NEWS

Task Shifting: an Answer to the Dire Shortage of Healthcare Professionals?

By Anne Hahn, health writer

An expert panel at the XIX FIGO (International Federation of Gynaecology and Obstetrics) Congress held in Cape Town, discussed task shifting and sharing as a response to the world's human health resource shortage, and called on governments to review the structure of their healthcare systems.

FIGO president, Dr Dorothy Shaw, explained the concept, calling it a rational redistribution of tasks among health workforce teams. Procedures usually done by one professional or technical group are transferred to, or shared with another health professional group that would not normally provide the service. In terms of pregnancy and childbirth, this has life-saving implications with the involvement of mid-level healthcare providers - non-physician clinicians (NPCs) like nurses, midwives, nurse auxiliaries - and even community health workers.

Implementation of task shifting involves various factors: assessing the needs of the specific population, assessing the number of professionals, clearly defining roles and competencies, and determining what training and evaluation would be required as well as feasible to ensure a sustainable healthcare system. Dr Shaw mentioned that to find a sustainable solution, it is best to start with things that are easy to do that will have a significant effect. A resolution of the congress was to allow nurses to administer drugs for postpartum bleeding - some countries still require a doctor to authorise this and women die waiting for a doctor. Maternal mortality statistics are of grave concern (535 900 maternal deaths per year worldwide). This simple intervention could prevent many deaths, Dr Shaw noted.

In low-resource settings, training NPCs to do caesarean sections can considerably reduce maternal mortality, as has already been shown in Malawi and Mozambique. NPCs receive three years of training to perform emergency surgery, and studies have shown that there is no difference in outcome between their surgery and that of 'surgeons'.

Training nurses for emergencies

Dr Pius Okong of Uganda, gave an example of how nurses at primary healthcare level can be trained in the management of emergencies. The nurse can make a diagnosis and give medication as part of 'first aid', e.g. give an antibiotic or anticonvulsant, and then refer the patient. Transportation of a patient with infection or having fits would then carry less risk. He pointed out the disadvantage of adding too much to healthcare workers who already have defined roles - they would need more support for what they were doing before. Task shifting needs to be conceived by looking into the whole system of health care to avoid a situation where people are just 'putting out fires'.

Dr Shireen Bhutta of Pakistan, pointed out that in low-resource countries task sharing is often already happening as a matter of necessity. In Pakistan her concern is that it needs regulation to prevent complications and mishaps. A 10-year report on community workers showed that the simple intervention of sending workers into the community to speak to women and girls has been effective in preventing pregnancy-related emergencies. Because the workers are in regular contact with pregnant women, providing them with supplements and giving advice, they can refer difficult cases before an emargency situation arises. She also mentioned that the profile of midwifery needs to be raised to attract the right kind of people.

Dr Shaw concluded, "Getting professional groups to train and share knowledge as well as technical expertise with other health professions is a realistic approach that would go a long way to saving lives by making personnel with needed skills more available to women. We need the right people with the right skills in the right place at the right time, to make progress towards universal access to reproductive health."

Best Care...Always Campaign Targets Ventilator-associated Pneumonia

In an effort to improve the quality of care in SA's public and private hospitals, the Best Care…Always campaign - a collaborative project initiated by private hospitals, funders and clinical leadership organisations - is promoting a collection of treatment protocols aimed at reducing preventable complications, such as ventilator-associated pneumonia (VAP), in hospital patients.

Best Care…Always task team member, Dr Gary Kantor

"VAP is the leading cause of death among patients who acquire healthcare-associated infections. It is one of the most common infections acquired by adults and children in intensive care units (ICUs), with between 10% and 20% of patients who have been mechanically ventilated developing this condition," said Best Care…Always task team member and spokesperson, Dr Gary Kantor. "A few simple interventions can lead to significantly reduced rates of VAP."

Best Care…Always has been designed to support the efforts of hospitals to reduce patient morbidity and mortality caused by hospital-acquired infections, by sharing best practices around the measurement and implementation of relatively simple quality improvement practices.

The mortality of ventilated patients who develop VAP is as high as 50%. VAP also results in patients having to undergo mechanical ventilation for extended periods, and leads to longer and far more costly ICU and overall hospital stays.

Some early-adopter hospitals enrolled in the Best Care…Always initiative began implementing the VAP 'bundle' before the August launch of the campaign. A bundle is a small set of practices that have been individually proven to improve patient outcomes and, when implemented together, are expected to result in a better outcome than when implemented individually. Bundles should be delivered by a healthcare team at one point in time to every patient meeting the bundle criteria.

Outcomes improved

The VAP bundle has been shown to effectively reduce VAP rates and improve associated outcomes. Over time, the rate of VAP in hospitals that successfully implement these practices can fall to almost zero, with months elapsing between VAP events in some high-performing ICUs.

"One hospital group found that VAP accounted for between 20% and 25% of its total hospital-acquired infections," said Dr Dena van den Bergh, chairperson of the Best Care... Always task team and HASA's quality committee. "After implementing the VAP bundle, recent results show a drop of over 30% from the highest rate over the period of a year."

She said one key element in preventing VAP is elevating the head of the patient's bed between 30% and 45%. "This simple intervention has been reported to reduce VAP by up to 70%."

Other interventions include performing daily oral hygiene on the patient with an antiseptic solution. The VAP bundle also includes taking steps to reduce the risk of deep vein thrombosis (DVT), as well as peptic ulcer prophylaxis.

"These practices are part of standard care for critically ill patients but are not always consistently implemented. In their unintended absence, patients experience preventable complications that can be devastating," said Kantor.

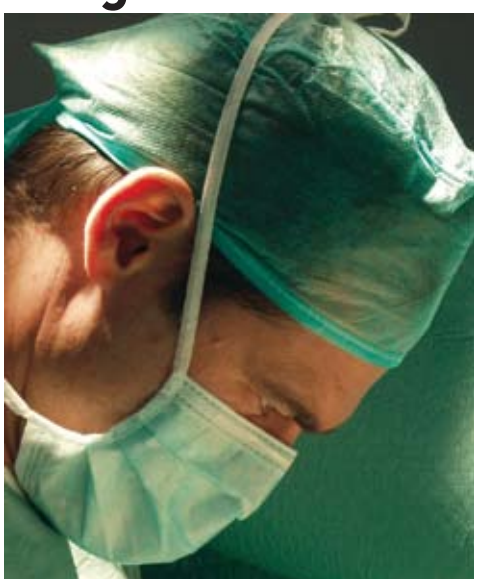
The final bundle element is providing a daily 'sedation vacation' during which a trial of spontaneous breathing can be attempted.

"One of the best ways of preventing VAP is to reduce the length of time a patient is on the ventilator in the first place," Kantor said. This 'awaken and breathe' part of the ventilator bundle enables the ICU team to assess on a daily basis the patient's need for mechanical ventilation.

So far, 131 hospitals have signed up for the VAP bundle with Best Care…Always. By enrolling, these facilities have agreed to implement the bundle at an accelerated rate and develop measuring capabilities to assess the impact of the changes being made. "We are pleased to now have endorsement from the national Department of Health and three provincial health authorities are becoming actively involved in plans to implement the VAP (and other) bundles in public sector hospitals," said Kantor.

Parties interested in becoming part of the initiative should call Dr Dena van den Bergh on 082-451-2284 or Dr Gary Kantor on 076-120-7560 or send an email to info@bestcare.org.za

Scientists Retract Findings on Surgical Masks



In a surprise move, Australian scientists have retracted the controversial findings of a study that found N95 respirators to be better than surgical masks in protecting health workers against respiratory diseases such as flu, including the rampant H1N1 swine flu virus.

After a re-analysis prompted by questions from reviewers, the findings were no longer significant, Prof Holly Seale, of the University of New South Wales in Sydney told *Medpage Today*.

The original study, presented at the Interscience Conference on Antimicrobial Agents and Chemotherapy in San Francisco in September this year formed the basis of several important new policy decisions, including guidance from the US Center for Disease Control (CDC) on the use of masks in a healthcare setting.

The retraction made at the end of a presentation at the annual meeting of the Infectious Diseases Society of America in Pennsylvania astonished delegates involved in flu prevention, one expert told *Medpage Today*.

The study's original findings elicited huge debate among flu prevention experts around the world, particularly after a study published in *JAMA* two weeks later found that surgical masks worked just as well as N95 respirators.

"The findings appeared to differ - not only from previous reports - but also from the abstract submitted to this meeting," said Dr Andrew Pavia of the University of Utah.

Prof Seale acknowledged those differences and agreed that the original results no longer stand.

When initially presented, the study conducted among health workers in Beijing, influenced a recommendation by the Institute of Medicine that healthcare workers caring for flu patients should use the more expensive N95 respirators.

"We now have public policy that's based on faulty science," said Dr Neil Fishman of the University of Pennsylvania.

The policy has practical implications, he said. The N95 respirators are more costly than simple surgical masks and are in shorter supply. According to Dr Fishman, the study results did not accord with other findings or with clinical experience. It was a cluster randomised trial in which the unit of analysis was the hospital. However, the control group in nine hospitals in which the study was conducted was not selected randomly, Dr Fishman said.

When the data were re-analysed excluding those hospitals, the differences between N95 respirators and surgical masks were no longer significant, Prof Seale reported.