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Experiences of a healthcare quality and safety expert in the largest military hospital in Ghana

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Quality of care is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (IOM, 2001). The Institutional Care Division of Ghana Health Service (2013) has adopted two definitions for quality healthcare which includes: "the degree to which health care interventions are in accordance with standards, safe, efficient, affordable, meet the expectations of clients and the community, and impact positively on morbidity, disability and mortality" and "is the extent to which health services provided to individuals and patient populations improve desired health outcomes. The care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision making".

The 37 Military Hospital is the largest military hospital in Ghana described as a specialist hospital located in Accra, Ghana. The hospital was originally founded in 1941 as a military hospital by a British Military Officer, General George Giffard to provide treatment for troops who were injured during the Second World War. The hospital has been expanded over the years and opened to the general civilian population. The hospital has become one of the major facilities especially in Greater Accra that has come to the rescue of the hospital-going population during strike actions by health workers especially doctors. It has also served as a major facility of respite for some major national disasters notably in recent times, the twin disaster that hit Accra on June 3, 2015 killing over 150 people. The Hospital has one of the magnificent infrastructures and is no wonder the first point of call for the bourgeoisies in Ghana.

This write-up provides an account of my experiences as a patient relative to the Medical Emergency Unit (MEU), Pharmacy, 37 Chemist, Laboratory & the X-ray Departments of the Hospital. It also includes some of the experiences my mum shared with me.

THE MEDICAL EMERGENCY UNIT (MEU)

I rushed to the 37 Military Hospital facility for the very first time with my mum who was suffering from chronic pain as a result of a six (6)-year history of Hepatocellular Carcinoma (HCC) expectant of nothing less than quality healthcare as defined by the Institute of Medicine (IOM) and our own Institutional Care Division (ICD) of the Ghana Health Service (GHS). I had been assured of the availability of a bed by a friend of mine who incidentally was a staff when the Korle Bu Teaching Hospital (KBTH) told me of the lack of bed space when I inquired via a phone call.

At 16:00 GMT, we were seated at the medical emergency unit with my mum and other relations but was unattended to until about 75 minutes after when I was able to get the folder done. It was only then that her vitals were checked (remember this is a medical emergency of chronic pain)! The Hospital has a

centralized medical records unit and a bank which was about a total distance of 140 meters from the MEU. The medical records system is largely paper-based (i.e. manual system) though some basic inputs of client's demographics are made into computers.

I got my mum "clacked" by a House officer who was visibly tired 45 minutes after getting a folder and $2^{1}/^{2}$ hours after getting into the Medical Emergency Unit of the Hospital. Obviously, after waiting for that period and observing the pain on my mums face, I had to call another relation of mine who happened to be a staff of the Hospital. So we sat waiting patiently as we had done for the past two and half hours until I heard a gentleman ask, "who is Dora Asare?', then I realized that, the last minute call had yielded some results. The gentleman apologized for the "delay" and requested us to hold on for some few more minutes as the House officer wraps up her clacking of the patient she was attending to. This was also after combing the entire Medical Emergency Unit futilely in search of a wheel chair to move my mum to the desk of the House officer.

As my mum was being clacked by the House officer, I witnessed a male patient fell off his bed. Instead of the health workers running quickly to pick this man up from the floor, one of the female nurses remarked, "you are lucky there are men around but if it were us (females) alone, you will lie on the floor forever." Another patient called for help and was snubbed by the staff irrespective of how incessant the relatives pleaded. Three (3) referrals were also turned away with the excuse of no bed space.

GOT A BED FINALLY

Finally, my mum was laid in a bed at about 10:00 PM after an intervention by a friend who was on night duty. Until then, she had been sitting in a wheel chair (we got through a favor from one of the members of staff). She however received her first IV Diclofenac medication at about 9:30 PM to soothe the pain she came in with at about 16:00 GMT ($5^{1/2}$ clear hours of arrival).

At about 22:50 GMT my mum complained of discomfort with the bed. She also requested for a chair to sit under the ceiling fan (since its effect was not felt). The ward nurses declined the provision of a chair and cheekily asked us to go buy a standing fan for my mum at 11:30 PM if she still needed one. I asked the nurse which store she expected me to go and buy a standing fan from at 23:30 GMT even if I had the means! Not able to bear the visible pain expressed facially by my mum, I moved out of the premises of the hospital in search of a standing fan at 23:30 GMT! Fortunately, I got one at the 37 station from one of the sellers who was fast asleep behind her wares. I also had to buy two sets of pillows since there was none on the bed that my mum was allocated and an extension board to plug the standing fan! The standing fan was connected for my mum.

At this point, the nurses asked us (myself and other family members) to leave the ward because it was past the visiting hours. They assured us my mum will be taken care of. We therefore gave the nurses the benefit of the doubt and bid my mum a good night and a sound sleep at 12:30 AM.

Pharmacy, 37 Chemists, Laboratory & X-ray

The House officer made some lab requests, X-rays & prescriptions. It took me close to 25 minutes to locate the 37 Chemist which had moved to a new location but the directional signage had not changed hence clients were still directed to the old location. We spent averagely 30 minutes in the department waiting for a chest X-ray to be done.

I got one of my students to facilitate the process in the laboratory. I got my FBC done in less than 20 minutes (about 20:25 GMT) but declined doing the chemistries (i.e. LFTs and BUE & Cr) because the results were going to be ready the next morning. I also had to do about 150m distance back and forth to make payments at a centralized bank. On the next day, I had come for a sample container for a DDimer test only to be told there was no sample container because the test could not be done in their facility. I was directed to a private facility which was located about 6 km (by car)! The options available to me were: (1) carry my mum in a taxi or an ambulance to this private facility for the DDimer test to be done or (2) go to the private facility for the sample container to the nurses on the ward to take the sample and

then send the sample back to the private facility for the analysis. I will then have to go back at a later time for the results. Such inconvenience and waste of precious time! The DDimer test was never done because I could not figure out how an inpatient sample could be taken.

DAY 2 AT MEU (31/12/2015)

I drove to the MEU of the 37 Military Hospital in high hopes to visit my mum on New Year's Eve. I was highly expectant especially when I had received the most important assurance I needed the previous night. I got to my mums' bedside at about 06:15GMT when she recounted how she could never sleep the entire night because of the unbearable pain! According to her, she sat in a chair (the nurses were generous to lend her the previous night) throughout the night because she could not bear the pain. No medication was administered to soothe the pain during the night though 75mg diclofenac tablet was available in her drug bag!

None of her medications (IV Lasix 20mg bd; Tab Lisinopril 5mg dly; Tab Carvedilol 6.25mg dly and Tab Spirnolactone 25mg dly!) were served by the nurses on Day 2 when she needed them most.

I had to carry a bucket of water from another ward which was about 450m away for her to take her bath in an unkempt washroom in the morning because there was no water in the MEU.

I brought a plastic chair from the house for my mum (because the nurses had denied her one the previous night when I was leaving her bedside) but was not allowed to be carried into the ward. I also bought my mum a brand new wheel chair (to prevent us from begging and roaming the entire MEU in search of one).

I met the Consultant who was reviewing the ward cases with the House officers and other care team. I gave him further information on my mum's condition and a decision was also taken for her discharge home!

Discharge Home

I made the necessary payments (located about a 150 m away from the MEU as usual). I could not make a photocopy of the receipt as requested because the personnel responsible for photocopying had closed at about 14:45 GMT when the payment was made! She was discharged on 75mg diclofenac tablets because the pain was described by the doctors as "inflammatory pain". I pleaded with some of the House officers to give her IV Diclofenac before we go home because of the persistent pain! The medicine (IV Diclofenac) was however administered by a first year student nurse under no supervision from any senior colleague!

At this point, one of the nurses confided in me saying; "young man, do you know something, your mum is not likely to make it so we don't want you to keep spending on medicines and investigations." A totally ignorant healthcare worker decided to play God! What was even annoying was that, the advice was coming from a visibly empty head with palpable gap in knowledge in the area of Chronic Pain Management! There was also a blatant display of ignorance in knowledge and skills in the communication of bad news to client relations! This is when I discovered the reason behind the negative attitude by the healthcare team towards my mum! Fortunately, my mum is still alive after her discharge at 14:45 GMT on 31/12/15. Even though death is inevitable, I believe our duties as healthcare workers is to ensure that clients who are in our care are given the best of care so they can go to their Maker in peace other than in pain!

I felt very sad for our health system especially for the blatant display of ignorance by a nurse in a Medical Emergency Unit (in the largest and most revered military medical institution in Ghana). I requested for a possible referral to the palliative care team but that request seemed to have fallen on deaf ears because my audiences were visibly clueless on the subject of palliative care and what care management options were available to such clients other than a premature condemnation to death!

The washrooms of MEU

The MEU had washrooms that were shared by males and females. At the washroom (though nicely tiled), there was no water for clients to wash their hands or even take a bath. The environment was very unkempt to say the least and defied every basic concept of infection prevention and control in any health facility! I had to get my mum a sanitizer to avert her acquiring any hospital acquired infection (HAI) to worsen her condition!

OPPORTUNITIES FOR IMPROVEMENTS

The care received from the narrative was short of:

1. Timeliness: time to first drug administration (of IV diclofenac) was approximately 6hours upon arrival at the MEU. There were visible delays in the entire patient journey and at all the service points that were visited. The presence of students (i.e. House officers and nurses) also affected the timely delivery of service in the ER. I ask myself why any facility worth the stature of 37 Military Hospital will pack its Medical Emergency Unit with students! Patients are used as experiments only for Consultants to come in the next day to do damage control.
2. Patient-centeredness: Most of the nurses on the MEU and the personnel in the Pharmacy (upstairs) were very uncouth to clients and their relations. They spoke to patients as if they were doing them a favor! One of the nurses had the gut to tell me "I can decide not to take care of your mum." A blatant mockery of Florence Nightingale & Hippocrates and all that these noble individuals stood for! This was also evident in the remarks passed when the patient fell off his bed. Elsewhere, a thorough root cause analysis would have been undertaken to identify the causes of the fall and institute measures to avert future occurrence. There was not a single occasion that I heard any of the relatives make any positive remark about the healthcare team! The centralization of the payment system and the medical records also created needless delays and patient's relatives also had to cover many kilometers in distance to access those services! The care received and experienced were miles away from the definition of patient-centeredness as posited by Dr. Berwick!
3. Patient Safety: this was obviously non-existent looking at how unkempt the washrooms of the MEU were. There were no sanitizers even on the desks of the care providers. There was no water or soap for hand washing. To ask for tissue paper was demanding the unthinkable! Less than 10% of the total beds had side rails evidenced in the patient fall. More than half of the beds were also either too high, not adjustable or rusty! Little talk about the sinks on the ward the better! There was no trace of the practice of waste segregation except with sharps.
4. Effectiveness: the MEU fell short in the dimension of effectiveness. This is defined as the extent to which care outcomes are attained. The fact that my mum was discharged with the same pain she came with implies this dimension was also not attained. The nurses displayed a deep ignorance and a lack in knowledge in chronic pain management and the communication of bad news to relations. Unfortunately, it did not look like they were teachable in this crucial aspect of their practice!
5. Equity: there was zero fairness and justice on display. In all the instances that I had timely service, it had had to be facilitated by either a friend, one of my students or somebody I knew! There was no instance that my mum received urgent care on the basis of her medical condition. We therefore have a health facility whose service provision is guided by "who you know" other than your "medical condition." The principle of equity was on sale to the highest bidder even in a military environment!

The care received was only good in the dimension of efficiency! The institution was largely interested in raking-in revenue other than the other dimensions of quality care. This was evident in the systems introduced to address revenue leakage such as the automation and centralization of the revenue

collection in the Hospital. How could relatives travel distances to make payments and make folders?

The care received also fell short of all the dimensions of service quality (reliability, appropriateness, timeliness, empathy and responsiveness) posited by Parasuraman! There was nothing responsive and empathetic about the care experienced!

RECOMMENDATIONS

The Management of the 37 Military should undertake an urgent quality and safety assessment to identify the various opportunities for improvement.

The Ministry of Health (MOH) and other health regulatory bodies in the country should strengthen their oversight responsibility to ensure that, patients are not handed raw-deals in their quest to seek healthcare.

The MOH should consider establishing a Healthcare Quality Commission as is done in the National Health Service (NHS) of England and other countries which ensures that, clients receive nothing short of quality and safe care. The UK health system took important lessons from the Mid Staffordshire Trust inquiry which culminated into the classic publication of "To Err is Human" & "Crossing the quality chasm"

The MOH and its agencies should also lead in the development of quality of care indicators. The National Health Insurance Authority can champion this and use it as an incentive for payment. In the US, no payer (i.e. Medicare & Medicaid) will ever pay a hospital that records a patient fall from the bed as happened in the 37 Military Hospital.

The MOH should institute a fiat that abhors staffing emergency rooms with students of all categories especially in institutions such as the 37 Military Hospital. This sanction is long overdue! You will only get to understand when you become a victim! It is very unfair to the patient and even the student (who is most often left alone with zero physical presence and guidance). Elsewhere, first year Residents are not even allowed to make prescriptions without the physical presence and supervision of their Consultant, why should our case be different!

The Educational, Health training institutions and health facilities should consider including Emotional Intelligence (EI) as an admission & employment criterion other than only Intelligent Quotient (IQ). Goleman and others have proven via countless studies that, we are better off with personnel with high EI than IQ. What will be the essence in admitting/employing personnel who have above average IQ but are less empathetic and deficient in all the EI competencies identified by Goleman?

To clients & relatives, ensure you demand nothing short of quality as defined by the IOM and the ICD/GHS. It is your right! Ensure that, you are very vigilant and guided by the dimensions identified in the earlier paragraphs. You should also be guided by the dimensions identified by Maxwell (n.d) such as acceptability, affordability, accessibility etc.

To colleague health professionals, let us provide care that is humane and patient centered. Let us move away from the supply-driven healthcare that we have been used to. Let us move away from the volumes and profitability of services to patient outcomes. Let us be intrinsically motivated other than extrinsic. We are better off quitting and pursuing other goals if we consider the incentives to be inadequate than masquerading as murderers and heartless personnel in institutions that is expected to champion the safety of the vulnerable persons entrusted in our care!

You should also as a patient or relative always remember to carry along your wheelchair; standing fan; an extension board; your first aid box; some rapid diagnostic test kits and equipments; bed sheet and pillow; buckets; a polytank filled with water (depending on your condition and length of stay); tissue paper; hand sanitizers and if possible a hospital bed! Also ensure that, you have friends who are very well connected and accessible (either physically or through phone) else your average waiting time maybe 24 hours! These are very necessary especially when your destination is the Medical Emergency Unit (MEU) of the 37 Military Hospital!

CONCLUSION

The care my mum received from the 37 Military Hospital was significantly (though I have not computed any p-value) short of the definitions of quality healthcare posited by the Institute of Medicine (IOM) and the Institutional Care Division (ICD) of the Ghana Health Service (GHS)! Little said about the attitudes of the care team especially the gentleman in the Pharmacy Unit the better.

There was visibly and obvious lack of knowledge in chronic pain management and the communication of bad news by the healthcare team at the time which requires urgent redress!

The MEU was also miles behind in terms of patient safety issues especially infection prevention and control practices.

The quality of nursing care was visibly millions of light years behind what was demonstrated by Florence Nightingale!

It is time for the health delivery system to change by putting the patient first at all times. There is an urgent need for a holistic system transformation that consistently meets and exceeds the expectations of its clients and caregivers!

My experiences can best be described as barbaric, murderous and an irony of quality and safe care in the largest military hospital in Ghana!