Mesas Redondas / *Round Tables*

Qualidade de Atenção na Prevenção de incapacidades / Quality patient care in prevention of disabilities

Professor WCS Smith
Department of Public Health,
Medical School, University of Aberdeen, Scotland.

INTRODUCTION

Quality patient care in leprosy elimination should not be considered as an unattainable ideal,as something that we would like to do but cannot. Quality in patient care must take account of the fact that resources are limited, that care must be effective and it must also understand and respond to the needs of patients. Quality in patient care is about being able to demonstrate that we deliver effective care of an agreed standard to a defined group of patients. There are a number of key issues in quality of patient care. Firstly that the care should be effective,delivering care which has not be proven to be effective cannot be regarded as quality care. Secondly there must be an agreed standard in the delivery of care which should be agreed by both patients and professionals. The targets set must be measurable and attainable. The target patients must be defined so that the patient coverage with the agreed standard can be assessed.

Finally we must be able to demonstrate that the agreed standard of care is being met by a process of quality assurance or audit. This assurance needs to be a regular, critical and systematic analysis of quality.

Quality of patient care can be evaluated in terms of the structure, process and outcome of care.The structure of care is about the standards of the raw materials that make up the service such as the physical facilities, the staffing levels, the training of staff, transport and equipment. The process is the programme and the outcome is what is achieved by the programme in terms of patients cured, disabilities prevented or patients

SETTING STANDARDS

Setting standards for quality in patient care is the first step. Standards must be specific, realistic and acceptable to all those involved including patients. Developing the standards *helps* to focus on the problems in patient care as well as reviewing the evidence for the effectiveness of different forms of care. The standards which have been achieved by other centres can act as a stimulus. There are two aspects to the standards, first the **criterion** and secondly the **target ,** for example that patients should receive WHO MDT to treat leprosy is the criterion and 100% coverage is the target. Targets should be realistic and there may be allowable exceptions which make 100% targets inappropriate. Criteria should be clinically relevant, clearly defined and easily measured. Sometimes this may not be easy, such as setting standards for patients education or rehabilitation.

The process of setting criteria and targets is important so that they are agreed by all those involved in patient care including patients, their families and communities. In many programmes standards are set externally, such as the elimination target, and then accepted by individual countries. The degree to which standards are accepted is important to the success of their implementation. Standards can also be set internally within programmes themselves, this can be time consuming but it gives a sense of ownership to the standards set. External standards can be adapted to the local situation to produce a pratical solution.

There have been many guides to setting standards for quality patient care in leprosy over the years. Documents such as 'A Guide to Leprosy Control' (3) and more recently 'A Guide to Eliminating Leprosy as Public Health Problem' (4) are good examples which give some externally set criteria and targets. Many of these standards have been adopted by national and local programmes. However these may not have been formally

presented as setting standards in quality patient care. Clearly it would impossible to deliver quality patient care . Clearly it would impossible to deliver quality patient care without treating patients with the most effective and safe treatment available.

A . STANDARDS IN THE STRUCTURE OF PATIENT CARE

Quality patient care requires a basic minimum of infra-structure which must include apropriate levels of adequately traineed staff. The level can be determined by the size of the population, their distribution and the incidence and prevalence of leprosy patients, but this is something that requires targets to be set locally rather than to be set externally. Similarly a criterion relating to the accessibility of services to patients can be set but how this is achieved is to be determined locally.

Referral hospitals facilities to provide in-patient care to the minority of patients who may require this is important but how many and where is to be locally agreed. The level of this provision should be proportional to the level of facilities available to patients suffering from other problems in the same area. This can be provided in a variety of ways other than through leprosy hospitals.

Leprosy programmes do not have a high requirement for physical structures but accessibility of patients to trained staff is an important criterion, the precise nature of the target should be determined locally.

B. STANDARDS IN THE PROCESS OF PATIENT CARE

Many of the patient care standards set in the leprosy programme relate to the process of care rather than to the structure or outcome. This is similar to most health care quality assessment. In leprosy this can be divided up into the different aspects of the programme as presented below.

1. Detection of new patients

The most important issue in patient detection is that patient are detected early. This can be measured in different ways but we need to have a method which is reliable and easily measurable. The most commonly recommended measure is detection before the onset of WHO grade 2 disability, hence the criterion of the percentage of new patients with grade 2 disability, or more positively the percentage of new patients with no disability. While this criterion is widely accepted the target level is more complex, but perhaps 10% is a reasonable initial target.

Patients estimated but undetected are also an important criterion for quality. A good quality of patient care can not be claimed if a large proportion of patients receive no treatment at all. The target level must be set low, perhaps as low as 5% but this need local discussion as well as external standard setting.

2. Chemotherapy for new patients

There are two criteria for patient treatment, firstly that leprosy patients start MDT and that patients complete MDT within the recommended time period (9 months for PB patients and 36 months for MB patients). These criteria are widely accepted but the target level of performance needs to be further discussed. MDT coverage should be very close to 100% although regions with frequent dapsone allergy may want to set slightly lower targets. The target for MDT completion is more open to discussion 100% may be unrealistic and unnecessry. A minimum of 50% gradually rising to around 80% could be considered.

3. Patient Education

Most people would agree that patient education was essential however what was communicated and how it was communicated is more difficult to determine. The production and distribution of printed patient leaflets is easier to measure but may be less value than counseling. Local discussion is needed to agreed the criteria and targets for patient education and similarly for community education.

4. Management of reactions

Criteria can be set regarding the prompt detection and treatment of reactions, particularly those which involve acute nerve damage. The targets for performance can also be set locally and then performance assessed in terms of the targets. Patients with nerve damage of less than 6 months duration at diagnosis can be used as a criteria for assessing quality and apropriate treatment targets set.

5. Prevention of Disability

The assessment of impairments and disabilities at detection can be used as a criterion for quality of patient care and a high target coverage rate set. Similarly patients with loss of plantar sensation should be advised about protective footwear and local targets set coverage of footwear use. More detailed criteria and targets have been proposed in this field(5).

6. Rehabilitation

Access to rehabilitation services for patients with impairment, disability and handicap forms a general criteria for leprosy programmes. However this is not easily measurable and not all such patients require services. Better defined criteria need to be developed for this aspects of programmes.

C. STANDARDS IN THE OUTCOME OF PATIENT CARE

In general outcome measures are more difficult to measure outcome health care programmes. Case detection as a proxy measure of incidence and transmission can be considered as a criteria but case detection is influenced by operational factors. Relapse rates could be used as a criterion for the effectiveness of MDT chemotherapy and community rates of leprosy related disability have been proposed as an outcome criterion for leprosy programmes (6).

QUALITY ASSURANCE AND THE AUDIT CYCLE

The use of the agreed standards should form a cycle whereby the standards are agreed, performance of current practice is monitored against the agreed standars, and the difference between current practice and the desired level of care identified as a motivation to change. The process should foster discussion, highlight problems and motivate change. The standards, both criteria and targets, may then need to be reviewed, as well as practice changed before repeating the cycle. This paper does not provide the detailed answers to the development of quality in patient care but it does present the approach that should be used to develop quality in patient care.

Agree Standards
(Criteria and Targets)

Remedy Deficiencies/
Review Standards

Measure Current
Performance

Compare Practice
With Standards

QUALITY PATIENT CARE IN PREVENTION OF DISABILITIES

Prevention of disabilities is the primary aim of all leprosy programmes. It is therefore important to apply the issues of quality assurance to the performance of prevention of disability activities. The key elements of prevention of disabilities are early detection and treatment of reactions, and self care of eyes, hands and feet.

(1) Early detection and treatment of leprosy

The criterion can be set by assessment of impairments and disabilities at detection. The standards set would be based on the proportion of new cases detected who had disability at detection. The percentage should be set low at levels of 5-10%. If this level cannot be achieved then aspects of early detection need to be remedied, this may be to increase community awareness of the diagnosis in health care staff.

(2) Early detection and treatment of reactions

The criterion set here should be based on nerve function impairment assessed by both sensory testing and motor testing. These tests should be done at detection and monthly during MDT. Standards set could be that there should be no new nerve function impairment during MDT, this can be monitored by reviewing the nerve function at release from treatment compared with that at diagnosis. Deficiencies identified during the assessment process need to be remedied. Problems may be due to lack of patient awareness of the possibility of reactions and what to do when they occur. The training of staff in the diagnosis of reactions and nerve function impairment may need to be reviewed and the availability of steroids in leprosy programmes where MDT is being used.

(3) Self care of eyes, hands and feet.

Criterion here are based on the development of secondary disabilities such as plantar and palmar cracks and ulcers or loss of bony tissue. Standards here can be the level of new secondary disability. It is possible to improve on these and standards based on the reduction of cracks and ulcers should be set. Failure to achieve the reductions should lead to a review of the training of staff and patients, the practice of self care and the use of aids such as cushioned footwear.

(4) The process of Prevention of disabilities

There are simple steps in the process of implementing prevention of disabilities in leprosy programmes. These can be set as criteria and standards adopted such as every programme have written, local guidelines for prevention of disability activities including nurses, doctors, basic health workers and not just physiotherapist and occupational therapists, and the provision of supervision for the prevention of disability activities.

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