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Review of the Quality Assurance Program of Colombo District, Sri Lanka: A Reflective Writing

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EXECUTIVE SUMMARY

Quality Assurance (QA) in health care is to maintain a high quality health care services, through monitoring of its' the effectiveness. The QA program of Divisional Hospitals, Primary Medical Care units and Medical Officer of Health (MOH) units are monitored at the RDHS level. Likewise, RDHS of Colombo district is responsible for all the above stated institutions in Colombo district.
All the above institutions have started 5S concept upto a certain extent. Work performance, clinic services, disease surveillance, supply chain management, health information system, performance reviews of MOH Units are functioning very satisfactorily. Even though the Out patient services, emergency services, Inpatient services, Supply chain management, diagnostic services, waste management, utility services are functioning well, there are significant deficiencies in every aspect in curative care settings.
I was satisfied about the achievements of preventive setting with regard to QA while I am not happy about the QA of curative care settings.
QA of curative care institutions are not up to the expected standards. It is mainly due to poor leadership competencies and commitment of managers, mal - functioning of the Quality Management Unit of the RDHS office, inadequate supervision and performance reviews.
Monitoring of curative care institutions by the directorate of Primary Care Services is also not satisfactory, while monitoring of preventive care institutions by National Programs is substantially high, which has resulted in high QA in preventive sector.
It is recommended to strengthen the functions of the QMU of the RDHS unit; to introduce monthly institutional meetings; to perform quarterly review meetings at RDHS office, strengthening health information system, training of the staff, increase the number of supervisory visits by RDHS and performance appraisal and recognition of good work.

KEYWORDS: Quality Assurance, RDHS

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1. INTRODUCTION

Quality Assurance in health care applies to the maintenance of a high quality health care services, by monitoringthe effectiveness of services provided by health care institutions. Almost every country has established its own monitoring bodies to carry out this function, to ensure delivery of a high quality health care service to its nation. Joint Commission and National Committee for Quality Assurance are some international agencies established to improve service quality and to accredit hospitals, laboratories, health plans, health providers and medical businesses.

Ministry of Health, Sri Lanka has initiated its National Quality Assurance Program, nearly 2 decades ago and several circulars have been issued in 2003 and in 2009, to all the health care institutions to implement the Quality Assurance Program.

"National Guidelines for Improvement of Quality & Safety of Health Care Institutions", have been developed targeting 6

types of institutions namely; 1. Curative sector hospitals above Primary Medical Care Units; 2. Primary Care Units 3. Medical Officer of Health units; 4. Health Management units 5. Specialized Public Health units and campaigns and 6. Training Institutions. These guidelines are to be used as handbooks for staff training activities and for external auditors when planning excellence awards.

National Policy on Healthcare, Quality & Safety2015 has identified 7 key result areas. They are 1. Customer Satisfaction2.Improvement of managerial systems3. Clinical effectiveness4.Patient safety and risk assessment5. Continuous Quality Improvement6.Staff welfare7.Research on Quality and Patient Safety.

Ministry of Healthcare & Nutrition has established a Quality Secretariat (QS) as the focal point to monitoring and technical guidance of the national Quality Assurance Program and Quality Management Units (QMU) are to be established in all hospitals above the level of Base Hospitals and in all campaigns, decentralized units and special units under the Ministry of Health to coordinate the program in their health settings. All types of Divisional Hospitals, Primary Medical Care Units and MOH Unitsare expected to manage their Quality Management Programme using a designated staff member guided by the Quality Management Unit of RDHS.

In this way, the QMU of the RDHS Colombo is expected to provide guidance to all the above mentioned institutions in the district.

2. DESCRIPTION

All the institutions have been made aware of the quality standards to be maintained, for nearly 2 decades. All circulars issued by the Ministry of Health have been circulated among them. National Guidelines for Improvement of Quality & Safety of Health Care Institutions have been distributed to Base Hospitals, MOH officers, Divisional Hospitals and some Primary Medical Care units. All six set of guidelines are accessible online in the website of the Ministry of Health.

Accordingly, all the above institutions have started managing their internal and external environment using 5S concept. A number of training programs have been conducted to educate the managers of these institutions on the concept throughout the whole period. Removal of unwanted items; maintenance of the environment; fixing identification boards, site maps, and directional sign; placing equipment; maintaining files, cupboards and drug trolleys; cleaning the premises; maintaining cleaning responsibility charts/schedules/ guidelines & check lists; marking dander signs; placing fire extinguishers; training and awarding are the main aspects seen in every institution with regard to implementation of 5 S concept. There had been competitions among institutions for Excellence Awards. However, Still there is more room for further improvement to include all the standards stated in guidelines.

When MOH units are considered;

- Their work performance in suggested aspects such as registration of pregnant mothers, post partum visits, immunization coverage, family planning coverage and school health activities are accurately assessed through monthly and quarterly returns sent to the RDHS and FHB; monthly MOH meetings and quarterly and annual district and national review meetings.
- Clinic services such as antenatal clinics, post natal clinics, family planning services, well women services and well - baby clinics are well monitored in this established system of management.
- Further, Disease surveillance activities are monitored through disease notification registers, infection disease registers and weekly epidemiological returns, by the MOH, RDHS and Epidemiology unit.
- There are monitoring systems for health education activities, supply chain management of drugs and vaccines and management of health information system including e – reporting system.
- Disaster and outbreak preparedness and response is satisfactorily coordinated and communicated with the RDHS.
- Leaders have established vision and mission statements of units; management is done on plans such as advanced programs of key officers; performance reviews are done through supervisory visits and monthly MOH conferences; intersectorial coordination done through participating in sectorial meetings and community mobilization is done through disease control activities and health promoting settings and so on.
- Staff training is done according to an annual plan which is communicated with the RDHS and in every MOH monthly conference. Waste management practices are also well established.
- Even though there is no strong Work Improvement Teams established the quality of almost every aspect is assured through the well established monitoring/ evaluation and feed back mechanisms.

Service provision done by Divisional Hospitals should maintain standards of: Out Patient and Emergency care; Responsiveness; In patient care; Diagnostic services; Medical and pharmaceutical supplies; Equipment management; Mortuary services; Infection control; Waste management; Medical Records; Health Education; Leadership; Management of Human resource, Office, Kitchen & Utility services; Performance Review and Productivity & Quality

Improvement program and Primary Medical Care Unitsare expected to maintain standards Out Patient Department; Emergency care; Responsiveness; Poly clinics; Supply and equipment management; Waste management; Leadership qualities; Public relations; Human Resource management; Utility services; Performance Review; Productivity & Quality Improvement program.

- Even though these institutions are under the administration of RDHS, monitoring and evaluation of their performance is not sufficiently carried out by the RDHS as in MOH settings.
- Therefore, the adherence to quality standards is mostly dependent on the interest and the commitment of the In - charge Medical Officers.
- When the guidance received by the Quality Management Unit of the RDHS office is concerned; it is not carrying out its responsibilities as expected.
- However, RDHS – Colombo has included all the institutions in his advanced program of supervisory visits and he performs supervisions by site visiting, directly observations and reviewing the documents.
- In addition, Public health Inspector of the area carries out supervisory visits to assess disease surveillance, infection control and waste disposal.
- There is no satisfactory mechanism to monitor; the effectiveness of emergency care, In - patient care, transfers and referrals, diagnostic services, drug availability, equipment management, health information management, functioning of Work Improvement Teams, patient satisfaction and handling patient complaints.
- Further, monthly staff conferences, accident and incident review meetings, and performance reviews are not to be seen in these curative care settings to achieve targeting quality targets.

QMU units have been established in Base Hospitals and above. Performance reviews of these institutions are conducted quarterly by the Quality Secretariat, Colombo. Therefore, monitoring and identifying the gaps in Base Hospitals (Homagama and Awissawella) are carried out by this mechanism.

However, Quality management of RDHS office is happening satisfactorily. There are;displayed vision and mission statement; advanced programs of key officials; annual and medium term activity plans;performance review meetings; very good supervisory system according to a plan; regular inspection of Hospitals and MOH units by supervisory staff/ reporting of supervisory visits/ meetings to discuss the performance deficits found/ corrective actions; Job descriptions of the staff; identifications of management assistants, file identification system, inventory management of office equipment, annual stock verifications, digitalized cash balancing and so on.

3. FEELING

As an administrator who has worked as a Deputy Director in a District General Hospital under the administration of the line ministry, I expected a well-functioning Quality Management Unit in the RDHS office, to coordinate activities of both preventive and curative care settings. I was unhappy to see the less priority given to this unit, which did not even have a designated Medical

Officer, compared to other units such as Maternal/ Child care, Epidemiology and Planning units.

Anyway, I understood that a considerable amount of monitoring activities to ensure quality service is carried out systematically by these units mentioned. However, the quality assurance made by these special units has focused mainly on the preventive sector ie. MOH units.

I was very satisfied about the leadership role of the RDHS and expertise and commitment of the heads of main units with regard to guidance, monitoring, reviewing and performance appraisal. I was pleased to see the efforts made by the RDHS, to extend his guidance even to curative care institutions, even if the monitoring was not performed using information management systems and review meetings. I hope if he had been supported by a well functioning QMU headed by a committed and a qualified Medical Officer, the quality assurance program of the district would have beena significantly better program.

4. EVALUATION

According to my perspectives, following aspects were seen as good / bad of the quality assurance program of the district.

Positive aspects identified:

- There is a consultant in the position of the RDHS who is well qualified in the field of community medicine to ensure quality of public health services.
- The leadership role of the RDHS is outstanding.
- At least basic principles of 5S concept are being implemented in both curative and preventive care settings in the district.
- Training programmes have been conducted to educate the managers and the staff in the district.
- There is a consultant community physician to supervise maternal/child care activities and diploma holders in community medicine to look after the epidemiological and planning activities.
- There is a very successful monitoring, review and guiding system for preventive care activities of MOH units.
- Health Information Management System of the preventive sector is well developed.
- Supply management of supplements, vaccines and Throposha is functioning well in MOH officers.
- Emergency settings have been established with essential equipment and supplies in almost all divisional hospitals.

- Emergency drugs are available in almost all curative care settings.
- RMSD supplies drugs/ surgical items to medical institutions according to requests.
- There is a Bio Medical Unit with an engineer to support management of equipment in institutions.
- There are some divisional hospitals with digitalized OPD systems to ensure safety and continuity of care.
- Waste management according to color coding system and disposal of pathological wastes in all institutions is satisfactory.
- There are some branch units of disease campaigns to monitor and review the performance of relevant activities.

Deficiencies identified

- Responsiveness of the staff towards clients is not monitored.
- Patient satisfaction surveys are not usually carried out to identify issues.
- There is no proper referral and transfer system established in divisional hospitals and it is not assessed by the DMOs/ MOICs/ staff of the RDHS office.
- There is no proper system to assess the adequacy of diagnostic services and availability of essential drugs.
- Availability of staff in working places during working hours and reporting leave details are not properly monitored.
- There are no adequate performance reviews conducted for the curative setting by in - charge officers or by the RDHS.
- Leadership qualities of managers of curative settings are not monitored and improved.

5. ANALYSIS

Health care settings need to be modified to initiate quality and safety improvement programs. It is necessary to establish Quality Management Units to coordinate the activities. This unit is expected to strengthen institutional setup and employee participation. Among the responsibilities of this unit; assisting the leadership in establishing Work Improvement Teams,Staff training, 5S implementation, improving patient care services, streamlining management of equipment and supplies, planning annual procurement, maintaining quality /safety information system, promoting environmental friendliness, and conducting performance reviews are the priorities.

The preventive sector has successfully achieved the objectives of many national programs because of correct guidance and monitoring done by the RDHS, Deputy RDHS, and regional focal points as well as the national focal points. In addition, the Health Information System which was manual in the past has been digitalized which facilitates quick access to required information from all levels.

5 S concept which was accepted by majority of health staff of both sectors is sustaining fairly satisfactorily. This change has actually made a significant difference in the day to day work and in the satisfaction of employees in their jobs. Further, it has improved the efficiency, accuracy and quality of service provision.

Work Improvement Teams have been initially established in almost every institution. However, their sustainability and achieving the objectives is not satisfactory. Frequently the sister in charge or the Nursing officer in charge has been appointed as the team leader. She finds it difficult to motivate the team members especially Medical Officers because active participation needs self motivation and self discipline which rarely found among medical Officers. This may be a major reason for the breakdown of Work Improvement teams.

Improvement of patient care services including emergency care, in – patient care, clinic facilities, availability of essential drugs and investigations, capacity building and clinical excellence are basically depend on the commitment of the DMOs/MOICs of primary care hospitals. As they are not having necessary medical administrative competencies, the hospitals are not getting the expected service. In adequate leadership qualities and deviated interests from work life to personal life could have aggravated the problem.

Even though the RDHSs are expected to supervise the duties of in charge medical officers; the distance, unavailability of a well established monitoring mechanism in the country and unavailability of a comprehensive health information system to gather data to monitor all the necessary curative care aspects have led to poor monitoring of primary care curative services.

There is a directorate established in the Ministry of Health for the development of Primary Care Services. However, it is not equipped with required number of staff including a sufficient number of administrators like in Family Health bureau, Epidemiology Unit and Other disease control programs and campaigns to give technical guidance and conduct performance review of the whole country. Unlike, the above mentioned agencies, Directorate of Primary care Services has only a poor coordination with the RDHS which has resulted in detachment of primary care institutions from the close monitoring of the RDHS.

Therefore, the implementation of quality assurance program in primary care settings is not as successful as MOH settings.

6. CONCLUSIONS

- Basic principles of 5S concept have been established in both curative and preventive care settings in the district. Last component "Shetsuki" – Training and Self discipline need further strengthening to sustain the first four components.
- All the components of the "Preventive Service Provision" of the Quality Assurance Program are well functioning in the preventive sector institutions.
- "Patient Care services" and "Overall Quality & Safety Improvement aspects" of the Quality Assurance Program has gaps in Divisional Hospitals and Primary Medical Care Units in the district.
- The contribution of the Quality Management Unit of the RDHS office is not satisfactory.

7. RECOMMENDATIONS

- A Medical Officer should be deployed to function the QMU functional.
- Deputy RDHS could be assigned to monitor the performance of Divisional Hospitals and Primary Medical Care Units supervised by the RDHS.
- Monthly Institutional Performance meetings should be conducted in these institutions with the participation of the RDHS/DRDHS and MO/ QMU.
- Quarterly Performance Review meetings should be arranged at RDHS office with the participation of DMOs/ MOICs and Director primary care services should be invited for these meetings.
- Information management systems should be strengthened to collect data related to quality/safety (e.g. patient accidents and adverse events, near misses, re-admissions, case fatality rates, referrals, and transfers etc.).
- In - service and On - the Job, training programs should be organized for the Medical and Nursing Officers, with the support of clinical consultants of BHs to improve patient care management skills.
- Customer satisfaction surveys and employee satisfaction surveys should be conducted in both MOHs and hospitals improve their satisfaction.
- Number of supervisory visits by RDHS/DRDHS should be increased to both MOH officers and to hospitals to make the staff to be available during duty hours.
- Good Performance should be appraised with both internal and external rewards.

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