

## Diverse roads headed in the same direction? – health care facility accreditation

Hospital managers and their provincial bosses are rarely held accountable when it comes to avoidable deaths and unacceptable health outcomes, mainly because of the national tangle of safety guidelines and policies and the absence of a uniform, credible means of probing health care delivery problems.

Dr Carol Marshall's Office of Healthcare Standards Compliance (OHSC) is introducing compulsory national core standards without which private and public health establishments cannot be accredited or access the massive National Health Insurance kitty next year. A statutory body to hold public sector hospitals accountable to minimum standards and for their outcomes is way overdue. Yet the OHSC's track record in working with the established local health care standards accreditation NGO, the Council for Health Standards Accreditation of Southern Africa (COHSASA), rings warning bells. COHSASA's tally of satisfied local and regional public hospital customers mounts by the month as adverse events plummet. Chris Bateman<sup>1,2</sup> reports on their progress and questions the OHSC's wisdom in taking the road less travelled, and whether it really will make all the difference.

## Stroke diagnosis and management in sub-Saharan Africa (SSA)

A study from Tanzania<sup>3</sup> confirms that no reliable clinical method of distinguishing ischaemic from haemorrhagic stroke exists. For the stroke patient a computed tomography (CT) scan of the brain is the equivalent of an ECG in the patient with chest pain, but is frequently unavailable in SSA.

De Villiers *et al.* show that even in an urban community hospital in Cape Town,<sup>4</sup> a CT scan may not be uniformly available. However, they demonstrate the power of a small 6-bed unit dedicated to the multidisciplinary acute care of the stroke patient, immediately after the incident. Mortality can be halved and disability in survivors reduced. Outcome in the stroke patient in poor socio-economic circumstances is dismal for those who cannot swallow, and requires continuation of nasogastric feeding after discharge.

## HIV/AIDS

South Africa experienced a measles outbreak beginning in 2009, which peaked in early 2010. Spread of the highly contagious infection was fuelled by overcrowding and poor vaccine coverage of the population. The prevailing HIV epidemic promoted the rare complication of subacute measles encephalitis (SME),<sup>5</sup> and 8 'silent casualties' in the evanescent phase of this outbreak are reported. SME, the diagnosis of which is difficult to make, proved almost uniformly fatal. Measles immunisation of the entire population, including those who are HIV infected, is key to preventing future outbreaks and protecting those living with HIV/AIDS.

GPs and specialists prescribing antiretrovirals (ARVs) to their HIV-positive patients are warned<sup>6</sup> that drug-drug toxic interactions are common, because all ARVs are metabolised through the same hepatic enzyme system. Such drug-drug interactions frequently go unrecognised and arise chiefly from errors in selecting daily doses. Advice is offered regarding appropriate paediatric and adult dosing to achieve efficacy and tolerability.

A survey among newly diagnosed, ARV-naïve HIV-infected individuals in Limpopo province<sup>7</sup> shows a reassuringly low prevalence of drug-resistant HI virus mutations, as reported elsewhere in South Africa and in Zambia and Malawi. This contrasts with higher rates in chronically infected but ARV-naïve patients in developed countries, perhaps reflecting earlier exposure of the virus to single-drug therapy before the advent of potent multidrug regimens.

## Anaesthetic mishaps

National strategies necessary to prevent largely preventable drug administration errors in anaesthetic practice are cited in the editorial<sup>8</sup> accompanying a survey of anaesthetic practitioners in 22 Free State public sector hospitals,<sup>9</sup> which elicited 329 reported errors occurring in the course of some 30 000 anaesthetics. This approximately 1% error rate (which mirrors overseas experience) appears modest, but might have been considerably higher had all incidents been reported. Common errors involved syringe swaps (because the established South African standard for colour coding syringe labels in theatre is not uniformly available in state hospitals), misidentification of drugs with similar names and ampoules that look alike, and doctor fatigue. The majority of the doctors involved were medical officers, community service officers and registrars.

## Infection alerts

Antibiotic susceptibility of *Escherichia coli* has changed in parallel with an increase in organisms expressing beta-lactamase. Practitioners<sup>10</sup> treating uncomplicated urinary tract infections are advised to re-consider an old drug, the urinary antiseptic nitrofurantoin, to which *E. coli* remains 100% sensitive, as their empiric choice and to cease prescribing trimethoprim-sulphamethoxazole and ampicillin, to which there is now a high level of bacterial resistance. Overuse of the quinolones (ciprofloxacin being the practitioners' favourite) should be avoided, as they must be reserved for second-line antituberculosis therapy.

A shock finding from rural Tugela Ferry in KZN<sup>11</sup> is that patients with HIV-TB co-infection have a 20% methicillin-resistant *Staphylococcus aureus* (MRSA) nasal carriage rate on admission to the Church of Scotland Hospital; a further 10% of negative carriers at admission become positive on repeat testing, suggesting nosocomial acquisition. Fortunately, most isolates remain sensitive to vancomycin, clindamycin and fusidic acid. Those living with HIV/AIDS potentially constitute a 'pool' of diverse infection and may represent a source of increasingly resistant organisms, as they tend to receive repeated courses of antibiotics as a variety of infections complicate their course.

## Dhai *et al.* challenged

Anthony and colleagues<sup>12</sup> challenge the suggestion by Dhai *et al.*<sup>13</sup> that there are strong ethical and legal imperatives for a practitioner to obtain authorisation for modern 'medicalised' vaginal delivery. Unchallenged, these views carry serious implications for overburdened public sector facilities.

## JS

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