Quality process, content and outcome is the

Quality of care measurement generally involves two basic concepts: (i) the quality of the general care, relating to care services incorporating organisational and the men- materials-money-machines inputs, and (ii) the other relating to cure service or the quality of the art-of-care that is, clinical audit.

1. A review of the process, content and outcome:

There are a number of strategies for assessing the quality of medical care.

Quality assessment methods differ, for example, in time frame for review (prospective, concurrent and retrospective), in data-gathering methods (record review, abstract, observation, and interview), and in the categories of criteria (structure, process and out-come). Quality of care assessment through the study of structure has been dealt with in a previous chapter (Chapter 23). Quality of the art-of-care through the process, content and outcome is the subject of this chapter. The term ‘ quality assurance’ is of recent origin which has replaced the term “ medical audit” which basically depended upon the study of medical records in retrospect. When the concept of medical audit originated, it was thought that a review of medical records was expected to answer the following questions. 1.

What did the patient have? 2. What was done for him? 3. Was something that was required to be done, not done? If not, why not? 4. Was the treatment optimum? If not, why not? 5. Was the outcome satisfactory? If not, why not? Analysis of the above questions provides the means for judging whether whatever done for the patient was done to justify diagnosis, treatment and end-results, and whether it was done in the best interest of

the patient. The process has also been envisioned as a self-motivated continuing education process for the physicians, and the findings of the quality assurance audit as springboards for remedial action. Quality is defined as adherence to standards and criteria that are based on current knowledge and sound experience.

Quality assurance is a planned programme which objectively monitors and evaluates the clinical performance of all practitioners, identifies opportunities for improvement, and provides a mechanism through which action is taken to make and sustain those improvements. The concept of medical audit originated in the USA. The Joint Commission on Accreditation of Hospitals-JCAH (a joint body formed by American College of Surgeons, American Medical Association, American College of Physicians and American Hospital Association) enforced the Process measures are simply those measures that evaluate what a provider does to and for a patient. They mean how well a patient is moved through the medical care system, in a “ micro” sense (e. g.

from arrival to departure at an emergency room or outpatient clinic). Outcomes reflect what happened to the patient in terms of palliation, cure, rehabilitation or death condition for accreditation that each of the hospitals should have an ongoing medical audit for assuring a satisfactory level of medical care. For those errant hospitals which did not care for accreditation by the JCAH, enforcement of similar precondition by the US federal government for reimbursement of the Medicare, Medicaid, Blue Cross and Blue Shield programmes has brought most hospitals under the ambit of medical audit.

USA and Canada are perhaps the only two countries and a few in Europe where the regulation of standards of medical care is carried out voluntarily by a system of accreditation of hospitals. In India, the importance of medical audit for quality assurance is gradually being grasped by some hospitals, most of which are teaching hospitals. Medical audit conducted as a pioneering experiments in 1978 at the All India Institute of Medical Sciences and Safdarjung Hospital not only brought out many shortcomings to the fore, but the presentation of the findings to the physicians and surgeons was a revelation to them whileas one study was only retrospective to highlight problems and shortcomings, the other one which was carried out prospectively proved to be of great value as accepted by the hospital's community of physicians themselves in answering questions posed in the beginning of this section.

2.

Theory and Practice:

The theory and practice of health care provision are often not the same. While in theory we should be able to take it for granted that sick will always receive the best possible treatment and care, in practice we know that we cannot. Thus, the provision of health care is paved with good intentions, but even the best hospital can fall below standards for a variety of reasons, ranging from accident, mistake and poor communication to lack of resources, mismanagement and malpractice.

Hence, the need for quality assurance procedures which ensure that every hospital has an arrangement for the regular checking and assessment of its

standard Take for instance the care of patients with serious infections who require the newer, more potent antibiotics, some of which require monitoring of drug levels to avoid harmful effects such as kidney failure. Physicians may argue strongly for purchase of the newer drugs as well as setting up tests for drug levels in the laboratory, both of which may increase costs. Yet in the very same hospitals, one can often find a number of patients on expensive drugs that were not strictly necessary or on more frequent dosing schedules than were required. Usually both the above types of quality problems can be found in many hospitals.

3. Purpose of Quality Assurance:

The purpose of the quality assurance programme is to: i. Help patients and potential patients by improving quality of care, ii.

Assess competence of medical staff, serve as an impetus to keep up-to-date and prevent future mistakes, and iii. Bring to notice of hospital administration the deficiencies and in correcting the causative factors. The process can also help to exercise a regulatory function, restricting undesirable procedures. This cannot but help the medical staff to improve upon their clinical and professional judgement. By timely verification, it cannot but help provide assurance for future actions so that better methods could be used.

4. Quality Assurance and Costs:

It is important to note that physicians will often be most conscious of those instances where resources were too limited to meet patient’s needs.

Thus, they will argue strongly for more resources to provide better quality of care, but the costs will be higher. Administrators, on the other hand, may have pressures on them to keep costs from rising, and they will eliminate either harmful or inefficient care before considering increasing the costs to improve quality through new services, new methods and new equipment. Quality assurance programmes to be successful will need to meet both sets of needs.

Institutions which are sensitive to these two sides of the cost/quality dilemma will most likely be able to achieve some of each of the desired goals.