Quality in hospital care

The prospects for improving and maintaining the quality of hospital care in Latin American and Caribbean countries through a process of accreditation are examined below.

Quality assurance in hospitals should guarantee to all patients the care needed to arrive at optimum results. The following elements are needed for the development of programmes having this objective:

— technical skills;
— efficient use of resources;
— greatest possible reduction of patients’ lesions derived from services;
— satisfaction of patients in respect of requirements, expectations and access to health services;
— local health systems with integrated external and internal hospital services.

Almost all the hospitals in Latin America and the Caribbean have a great deal to do if they are to achieve these conditions. Reasonable basic coverage already exists; the need now is for quality assessment and the rapid attainment of satisfactory standards.

Perceptions

If the goal is to assess quality in a specific geographical or catchment area, attention should focus on structure, function and the impact of services in communities. If, however, the intention is to assess specific services, with checks on hospital payments and receipts, or if professional performance is to be evaluated, different approaches are necessary.

The evaluation of medical care in many parts of the world depends more on subjectively assessing the art of healing than on scientifically measurable parameters. Medical practice undergoes permanent evolution, and assessment methods should take this into account. However, it is also desirable to make allowances for specific contexts, especially in relation to the values and criteria of professionals and patients, in order not to fall into the trap of setting quality standards that are unrealistic in the region or area in question.

The assessment of patients’ satisfaction is inevitably subjective, because of educational, social, economic and linguistic differences between health professionals and their clients. The perception of quality varies from person to person according to the individual’s knowledge, values and resources. For patients and their families it means correct diagnosis and satisfactory treatment as they see these things. Physicians apply strict technical criteria in an endeavour to improve their patients’ quality of life, but such factors as the context of their work, the medical school
they attend and their personal values also come into play.

In general the medical conduct of a physician is based on implicit criteria and these can only be assessed by another physician. It is necessary to define them in relation to all the steps taken to arrive at a diagnosis and correct treatment at the local level. The resulting guidelines should be appropriate resources, and in professional performance. Unfortunately, hospitals frequently concentrate on matters of secondary importance in quality assurance.

The APACHE II system, developed at George Washington University, is frequently used in the USA, especially with critical patients; it uses 12 physiological parameters to classify cases. Other systems, developed by private companies, are based on the manual or computerized revision of medical records, symptoms, signs, laboratory tests, X-rays and other clinical evidence. Maps showing sequences of clinical criteria have been developed to verify, for example, whether physicians have made correct decisions on admission in cases of precordial pain. In Latin America these techniques have been used only in some university hospitals.

As yet there is no ideal method for assessing health care in absolute terms. The assessment of technical skill relies on the use of medical records; physician-patient or hospital-patient interaction relies on direct observation or questionnaires. Each method is applicable only to a specific clinical situation.

The assessment of structures is easier, faster and more objective, whether in relation to supplies, personnel, qualifications or management, but good structure in itself does not, of course, guarantee good quality. The assessment of the process of medical care is based on information contained in medical records or on direct observation. However, dedicated junior hospital doctors may maintain detailed medical records yet omit important subjective data on overall clinical status. Variables such as the accessibility of hospitals to patients, and levels of service utilization, can also be analysed.
The assessment of the results of care is the final goal of quality assurance programmes. This process is subject to the influence of personal reactions to physical and psychological aggressions during the period of observation or hospitalization. The assessment of the impact of health care in the community is also a complex matter.

At present an attempt is being made to develop several indicators of the quality of health care in local health systems. For example, a serious case of pneumonia in a hospitalized child suggests inadequate attention to respiratory disease at the primary care level. Such indicators point to the need for the correction or improvement of structures and processes in health systems, without the need for long-term, expensive epidemiological analyses. The objective, of course, is not just to assess quality but to maintain it permanently.

Quality improvement

In the USA the Joint Commission for Hospital Accreditation was created in 1951. This private organization tried to introduce concepts of retrospective case analysis. A quality culture gradually emerged in academic and institutional settings, communities began to press for more complex legislation, and private bodies were set up to examine bills paid by social security offices. In 1986 the Commission introduced a project with the goal of developing a quality-monitoring and assessment programme that would continue until the year 2000. The programme is directed at clinical results, with emphasis on organizational and health team performance, and uses specific indicators identified by scientific societies or panels of experts. Among these indicators are brain lesions after anaesthesia, and infection in postoperative wounds.

The project aims to concentrate assessment on the most common clinical events indicative of failures in medical care, whether caused by institutions or professionals. It is also concerned with initial clinical assessment, the inappropriate use of diagnostic examinations, inadequate types of treatment, and poor orientation after discharge from hospital. It is vital that commitment to improvement in the overall quality of medical care be monitored continuously. The objectives should never be lost sight of, whether in hospital planning, resource allocation, performance evaluation, or the distribution of prizes and incentives. It is no longer enough to have a job description for each hospital director; verification is required as to whether the directors demonstrate a practical commitment to quality-building principles.

During the 1970s, quality programmes were initiated at the Heart Institute of the São Paulo Medical School. The best possible professional team was formed, bearing in mind not only medical considerations but also requirements in the areas of nursing, social assistance, nutrition, physiotherapy,

Health workers gradually become interested in identifying discrepancies between practice and acceptable standards, and find ways to reduce deficiencies.

medical physics, bioengineering, pharmacy and biochemistry, among others. Categories of personnel and their respective tasks were identified for each area of activity. Thus the giving of medication involves various categories of staff, ranging from physicians who examine patients and prescribe drugs,
to pharmacists who provide specific dosages of drugs to patients. Failures can occur at any moment, with serious consequences for the patients. It was recommended that the staff concerned should discuss their routines at specific times, and quality groups were thus set up.

Accreditation programmes can contribute to the improvement of hospital routines in Latin American and Caribbean countries by motivating professionals to assess the strengths and weaknesses of their institutions and establish clear quality goals for medical care.

The creation of quality is not a passive, top-down process but a dynamic activity in which there is unremitting identification of failures in routines and procedures. These have to be revised, updated and published on a regular basis, with support and participation from all levels of the hospital structure. A nursing aide who is not committed to infection control procedures is as responsible for the spread of infection as is a surgeon who fails to prevent the infection of a surgical wound.

The notion of continuous improvement in quality (1) derives from observation of Japanese industrial production. It is based on the following tenets:

- Constant improvement of all planning, production and service processes
- Institution of training on the job
- Leadership development
- Driving out fear
- Breakdown of barriers between staff areas
- Elimination of slogans, exhortations and targets for the work force
- Elimination of numerical quotas for the work force and numerical goals for management
- Removal of barriers that rob people of pride of workmanship
- Institution of a vigorous programme of education and self-improvement at all levels
- Involvement of everyone in the work of accomplishing transformation.

All personnel in hospitals and elsewhere in the health sector can contribute. In the family and community they receive valuable information about demands and reactions relating to health services and clinical skills. The suggestions of health service employees should be reflected in decision-making and strategic planning. Governing bodies and other leadership groups should use this source of knowledge, skill and foresight, and commit entire institutions to continuous quality improvement.

The use of industrial quality assurance techniques in the health sector invariably gives rise to debate concerning “health care” on the one hand and “health per se” on the other. The first has to do with the logistics of medical care, the second with health in a wider sense. The weight of factors such as life-style, genetics and environment is greater than that of health service organization because they are closely associated with heart disease, stroke, road accidents, and so on (2).
In industry, quality is a condition of survival, especially in very competitive markets. It cannot be measured simply in terms of employees, machinery and equipment if the people involved are not profoundly committed to the goals, policies, objectives and programmes of their organizations. From the standpoint of total quality it is imperative that workers be proud of their products and take part in the identification and solution of problems. The same principles are applicable in hospitals, as has been shown in the São Paulo Heart Institute, where quality groups function within a programmed flow of services.

In Latin America the main barrier to such progress is that physicians in leadership positions are heavily committed to their own professional matters. Other limiting factors are low salaries, rapid staff turnover, and trade union pressure, almost always exerted against senior management because of fears that multiprofessional activities could weaken the positions of individual unions. Further difficulties are presented by the lack of precise definition of standards of reference in several areas of medical science and by deficiencies in scientific publishing and other information systems.

It is obviously right to pursue methods aimed at institutional change which interact with the organizational behaviour of hospital workers and involve group dynamics. However, implementation requires strong support and the participation of the highest hospital authorities. Clear acceptance of suggestions and their incorporation into institutional routines is essential. Regrettably, in some organizations a major barrier to progress exists in the form of resistance to teamwork.

In order to implement a total quality programme it is necessary for the institution concerned to be seen as a whole; the facilities of different services have to be shared; teams of personnel have to be well prepared for their tasks; and reliable quality indicators have to be identified.

Even if only some of the above objectives were attained, improved quality would result. But how many hospitals would accept the challenge? Perhaps one should begin with simpler procedures, applicable in the majority of public and private institutions.

**Accreditation**

A model of hospital accreditation for Latin America and the Caribbean has been developed (3). It is flexible enough to be adapted easily to the differences that exist in the region, and covers all general hospital services for the treatment of acute cases. It was written as a guide and reference document for national multi-institutional committees planning their own assessment instruments. Meetings at national level have already been held in English-speaking Caribbean countries, Bolivia, Brazil, Chile, Colombia, Paraguay and Venezuela;

---

A nursing profession committed to achieving advances in quality is essential.

---

workshops are planned for other countries, as are subregional meetings for southern South America, the Andean subregion, Central America, and Mexico. A conference for all Latin America and the Caribbean is to be held in Washington in 1993.
Standards have been set for each hospital service, the initial ones representing the minimum level of quality required. No hospital in any given country should be below that level after a specified time. As each level is reached a new one should be set.

It is important to remember that hospitals function in a social context.

Example of assessment of quality

In respect of medical records the first level involves maintaining data on all individuals seen, whether as inpatients or outpatients. The records should be legible, signed by the physician in charge, and have a conclusion. Over 80% of a sample of the records should have been updated the day before assessment. A specific place should be designated for the maintenance of medical records, and these should be entered both alphabetically and in numerical sequence. At this level the evaluators should proceed as follows:

- The highest medical authority of the institution under consideration should be questioned as to: whether medical records are maintained for all cases; the locations where they are filed; the administrative means of opening them and delivering them to staff on request; the records for admissions, medical offices outside the hospital, and emergency and special services.

- In a sample of 20 medical records chosen from those of the last patients admitted, a check should be made as to whether they are signed, legible and have a conclusion. The medical authorities should be questioned about the existence of standards, how they were published and how professionals were informed of them. A check should be made as to whether details of the standards are easily accessible to staff.

- Various professionals should be questioned about their knowledge of the standards.

- A random sample should be taken, representative of the wards but excluding patients in critical condition, of at least 20 medical records in institutions with more than 20 beds. At least 80% of these records should be checked for entries on the last working day before the assessment. The same procedure should be followed with the records on file. There should be one or more places where medical records are filed exclusively, without interference from any other administrative or support activity.

For the second level’s standard there should be supervision of the medical records.

For the third level’s standard there should be a single medical record for both outpatient and inpatient care. A medical records committee should be functioning and the movement of records should be noted. The evaluators should examine the outpatient records of the day to see if previous hospitalizations have been noted, and should check whether there are notes on outpatient care. A single medical record means the concentration of all medical data in only one envelope, file or container. All movements of medical records should be indicated in notebooks or on charts or cards, with the date of delivery, the names of the person and service involved, and the date of return. If a record is to be transferred from
one service to another, procedures should be in place to inform the records department accordingly.

For the fourth level’s standard there should be personnel exclusively dedicated to maintaining medical records, to which there should be 24-hour access. The evaluators should check that these conditions are fulfilled. If employees responsible for medical records also have related tasks during working hours, such as the maintenance of other records, they should be considered as meeting the requirement of exclusivity provided they are always available to handle medical records.

When the first level has been achieved the next step is obviously to proceed to the succeeding levels. Since hospitals do not have services that are independent and isolated from one another, accreditation requires all services in any given institution to reach at least the first level.

Individual services do not receive accreditation. Even if a unit in a hospital is at the third or fourth level, the institution cannot be accredited if other units do not reach the first level. Structures and processes are limited in such a manner that the malfunctioning of one component affects the whole hospital.

**Accreditation commission**

The first instrument for objective, explicit, technical assessment of quality is the accreditation manual and the second is the accreditation commission, which should be nonpolitical. If such a commission it is subject to distorting political pressure, with the result that either hospitals are not submitted to accreditation or corrective measures recommended by the commission are not implemented. No single body should assume the role of judge, jury and public prosecutor.

Because it is dependent on the public sector, the private sector in Latin America is likely to require state support for a number of years in order to develop social programmes. Health is a major factor in these programmes, requiring frequent financial subsidies to correct deficiencies, especially in medical care for the needy. If the commissions were to become a responsibility of the private sector, incentives would be lost which are mainly obtained through government initiatives.

The best recommendations for establishing these commissions always refer to:

- representation of the public sector, especially the ministries of health and social security, and the private sector;
- participation of professional associations;
- representation of the most distinguished medical councils and academies.

Assessors are usually professionals of impeccable prestige and vast experience. Such people can make recommendations and help to improve the running of hospitals by visiting them and discussing problems with staff members. Accreditation takes place periodically, is confidential, and includes the setting of deadlines for the correction of deficiencies. It can be regulated regionally in order to match assessment criteria with local development. As an alternative to the use of subjective criteria by physicians in assessing the quality of medical care,
hospitals can develop precise criteria that make assessment by nonmedical personnel much easier and simplify accreditation procedures.

Benefits

Accreditation programmes can contribute to the improvement of hospital routines in Latin American and Caribbean countries by motivating health workers at all levels to present group familiar with management and clinical audit. Their skills and academic background are of inestimable value in both implementation and monitoring.

Of course, it is important to remember that hospitals function in a social context. Notwithstanding progress that may be achieved within the institutions, numerous problems are bound to persist. In Latin America, 50–70% of cases dealt with in the usually overcrowded hospital emergency rooms require only primary care, like that available in any reasonably equipped health post, health centre or polyclinic. Hospitals tend not to handle such cases properly because of pressure to concentrate on the more serious emergencies. Furthermore, hospitals tend to neglect health promotion and disease prevention, which are dealt with much more efficiently at health posts or health centres.

***

In order to implement a quality assurance programme, a hospital should be undergoing permanent administrative analysis, redistributing resources according to service priorities, and maintaining a balance between short- and long-term goals. New programmes derived from the emphasis on quality contribute to the renewal of ideas and help to replace old concepts and habits. Hospital leaders should be aware of the social duty of their institutions to provide services of excellent quality for which there is joint rather than individual responsibility. Precise short- and long-term goals, and frequent monitoring, lend direction to plans for action, organizational strategies, and programme implementation. All facets of the sociology of medical care should be interpreted through analysis of the outside environment, the accessibility of hospitals to patients, and the matching of hospital services to community demands.
Success requires the direct involvement of hospital directors, whose commitment and dedication should be clearly demonstrated. Moreover, it is impossible to implement quality programmes if clinical staff are not adequately qualified. The principal challenge for the health sector in Latin America during the twenty-first century may be that of education for the medical profession. Quality programmes demand proper attention to the recruitment, development, assessment and retention of hospital personnel and above all to the knowledge and skill of clinical staff. It is unacceptable that medical schools should lack adequate teaching facilities, that medical residencies should lack orientation, and that the routine assessment of medical practices should have no legal basis.

In the USA, where various methods of assessment are used, over 5000 hospitals have been accredited on the basis of stringent quality standards of structure, process and results. Yet the health sector is frequently a target for lawsuits involving enormous quantities of money. Lawsuits against hospitals and physicians for malpractice or negligence have distorted the country’s entire quality assessment system and caused medical care to become extremely defensive. The risk management committees in hospitals have become preoccupied with protecting their financial assets and preventing undesirable events.

The analysis of quality, based on observation of the effects of care on the health of the population, has consequently been somewhat neglected.

If methods of quality control in medical education and hospitals are not widely implemented in Latin America, a situation similar to that in the USA is likely to arise in the near future, with a plethora of lawsuits for malpractice and negligence. This should be avoided at all costs. The absence of quality control militates against the adoption of self-assessment methods and external control by accreditation commissions, and tends to favour financial forces outside the health care system.

References