subject of the ABUEL study and the results have been documented by Stankunas *et al.* in their paper. Satisfaction ratings were reasonably high, but not exceptionally so, in several countries but hovered around the halfway mark in Portugal and Greece (two countries badly affected by the austerity measures in response to the Global Financial Crisis). In a paper laden with fascinating insights into the attitudes and behaviours of our elderly citizens it should concern policy makers that people at the end of their lives do not always see the healthcare services as a harbour of safety or tranquillity.

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The final paper in this issue, by Elikplim Pomevor and Adomah-Afari, is a stark reminder of even more glaring inequalities in healthcare delivery where babies and infants can often be placed four to a cot. Knowledge is important; infrastructure is important but integration of the two is just as important. Poverty of any of these elements of healthcare delivery is distressing to anyone with a conscience.

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