INTERACTIVE SHOWCASE
BY UCMB

Quality Improvement Efforts
1st February 2012
Interactive Showcase
National Quality Improvement Conference
27th – 29th February 2012
QUALITY AND PATIENT SAFETY

- Patient Safety Initiatives
- Quality Measurement
- Patient Involvement
PATIENT SAFETY INITIATIVES

Incident/ Error Report and investigation August 2010:

Reporting is done VOLUNTARILY in a systematic manner using a reporting forms to stimulate the culture of reporting errors and incidents and analysing cause

Piloted in UCMB hospitals: Kisubi, Nsambya, Virika, Nkozi, Buluba, AND

Facilities in: Arua, Moroto, Kotido, Nebbi, Luwero catholic dioceses
**Safe Surgery Checklist use August 2010:**

- Used to intervene on the missing surgical processes, identifying risk factors, prepare patients accordingly.

- To monitor and reduce morbidity and mortality through preoperative risk assessment.

### UCMB Surgical Safety Checklist

<table>
<thead>
<tr>
<th>Before Leaving the Ward</th>
<th>Before Anesthesia (in Theatre)</th>
<th>From Theatre to the Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the patient confirmed his/her identity, site, procedure and consent?</td>
<td>Name of the procedure, recorded.</td>
<td>Name of the procedure, recorded.</td>
</tr>
<tr>
<td>Audited data</td>
<td>Cross checked the patient file.</td>
<td>Cross checked the patient file.</td>
</tr>
<tr>
<td>Telephone</td>
<td>Identified instructions on the operation</td>
<td>Identified instructions on the operation</td>
</tr>
<tr>
<td>Name, Date, Time</td>
<td>Induced of in case instructions</td>
<td>Induced of in case instructions</td>
</tr>
<tr>
<td>Blood &amp; wounds removed (e.g. rings)</td>
<td>Haemodynamic and resuscitation</td>
<td>Haemodynamic and resuscitation</td>
</tr>
<tr>
<td>Difficult intubation or rapid response?</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>Yes/No, resistance visible</td>
<td>Yes/No, resistance visible</td>
<td>Yes/No, resistance visible</td>
</tr>
<tr>
<td>Had chronic disease</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>Yes/No</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>Any allergies</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>Yes/No</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>Nont首家, allergies</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>Yes/No, allergies</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>Risk of blood loss &gt;500ml</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>(Packing in, bleeding)</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>and two P/V control access and blood gained</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>Anticipated critical events</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>1. Any problem encountered intraoperatively</td>
<td>Signs</td>
<td>Signs</td>
</tr>
<tr>
<td>2. Any problems for recovery and management of the patient</td>
<td>Signs</td>
<td>Signs</td>
</tr>
</tbody>
</table>

**Piloted in UCMB hospitals:** Kisubi, Nsambya, Virika, Nkozi, buluba,
PATIENT SAFETY

INCIDENT REPORTING FLOW CHART: CASE OF BULUBA HOSPITAL

ERROR REPORTING AT WARD BY STAFF + SUMMARY BY IN-CHARGE AT DEPARTMENTAL LEVEL

IN-CHARGES HOLD MONTHLY MEETING TO DO ANALYSIS AND DISCUSS

In-charge give a report to the chairperson Q&S and ward Staff

STAFF RECEIVE REPORT FROM THE IN-CHARGE IN ADDITION TO THE DAILY CLINICAL REPORT

CHAIRMAN COMMITTEE RECEIVES REPORTS (ANALYSIS AND DISCUSSION) AND PREPARES REPORT FOR MANAGEMENT

MANAGEMENT RECEIVE REPORTS (FOR ANALYSIS AND DISCUSSION)

QUARTERLY CME / FEED BACK TO/ FOR STAFF
INCIDENT REPORT AND INVESTIGATION:

Total of 15 reporting books (with 100 forms) were given out hospital.

A total number of 128 incident reports / forms were submitted in period covering September 2010 to March 2011, from four hospitals (Buluba had not used the forms at all).

Most of the forms (98% of them) were submitted by the nurses and less by the Physicians.

SAFE SURGERY CHECKLIST USE:

Total of 500 checklists per hospital were left behind for use.

The progress assessment indicated that 3 hospitals Buluba, Kisubi, Nkozi utilized the all checklist and were found useful.

Incompleteness was a major problem during the use of the checklist.
Lessons Learnt:
- Reporting errors / incidents is possible.
- Nurses are more compliant than physicians
- **Workload** - Incompleteness of the forms
- Inadequate staff and attritions affect the institutionalisation and continuity of the quality

But there is need for:
- Continuous Sensitisation
- Formalise inductions process
- Supportive leadership
- Change / strengthen safety culture
- System thinking – non punitive
Quality Measurement

UCMB MEASUREMENT GUIDE 2005

Seven Proxy indicators

1 input indicator (structure input)
5 clinical indicators (process of care)
1 outcome indicator

Indicators

1. Maternal mortality death rate after admission in the hospital and known to be alive
2. Fresh still birth rate
3. Recovery rate on discharge
4. Infection rate in caesarean section
5. Patient satisfaction rate
6. Drug prescription practices
7. Proportional of clinically qualified staff.

MEASUREMENT IS SPEARHEADED ANNUALLY BY THE HOSPITAL MANAGERS AND DIOCESAN HEALTH COORDINATORS (THE DHCs ASSESS THE LOWER LEVEL UNITS QUALITY PERFORMANCE).
Quality Measurement

Median of the total quality score in a network of 28 hospitals

Seven Proxy indicators
Ensuring patient satisfaction through Patient experience’s Survey in Health Facilities (All)

ADDRESSING FIVE ASPECTS

• Clinical Effectiveness and outcomes
• Humanity of care
• Organisation of care (WAITING TIME)
• Environment
• Overall impression
QUALITY ASSURANCE

1. LEADERSHIP – GOVERNING SYSTEM
2. UCMB QUALITY AND SAFETY COMMITTEE 2010
3. ACCREDITATION PROGRAM
4. SURVEY AND TRAINING
5. GUIDING DOCUMENTS
QUALITY ASSURANCE

Strong Leadership – Governing System

Bishop Egidio Nkaijanabo of Kasese Diocese, the Chairperson Chairperson of the Health Commission and his Vice Arch Bishop Paul Bakyenga of Mbarara Arch Diocese during the AGM 2011
QUALITY ASSURANCE

Strong Leadership – Governing System

UCMB QUALITY and SAFETY COMMITTEE 2010

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Ziiwa G. Buuka</td>
<td>MS Buluba Hospital</td>
</tr>
<tr>
<td>Dr. Martin Nsubuga</td>
<td>MS Nsambya Hospital</td>
</tr>
<tr>
<td>Dr. Mutakirwa Joseph</td>
<td>MS Rubaga Hospital</td>
</tr>
<tr>
<td>Sr. Max Nambaziira</td>
<td>Kisubi hospital</td>
</tr>
<tr>
<td>Ms. Margaret Nakiganda</td>
<td>Nkozi</td>
</tr>
<tr>
<td>Dr. Martin Ogwang</td>
<td>Lacor Hospital</td>
</tr>
<tr>
<td>Ms. Dorcus Musubaho</td>
<td>DHC Jinja Diocese</td>
</tr>
<tr>
<td>Amandu Gerald Matua</td>
<td>IHSU</td>
</tr>
<tr>
<td>Dr. Okello Ayen Daniel</td>
<td>Star- E</td>
</tr>
<tr>
<td>Ms Monica Luwedde</td>
<td>UCMB – Q &amp; S Coordinator</td>
</tr>
<tr>
<td>Dr Johan Dekoning</td>
<td>Lead Q &amp; S Consultant</td>
</tr>
<tr>
<td>Dr Sam roach</td>
<td>UCMB – Executive Secretary</td>
</tr>
</tbody>
</table>
Standards during Manager TWS: Hospitals, Lower Level Units, Health Training institution

Compliance of UCMB units with Accreditation Criteria over years

<table>
<thead>
<tr>
<th>Year</th>
<th>LLUs accreditation %</th>
<th>Hospitals accreditation %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>80</td>
<td>92</td>
</tr>
<tr>
<td>2004</td>
<td>91</td>
<td>100</td>
</tr>
<tr>
<td>2005</td>
<td>89</td>
<td>100</td>
</tr>
<tr>
<td>2006</td>
<td>88</td>
<td>100</td>
</tr>
<tr>
<td>2007</td>
<td>89</td>
<td>100</td>
</tr>
<tr>
<td>2008</td>
<td>93</td>
<td>100</td>
</tr>
<tr>
<td>2009</td>
<td>97</td>
<td>100</td>
</tr>
<tr>
<td>2010</td>
<td>83</td>
<td>100</td>
</tr>
<tr>
<td>2011</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>
QUALITY ASSURANCE

SURVEY AND TRAINING

• MHCP SURVEY

DEGREE OF COMPLETENESS MHCP

<table>
<thead>
<tr>
<th></th>
<th>All HC</th>
<th>HC III &amp; HC IV</th>
<th>HC II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median DC 2009</td>
<td>75%</td>
<td>71%</td>
<td>78%</td>
</tr>
<tr>
<td>Median DC 2006</td>
<td>73%</td>
<td>75%</td>
<td>63%</td>
</tr>
<tr>
<td>Median DC 2003</td>
<td>64%</td>
<td>68%</td>
<td>54%</td>
</tr>
</tbody>
</table>

EMOC SURVEY

THE UNITS PERFORMING THE SIX SIGNAL FUNCTIONS OF EMOC AGAINST THE SAMPLE SIZE 2005 - 2011

- Sample size
- All units - Provision of Basic EMOC Services
Trainings:

- Quality and Patient safety training into health management
- Clinical Mentor Training
- Up-coming Module for use in-service and pre-service (quality and patient safety)

Collaboration

- Uganda Martyrs University
- Nsambya Health Training School
- Health Training Institutions
QUALITY ASSURANCE

GUIDING DOCUMENTS

MANUAL FOR QUALITY AND PATIENT SAFETY MANAGEMENT IN HEALTHCARE FACILITIES

UCMB

Uganda Catholic Medical Bureau
P.O. Box 6304, Kampala - Uganda

SOURCE: UCMB QUALITY AND PATIENT SAFETY DEPARTMENT
1st December 2011

UCMB Guidelines for Hospital Care Quality Measurement

NURSING & MIDWIFERY
PROCEDURE MANUAL

November 2005
THANK YOU

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