

# THE NHI UNDERPINNED BY QUALITY

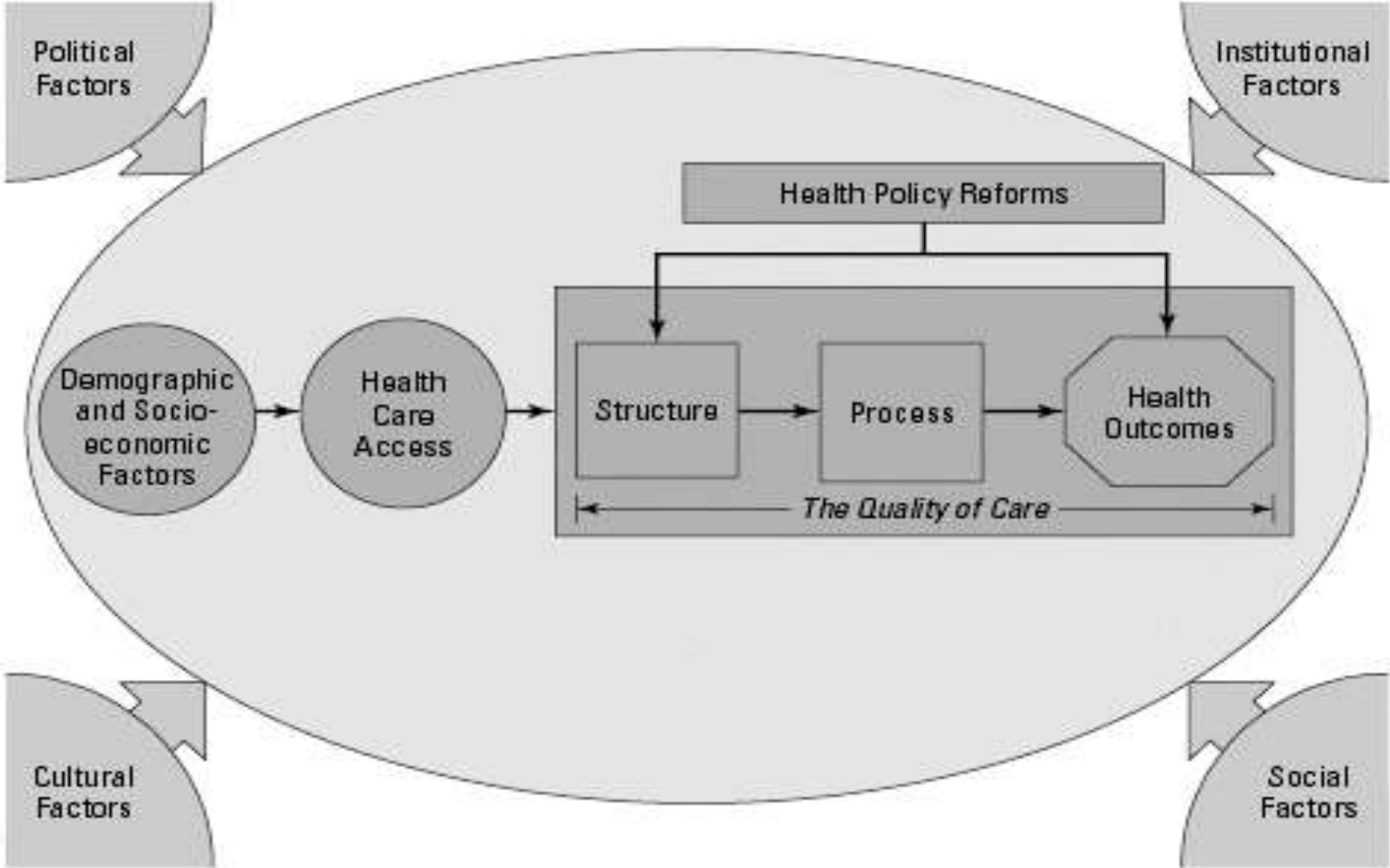
by

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**UNIVERSAL ACCESS TO AFFORDABLE  
QUALITY HEALTHCARE**





Source: Peabody and others 1999.

# **STRATEGIC PLAN 2009/10 to 2011/12**

- 1. Improvement, refinement and scaling up of a detailed plan on the improvement of quality of health services.**
- 2. Establishment of a National Quality Management and Accreditation body.**
- 3. Development of National norms and clinical guidelines.**
- 4. Public sector facilities supported to produce Quality Improvement Plans, including Infection prevention and Control plans.**
- 5. National adverse event reporting and response system is to be designed, consulted and implemented.**



**Private hospitals have invested in establishing systems to manage and measure quality delivery.**

**Clinical Governance programs have been established as a framework that ensures that all individuals remain accountable for delivery of high quality healthcare to patients for the duration of their stay in hospital.**

**Adverse Events are monitored.**

**Infection Control Management**



# **THE NATIONAL COLLOQUIUM ON QUALITY**

## **Nov 2008**

**Consensus was reached that places “ quality at the center of all we do” .....by:**

- 1.Mobilizing staff and communities.**
- 2.Establishing long-term mechanisms to build quality into all our operations and performance.**
- 3.Fast-tracking the use of cutting edge methodologies to improve the quality in priority areas in healthcare.**



# **MINISTERIAL ADVISORY COMMITTEE FOR QUALITY ,SAFETY AND STANDARDS....to advise the MOH on....**

**policies and best practices for quality and safety.**

**means to ensure compliance and make  
recommendations for specific or system-wide  
corrective action.**



**.....continued**

**process towards defining of evidence based standards, norms, guidelines, indicators of quality, appropriate priorities in the field of HAI and patient safety standards.**

**effective and appropriate methodologies for improving quality throughout the system.**



# **INFECTIOUS DISEASES.**

**Management of infections, both community and hospital acquired is the most important pillar of quality of care and patient safety.**

**HAI ↑ morbidity and mortality; ↑ costs of treatment and antibiotics; ↑ length of stay ;lost productivity; litigation costs and time and causes death.**



**Surgical site infections ↑ costs 119%.**

**MRSA ↑ hospitalization costs threefold.**

**VAP ↑ mortality by 27% to 43%.**

**ICU patients who get VAP have a 7 to 10 fold risk of death.**



# **ANTIBIOTIC STEWARDSHIP-The JHB Hospital summit.**

**lack of compliance with established Rx guidelines.**

**excessive use of antibiotic combinations.**

**inappropriate choice of and unnecessarily long  
duration of antibiotic use in surgical prophylaxis.**

**RESULTS...MICROBIAL ANTIBIOTIC RESISTANCE**



# **CONSENSUS.....that there is a need for:**

**ongoing education about antibiotics.**

**multidisciplinary ICU antibiotic rounds with microbiologists/pathologists.**

**establishment of guidelines/ pathways on antibiotic use.**



# **THE BEST CARE ALWAYS CAMPAIGN**

**“ a patient health and safety initiative aimed at supporting South African healthcare organizations to implement specific internationally recognized evidence based interventions in patient care”**



# **I. Prevention of Ventilator Associated Pneumonia**

**Intubated patients who develop VAP have a 30% mortality risk.**

**Elevating the head of the bed 30 to 45 degrees reduces the risk of developing VAP by about 70%.**

**Daily interruption of sedation/awakening trials can reduce the length of mechanical ventilation by up to two days.**



## **ii. Prevention of surgical site infections.**

**Surgical site infections account for 15% of HAI.**

**Patients with surgical site infections are twice as likely to die than non infected surgical patients.**

**Preoperative antibiotics given an hour before the surgical incision are more effective than prophylactic antibiotics administered during or after the operation.**

**prophylactic antibiotics should be discontinued within 24hrs longer duration has not been shown to offer any benefit and may actually increase the risk of resistant bacteria.**



### **iii. Prevention of catheter related bloodstream infections**

There is a 5% to 20% risk of death in patients who develop catheter related bloodstream infections as well as associated costs due to increased hospital stay.

Implementation of a multi-step central line bundle( including evidence based infection control guidelines for hand-washing ,use of full barrier precautions during insertion of central venous catheters, chlorhexidine skin antisepsis, optimal site selection , and removal of unnecessary central lines) can nearly eliminate catheter related bloodstream infections.



## **iv. Promotion of antibiotic stewardship in Intensive Care Units.**

**Interventions aimed at optimizing antibiotic use include:**

- 1. Optimizing antimicrobial prophylaxis for operative procedures.**
- 2. Optimizing the choice and duration of empirical treatment.**
- 3. Improving antimicrobial prescribing by education and administrative means.**
- 4. Monitoring and providing feedback regarding antibiotic resistance.**
- 5. Defining and implementing healthcare guidelines for important types of antibiotic use.**

**These we believe can be achieved through multidisciplinary ICU infections/antimicrobial rounds.**



## v. Prevention of catheter related urinary tract infections.

The risk of acquiring a UTI depends on the method and duration of catheterization, the quality of catheter care and host susceptibility .

Virtually 100% of patients with an indwelling urinary catheter draining into an open system for more than four days will develop a UTI.

To reduce catheter related UTIs, the following precautions need to be taken,viz, mandatory use of closed systems catheterization under strict aseptic conditions and urine bags must be kept below the patient for gravity flow.



# **The campaign strategy is to:**

**continuously seek buy-in from doctors and their professional societies.**

**to integrate pharmacists, microbiologists, infection control nurses and other infectious disease specialists into antibiotic management processes at local hospital level.**

**to create systems for measuring antibiotic utilization and infection outcomes, and for sharing best practices.**



## **IN CONCLUSION...**

**The campaign should be a collaboration underpinned by trust, and no punitive measures must be taken against any participant.**



**KE A LEBOGA.....NGI YA BONGA**

**THANK YOU.....DANKIE**

