Why quality in healthcare?

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WHY QUALITY IN HEALTHCARE?

Recipients of healthcare expect the HealthCare Delivery System to provide them with 100% quality care but may be satisfied with less, provided they find some relief and succour from their ailments. Ninety-nine percent defect-free quality, i.e. one error in a thousand seems to be a high standard and close to flawless performance. Yet, at a 99.9% “quality” level our heart fails to beat 32,000 times each year, 18,000 babies are dropped by healthcare providers at birth every year, 20,000 incorrect prescriptions are made each year, 500 operations are performed wrongly by surgeons every week, and 12 newborns are given to the wrong parents daily.¹

In our profession, there is no scope for error as any error means all the difference between life and death, relief and disability, and cure and morbidity.

MALADIES IN HEALTHCARE DELIVERY IN INDIA

In the past decade, the press has brought awareness regarding the state of public and private hospitals and nursing homes in India. For millions of Indians, going to a hospital remains a nightmarish experience; big crowds, confusing maze like layout, incomprehensible instructions, tedious procedures, casual diagnosis, rough handling by sullen staff, rude physicians, complete absence of accountability, and unjustified delays.²

The rural health suffers from maladies like lack of suitable accommodation, inadequate staff and inadequate diagnostic and therapeutic facilities. Laboratory, radiographic, and operation theatre facilities are not being utilized due to lack of human resources in many centres resulting in a constant flow of patients from periphery to the district and city hospitals. This leads to overcrowding and an adverse effect on the quality of services rendered in these hospitals.

Media reports of adverse events in healthcare settings raise questions about whether these are isolated exceptions or part of a larger problem. Advances in technological, pharmaceutical, and clinical sciences are providing lifesaving capabilities; however,

the complexity thus added to the system makes it more prone to errors. The hospital is an unsafe environment both for the patients as well as the staff. Every medical procedure has an inherent risk of complications and even small errors in processes like medicine administration, hand hygiene or patient identification may have dangerous consequences. The outcome of unsafe practices include poor patient satisfaction, increased morbidity and mortality, extended length of stay, increased cost per discharge, lower revenue per bed, loss of productivity, loss of reputation, litigation risks, and costs.

The leadership in healthcare delivery thus needs to ensure that safety is accorded the highest priority. In most cases the fault is in systems, communication and processes highlighting the importance of quality in Healthcare.

DEFINING QUALITY IN HEALTHCARE

Everyone is in favour of quality as desideratum and most recognize it when they see it; however, defining it especially in healthcare is much more difficult. Various definitions of quality are available. The Joint Commission defines quality as “the degree to which patient care services increase the probability of desired outcomes and reduce the probability of undesired outcomes given the current state of knowledge”³ and the Institute of Medicine (IOM), Washington defines it as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”.⁴ Quality could be simply defined as the degree of adherence to pre established standards based upon prevailing knowledge and practices.

QUALITY PERSPECTIVES—WHOSE VIEWPOINT?

As recipients, the patients are the only source of information about whether they were treated with dignity and respect. Their experiences can stimulate important insights into the kinds of changes that are needed to close the chasm between the care provided and that should be provided. The patient perceives quality in the light of accessibility and affordability of healthcare, promptness of delivery, early diagnosis and treatment, thereby ensuring early return to productivity and to be treated with empathy, respect, and concern.⁵

The providers of care perceive quality based on the parameters of providing care as per established practices, availability of resources, self-satisfaction with outcomes and acquisition of knowledge, skills, and competence.⁶

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The organizers of care are responsible to the society for the funds they spend on healthcare. Hence they perceive quality in terms of ensuring safety of public and preventing inappropriate and/or suboptimal care. At the same time the organizers of care endeavour to meet the requirements of both the recipients and providers of care at acceptable costs.⁷

Quality also relates to structure, processes, and outcomes. The structure represents the facilities and the human resources while the processes represent the various clinical, supportive and administrative interactions between the providers and recipients. The outcomes reflect the changes in the healthcare status i.e. relief from symptoms or cure of a disease. Reduced morbidity and/or mortality, prevention of disease or accidents and employee and patient satisfaction too represent outcomes. The focus of all quality efforts must be on the results produced.⁸

The emphasis should be on what is achieved and not what is done as “doing something may be confused with getting something done”.⁹ To reiterate, “quality in a product or service is not what the supplier puts in, it is what the customer gets out and is willing to pay for”.¹⁰ Moreover, in healthcare there is no excuse for failure to do things right the first time.

THE QUALITY TOOLS

In order to monitor the quality of care there is a need to measure the quality of services being rendered against pre determined norms or standards of performance. This is only possible if appropriate methods or tools are available and used by the hospital management in their quest for quality. Some simple tools such as brainstorming, Pareto graph, Control charts, and satisfaction surveys are well known. Others are multiple-method tools such as re-engineering, while few others are frameworks such as the plan-do-check-act (PDCA) and audit cycles. The choice of the tools depends solely on the predefined quality situation or the problem that one desires to monitor or investigate.¹¹ Use of validated tools like SERVQUAL can bring out hitherto unknown gaps in the quality of care, as found out by a study published in this issue.¹²

THE QUALITY PROBLEM

Past couple of decades has witnessed a profound change in the healthcare scenario with path breaking advances in therapeutics, investigations rather in all fields of healthcare. However, these advances are taking place in the framework of a care delivery system that is operated and managed in much the same way as it was decades ago. Quoting Sir Cyril Chantler, “Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective and potentially dangerous”.¹³ While no one can deny the fact that modern medicine has saved numerous lives, it is also true that medication errors have killed or harmed quite a few. Research has shown that the most common causes of medication errors are similar drug names, similar packaging and labelling, and illegible prescriptions.⁴

WHO'S FACT FILE

The WHO global patient safety challenge has compiled the burden of medical errors and their consequences in terms of morbidity/mortality and economic losses.¹⁴ To list a few: one in 10 patients is harmed in developed countries due to a range of errors or adverse events; at any given point in time, 1.4 million people worldwide suffer from infections acquired in hospitals; in developing countries, the probability of patients being harmed is higher than in industrialized nations; at least 50% of medical equipment in developing countries is unusable or only partly usable; additional hospitalization, litigation costs, infections acquired in hospitals, lost income, disability, and medical expenses have cost some countries anywhere between US\$ 6 billion and US\$ 29 billion a year; industries with a perceived higher risk such as aviation and nuclear plants have a much better safety record than healthcare; healthcare associated infections are acquired by one out of every 136 hospital patients (USA), 100,000 patients (UK), and 450,000 patients (Mexico); the yearly estimated cost of healthcare-associated infections is £1 billion, US\$ 4.5–5.7 billion, and US\$ 1.5 billion in UK, USA, and Mexico, respectively.

TO ERR IS HUMAN

The IOM report entitled, “To err is human” has detailed significant problems with patient safety in the healthcare system of USA. It clearly showed that more than half of the adverse events resulted from medical errors and could have been prevented. When extrapolated to more than 33 million admissions to United States hospitals each year, the results implied that between 44,000 and 98,000 Americans die each year as a result of medical errors. Thus more people die because of medical errors than from motor vehicle accidents, breast cancer, or AIDS.⁴ The concept that errors result largely from the failures of systems and not from individual carelessness or inadequacy runs counter to the traditional focus of medical training on individual performance but should be fundamental to the new efforts to address safety.

In an international survey,¹⁵ almost a quarter of the respondents who had health problems claimed they had experienced either a medical or medication error in the past two years (Figure). Over half of those reporting a medical error mentioned that it had caused serious health problems.

PROBLEM OF THE “BLAME GAME”

Healthcare delivery is an increasingly complex and high-risk activity. Despite the dedication and professionalism of staff, things can and do go wrong. It is estimated that up to half of all incidents may be preventable.¹⁶ The way in which such incidents are handled is of critical importance to the future safety of patients and to the effectiveness of healthcare delivery system. However, patient safety incidents have been infrequently

Figure Percentage of diagnostic and therapeutic errors.

reported. Even when submitted, reports have been discussed locally only and not utilised as learning tools to prevent similar occurrences elsewhere. One of the primary reasons for low reporting levels has been the predominance of a blame culture, where the likelihood of disciplinary action by the employer and/or regulatory body, coupled with the growing threat of litigation, has conspired to keep healthcare professionals from speaking out. A punitive work environment and the widely held belief that errors are evidence of personal carelessness push many healthcare workers into reporting only what they cannot conceal. Punishment for making mistakes is the single greatest impediment to error prevention and we must move from a punitive environment to a just culture.¹⁷

THE END GAME

There is a lack of large scale studies in India but if the international studies are any indication then our healthcare system is facing a medical crisis of epidemic proportions. Preventable medical errors and hospital acquired infections are shockingly pervasive in all hospitals and they affect all patients, regardless of age, gender, race or financial resources. While in the Armed Forces we are generally aware of such errors and take requisite steps to ensure that they do not occur with any regularity, yet we cannot allow complacency to get the better of us. We need to continue monitoring potential errors and apply tools to evaluate the quality of care rendered by up with the aim of improving

as well as encourage reporting of errors related to provisioning of care and disseminating information on these errors to prevent their recurrence. The ultimate goal should not be who did it, but what happened and how it can be prevented. To err is definitely human but to learn from and rectify the errors is divine.

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