AAGBI Report

In May 2015, my 4 week elective took me to Manguzi Hospital, a rural district hospital in KwaZulu-Natal (KZN), South Africa. Situated on the most north-eastern coast of South Africa, Manguzi's landscape, people and atmosphere couldn't have been further from the hustle and bustle of Durban only a few hours drive away. The hospital is nestled in an area full of sandy dirt tracks, lakes, national wildlife reserves, and of course the beautiful coast.

The hospital is one of KZN's best rural hospitals[i], with 280 beds, 6 wards, 3 theatres and emergency and outpatients departments (OPD). Its 3 mobile clinics, and 11 community clinics ensures that the >100,000 population are not far from healthcare.[ii] Saying that, patients would still often walk for miles to seek medical expertise.

Experience

My time at Manguzi Hospital was divided between theatre, wards and OPD.

Whilst on the wards and in OPD, what struck me was the huge prevalence of HIV. I understood the national average to be 18%, however my experience of the patients saw the local figure more like 50%.[iii] With the huge proportion of patients on anti-retroviral medication, came a huge intake of patients with side effects of the drugs and complications of the disease. Pneumonia and TB were also rife. However, so too was poor drug compliance. The hospital therefore had 2 multiple-drug resistance TB wards where patients would receive at least 6 weeks of intense anti-TB treatment.

My elective gave me an insight into a world where medication is not available on tap. Every week, the pharmacist discussed the drug availability at the morning multidisciplinary team meeting, and it was clear that the hospital was in the midst of a national drug shortage. Some weeks, there was no paracetamol, ibruprofen or codeine. The pain ladder in essence consisted of tramadol and morphine. There were fears that morphine would become scarce, in which case all the surgery would therefore have to come to a standstill. It was amazing, however, to see how adaptable the doctors were given the circumstances.

The majority of my time was spent in theatre, assisting with caesarean sections, abscess drainage procedures, biopsies etc. It was great to have hands-on experience to improve my practical surgical skills. Unlike in NHS hospitals, there was no specialised anaesthetist. Instead one of the doctors took on the role. The main anaesthetic used was IV ketamine- a drug widely accepted as a safe choice of anaesthesia in district hospitals in South Africa, particularly in short day-case procedures.[iv] This formed the basis of my elective project.

Project

In my project I was keen to look at the recovery of patients following ketamine anaesthesia. I interviewed the recovery nurses to gain an insight into their level of understanding of ketamine, its side effects, and the recovery protocol within the hospital. I found that many of the nurses had an understanding of ketamine, however there was not consistent understanding of the recovery protocol (Theatre Recovery → OPD recovery → Discharge Home). While a proforma was used in theatre recovery to aid assessment of when patients were safe for discharge to OPD, there was no similar proforma used in OPD to ensure patients were safe for discharge home.

I also looked at the theatre log books and patient notes to analyse the average length of recovery of patients in the various areas. Of the 29 patients who had a day-case procedure under ketamine anaesthesia, 14 patients had recovery notes in their file. I am in the process of fully analysing the results.

With the help of my local supervisor, I created a proforma to use in OPD to assess when patients are safe for discharge home. This was based on the Post-Anaesthetic Discharge Summary Score, which assesses 'home readiness.'[v] The score, which included vital signs, ambulation, nausea and vomiting, pain and surgical bleeding, was extended to include cognition, function, and being accompanied home with a reasonable adult. These factors were important since patients often have to travel far to get home, be it by walking, public or private transport.

The future

I thoroughly enjoyed my experience at Manguzi Hospital. In the future, I would love to return to South Africa to work in a similar hospital- to discover more of the country and to develop my medical skills in an environment requiring adaptability. Many thanks to AAGBI for my elective grant!

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[i] Department of Health Province: KwaZulu-Natal. *The Department of Health Biggest Win (Gold Award) in the KwaZulu-Natal Premier's Service Excellence Awards.* http://www.kznhealth.gov.za/mediarelease/2012/psea6.7.2012.htm (accessed 28/08/2015)

[ii] Manguzi Hospital. *Demographic Profile.* http://www.manguzihospital.za.net/Manguzi_Hospital_demographic_profile.htm (accessed 28/08/2015)

[iii] AVERT: AVERTing HIV and AIDS. *HIV & AIDS in South Africa*. http://www.avert.org/hiv-aids-south-africa.htm (accessed 28/08/2015)

[iv] World Health Organisation. *Surgical Care at the District Hospital*. http://www.who.int/surgery/publications/en/SCDH.pdf?ua=1 (accessed 24/08/2015)

[v] Chung et al. A Post-Anaesthetic Discharge Scoring System for Home Readiness after Ambulatory Surgery. *Journal of Clinical Anesthesia* 1995; 7: 500-506. http://www.stopbang.ca/pdf/pub164.pdf (accessed 15/12/2014)