BIZCOMMUNITY

Is healthcare accreditation worth it?

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A look at six accredited South African private hospitals and how they managed to operate during Covid.

The Covid pandemic has taught the world many lessons. At a base level it taught hospital staff that if they wash their hands regularly, infection rates drop dramatically. It has also shifted paradigms that global public health has taken for granted. The question that remains foremost in the minds of many is this: can health systems be made robust so that when the next pandemic hits, we will be ready? Factored into all of this is the burning question as to what impact, if any, quality improvement programmes and accreditation actually do have on healthcare delivery.

Events at Mediclinic hospitals in South Africa in the past two years provide a strong case for the value of accreditation, especially accreditation that has become entrenched in hospital operations. It seems that quality improvement programmes and accreditation can and do ensure the foundation and the architecture that produces robust health systems needed to withstand the onslaught of global health emergencies.

Surveyors at the Council for Health Service Accreditation of Southern Africa (Cohsasa) noted after several surveys of hospitals in the Mediclinic Southern Africa Group (the largest private health group in South Africa), that not only had standards been maintained but compliance scores in some instances had actually increased.

It is fair to observe that Mediclinic is one of Cohsasa's oldest clients and that the culture of quality improvement is well rooted. Nevertheless, it became quite clear through separate interviews with six Mediclinic managers that their ability to cope with the Covid pandemic was enhanced due to the structures, the policies, the procedures and the practice of adhering to international standards demanded by accreditation.

Without exception all the managers interviewed said that the Cohsasa accreditation programme had created an environment where everyone knew what to do.

Carl Buhrmann, hospital manager of Mediclinic Bloemfontein whose hospital has just achieved a score of 99 out of 100 in its latest accreditation survey says: "Having the Cohsasa policies in place creates order, structure and control and that is

what you need in a crisis. Management knows what to do; it knows what it is expected. Covid creates a situation where one does not have weeks to decide on anything; one sometimes has only an hour or a day. The requirements of the Cohsasa programme and internal Mediclinic policies have equipped us for this."

Carmen Savva, general hospital manager of Mediclinic Nelspruit: "We have been involved in the accreditation programme for 19 years and are now on our sixth accreditation award, so it is part of our culture. It is not something that we need to do over and above our daily activities; it is ingrained in us; it is part of our DNA."

An orderly structure

"Accreditation requires an orderly structure in the hospital – we have infection control meetings and patient safety meetings, and we give feedback to the staff. We continually examine our policies and improve them all the time. It is a mindset," according to Annatjie Meyer, nursing manager at Mediclinic Nelspruit.

Henk Laskey of Mediclinic Constantiaberg is convinced being accredited helped the hospital cope with Covid: "Definitely, I think that when you focus on systems and processes and when you measure what you are doing and concentrate on quality, the hospital that has these procedures in place – in other words, an accredited hospital – finds it easier to adapt to a crisis like Covid. So, we just tweaked already existing systems at Constantiaberg, courtesy of accreditation, to deal with the pandemic. It definitely gave us a head start. I have worked for other hospitals groups that are not in the Cohsasa programme and I definitely missed the structure that accreditation provides."

Hospital general manager of Mediclinic Midstream, Dr Shane Kotzé: "The Cohsasa accreditation programme set the basis for quality in the hospital, and it was something we referred back to. It helped us to know what standards we needed to achieve and continuing with the Cohsasa Quality Information system (CoQIS) process throughout kept our pencils sharp. We knew what was expected of us and we continued to meet those targets.

"With each wave of the pandemic we measured our performance against our own benchmarks or that of our peers. Where we identified gaps, we made incremental changes to make improvements. We used patient outcomes as one of the measures, but mortality rates are a crude metric, so our physicians challenged us to look at other finer and more sophisticated targets. We started looking at hospital acquired infections (HAIs) and device infections. We did not let go of our quality measures during the time and I think that was quite important because by chasing only the crude measures one might lose the detail and it's the detail that contributes to the mortality."

Mediclinic Pietermaritzburg general hospital manager, Tabitha Lolliot, says: "I think the Mediclinic company handled and navigated through the pandemic phenomenally well. I do think a contributing factor to managing everything was our Cohsasa accreditation. We all went in blind – none of us knew what was happening. Having governance structures in place and having support from a team at corporate head office really worked in our favour. Given all these stressful external pressures on the hospital, our governance structures were so strong that the system didn't fail.

"It is second nature to us. Having proper policies and procedures in place protects the patients – first and foremost – and also protects the business and the employee. It was that continual focus on quality improvement, even with the few resources we had at that time – whether it was the 2nd Covid wave when we were overwhelmed or the riots or the flooding. The staff at the hospital pulled together. They knew exactly what was required of them and I put that down to the governance of the company – right from the top levels to governance at hospital level. It is through Cohsasa requirements that we were continually focused on questions like 'what is the right thing to do?' and 'how do we put our policies and procedures in place?'.

"I compare us to the independent hospital colleagues in the Pietermaritzburg area. They struggled. They didn't have the support of an infection control specialist at corporate head office or a procurement department to sort out the PPE. I do think that the audit process, the governance process, which is directly linked to Cohsasa, is what got us through. The independent hospitals had no structure to fall back on. There are often no policies, no procedures and no rules. At Mediclinic we all know what is expected of us in our jobs and in our roles."

Tweaking policies

Even though you are going through a crisis, you are focused on quality. You don't want to cross-infect patients, you make sure your zoning is correct and that patients are placed properly. If there is a breakout of infections, you investigate it – you look at what caused it, you looked at how to mitigate that risk and how to go forward. The Cohsasa programme requires the infection prevention and control structures to be there and because they were in place, we just had to tweak certain aspects to adapt to the pandemic.

The CEO of Cohsasa, Jacqui Stewart, has always said that achieving accreditation is not a sprint; it is a marathon. It is during the long and winding road of accreditation that there is a transformation in the way staff deal with problems that arise in a hospital. The drastic demands of Covid only emphasised this process. For example, the way many of the Mediclinic hospitals handled operational problems was informed by adherence to standards and quality improvement methods.

"The pandemic created various challenges for us at Mediclinic Vergelegen," says hospital manager Marquin Crotz: "We suddenly saw a huge increase in oxygen usage requiring frequent deliveries. Our clinical manager then initiated a review of the oxygen usage with everyone in the chain. They investigated what was happening in the wards and found that oxygen flow rates weren't always optimised for the specific masks through which oxygen was administered. But as more people gained more knowledge about the treatment and how patients responded, oxygen supplies were streamlined to meet actual, not estimated, patient need.

"Specific treatment action plans were drafted and immediately the clinical team trained all the ward staff on efficient protocols for oxygen use. This was a huge success and shared with other hospitals as well."

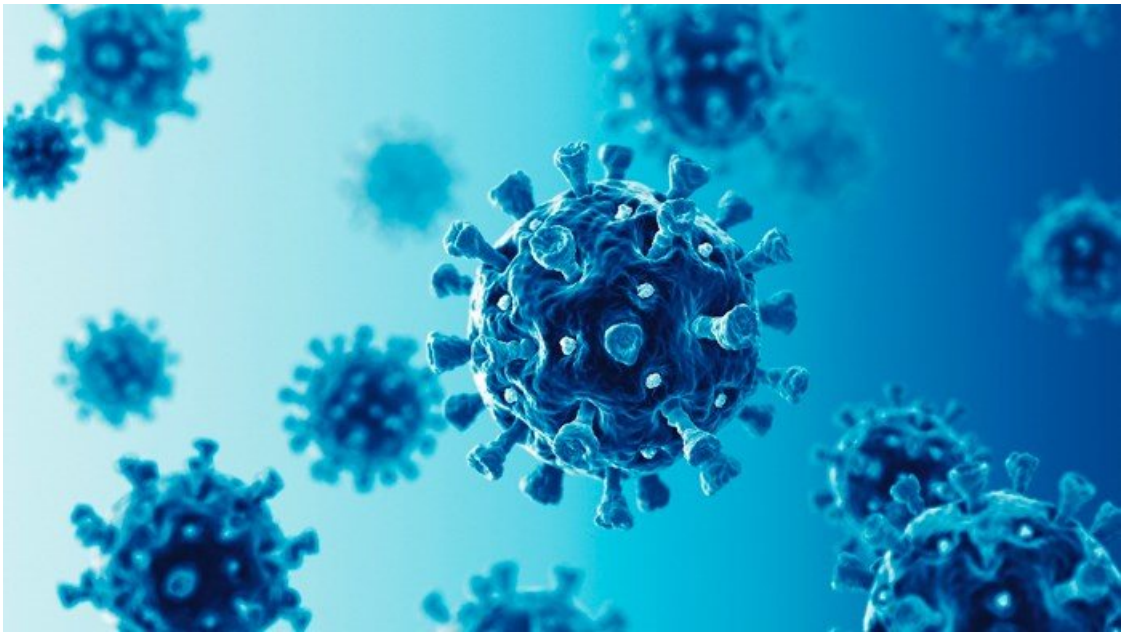
Compromised systems

"During this Covid wave we also introduced the position of a resuscitation medical officer because when the system was overwhelmed, we had to triage who got the next ICU beds. It was a very difficult position to hold because every doctor believes their patient deserves the oxygen and the ICU bed, but it was this doctor who made the decision because they did not know the patients and decisions were not based on emotional involvement. They looked at statistics and potential survival rates and that was how they made their decision."

But it is not just a set of observations and anecdotes that should be noted for the argument's sake. Some hard figures, although not formal research, about how the culture of QI and safe patient care filters into decision-making might be

considered.

Mediclinic Midstream, accredited for the first time in 2018, is a 181-bed multidisciplinary hospital situated in the heart of Gauteng and serves a catchment population of half a million people.



Says hospital general manager, Shane Kotzé: “We threw sub-categories at the vital data capturing process. They were given an early-warning system tool to use that they could plot the data and if they had any concerns, they could immediately call upon a Critical Care Outreach Team. There were ICU nurses on the floor. And so, with very minimal tweaks, we could nurse 34 patients in a ward as a high-dependency ward, without having to only direct high-care nursing at a specific patient. We rationalised the nursing notes, we rationalised the measuring of data and we made the patients part of their own recovery. We went down from 108 patient critical events in the second wave to one in the third wave.”

“We changed the diet. We found that these patients did not want to eat heavy meals. They did not have an appetite, so they didn’t take in nutrition, and they didn’t hydrate themselves. We came up with the idea of smoothies as an extra patient option. We asked the dieticians and the kitchens to prepare highly nutritious, high calorie diets so that patients could simply sip through a straw between breaths.

A galvanised therapeutic team

Says Kotzé: “Our methodology was to follow PDSA on a very rapid cycle. Every day we sat together – a short huddle – and had a clinical command meeting with our core team and relevant doctors. We looked at the current situation – the so-called SitRep – and then we looked at what we needed to do on the day. That could be purely operational, but it could also be about improvement. The next day at the next huddle we would evaluate the preceding 24 hours."

Daily huddle

Kotzé continues: “We diligently documented every decision and every conversation. We developed a daily huddle board and every day it was plotted out and recorded. So, every day we knew what the situation was and also what action was required from various departments.

“We were also strict in terms of communication. Whatever was discussed and agreed upon was then communicated and we had a standardised methodology to impart this and documenting the fact that such communication had taken place. We made sure we communicated what was expected so that it could be reproduced.

“At no point did we throw the book out. We kept looking at our KPIs and we kept as many of the structures in place as we could. We realised, especially during the second wave, that if one took one’s eye off the ball for a second, no battles

against Covid would be won because the whole hospital could potentially be put at risk.

“We found it was essential to stick to the framework and make sure that each and every unit was managed in a structured manner. I think the Cohsasa process definitely added something there. We held each other accountable. If one department wasn’t quite happy with something, we’d call each other out quite quickly.

“We used the EVPs (self-evaluation against the accreditation standards) quite often during the pandemic to make sure that we weren’t allowing our quality to slip. We looked internally continuously, and we conducted peer reviews of units.

“We also used a ‘robot system’ – stop, continue, go – it was a stop, maintain and implement new processes. If we stopped something, we documented it. If we maintained something or put something new in place, we knew what these were. So, when the Covid wave was over, we knew what to start, maintain or change."

Marquin Crotz, hospital general manager of Mediclinic Vergelegen says there were certain standards that were integral to helping the hospitals get through Covid.

Preparing a response

According to Crotz: “Two areas of standards compliance in the Cohsasa programme – disaster management, and infection control – were critical in preparing for our response, and human resources became very important in terms of the upskilling we had to do.

“We had to re-examine our disaster management plan when we knew that Covid was on the horizon. It was quite special to get all the doctors and specialists from the community attending a meeting. They were involved right at the start of the planning process and that for me was key in updating our disaster response plan.

“We did not have sufficiently trained staff, so we had to get many of them specially trained so they could work – under supervision – and assist in higher level of care situations. We used a lot of theatre staff because we had cut down on our theatre lists. It wasn’t an easy step for staff to take. It was not their normal areas of expertise. I have to take my hat off to the staff; they were always willing to assist – even in unfamiliar territory.

“The second wave in December 2020 was difficult to respond to in terms of resources. That was the biggest challenge. We had to call staff back from holidays to help out.”

A QI culture

Much has been written and said about the supererogation of hospital workers during the Covid pandemic. What has not been correlated has been the effect of a QI culture on propagating those actions.

Carmen Savva, general manager of Mediclinic Nelspruit says: “We had staff come back to nurse babies in the neonatal unit and deputy nursing managers directing ambulances. On Saturdays and Sundays, the nursing manager and I would sit in the office doing contact tracing. There were no limits, no boundaries. We were all on fast forward.”

Henk Laskey says that Mediclinic Constantiaberg found the second wave of the Covid pandemic in December–January of 2020/2021the most difficult to manage. “We had a massive patient load; we were using anaesthetic machines as ventilators. We had to upskill and train our ward nurses to assist in ICU with ventilators. Some of our doctors worked as nurses in the ICU helping to prone patients, mix medicines and assist the nurses. There was one dermatologist who had qualified as a physician. She left her private dermatology practice to work as a physician in the ICU.

“We focused a lot on mental wellness of our staff and psychiatrists organised debriefing sessions for our staff."

Beyond the call of duty

Marquin Crotz, the hospital general manager of Mediclinic Vergelegen says: “A prayer group was initiated every Wednesday morning by one of our specialists for all staff for emotional and spiritual support. This was for everyone – whether they were cleaners, nurses or doctors. A paediatrician organised a community support initiative for staff, getting meals to them when they could not get home because they were working long hours.

“When we had staff shortages, we had a couple of doctors who said, “I will be a nurse tonight” and they went on duty as a nurse."

Says Carl Buhrmann of Mediclinic Bloemfontein: “When we had staff shortages due to them contracting Covid, we moved people around so if there were shortages in the kitchen, we got cleaners to help out. We moved different staff into the laundry. We used security people for completely different jobs than what they had been appointed for, like being porters. Sometimes we had the nursing manager working in the kitchen. This created a team spirit and brought us all closer together.

Dr Shane Kotzé says many staff at Mediclinic Midstream went the extra mile during the pandemic for their patients: “It wasn’t foreign to see doctors pushing beds around the hospital. We had staff that worked really long hours and were willing to stretch themselves. Our theatre staff were called upon at peaks of the pandemic to nurse patients in our emergency centres and ICUs."

Tabitha Lolliot of Mediclinic Pietermaritzburg believes that the hospital survived due to team spirit: “I recall in December 2020 that all the staff were recalled from their leave – during Christmas and New Year when people are normally celebrating. During the second wave we had fantastic support from the community. We got support parcels and care packs from people in the Pietermaritzburg area who wanted to rally and thank the staff at hospitals.”

These stories demonstrate that adhering to standards, having policies and procedures in place and working a quality improvement and accreditation programme are indispensable to building a robust health system to withstand future pandemics and health crises.

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