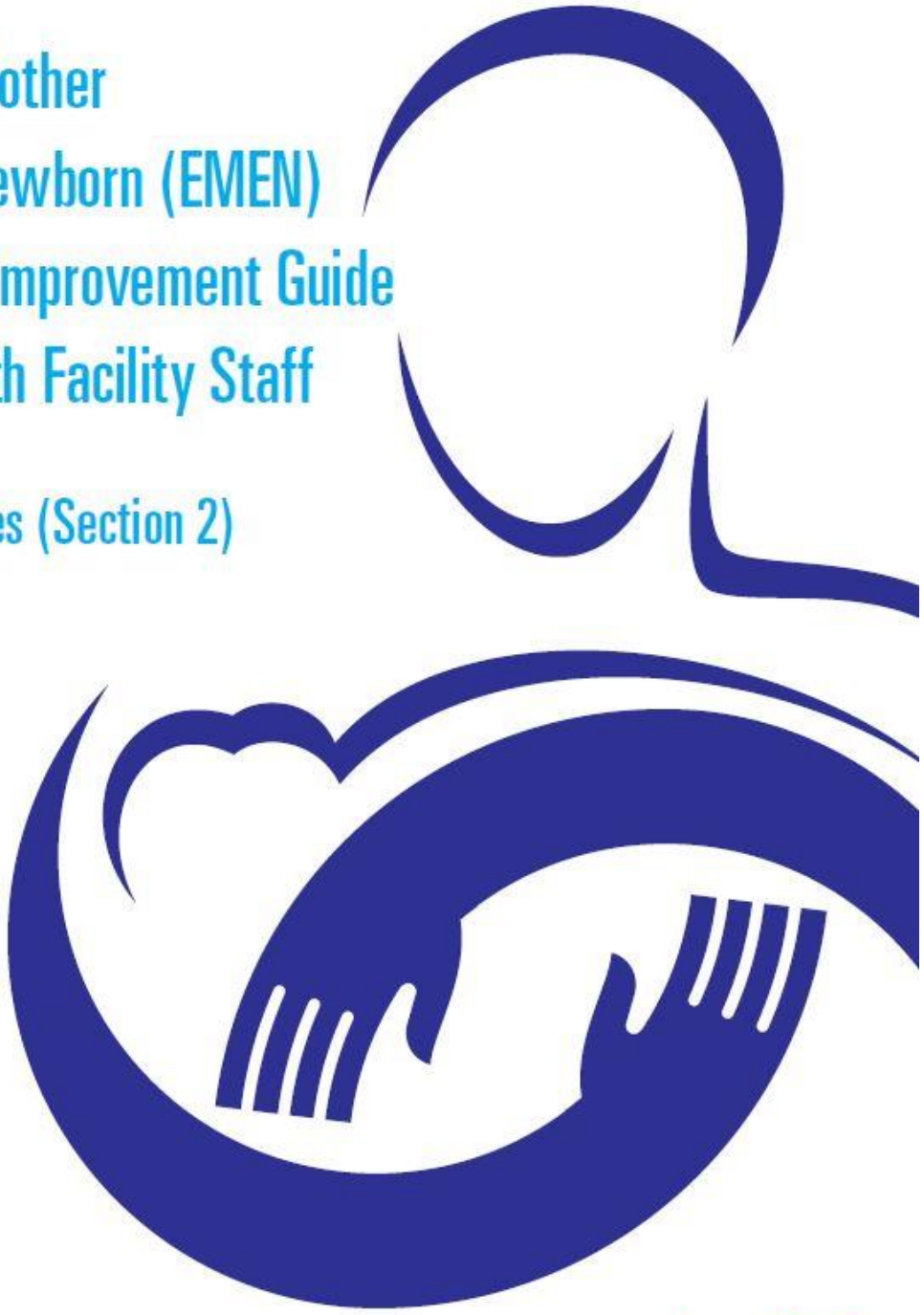
Every Mother Every Newborn (EMEN) Quality Improvement Guide for Health Facility Staff

Appendices (Section 2)



unite for children

unicef

Table of Contents

REFERENCE DOCUMENTS

Appendix 1. EMEN Standards with Intents

Standard 1. Evidence-based safe care is provided during labour and childbirth.

Intent:
Quality care at the time of labour and childbirth can have the highest impact on reducing maternal and neonatal deaths and stillbirths, as most of these deaths are concentrated in this time period[i] with increasing rates of facility deliveries, there is a golden opportunity to achieve the best clinical outcomes through provision of evidence-based high impact interventions[ii]. Interventions include: during labour (active management of the third stage of labour, clean birth practices, labour and delivery management, antenatal corticosteroids for preterm labour, antibiotics for preterm premature rupture of membranes and magnesium sulphate for pre-eclampsia and eclampsia; immediate newborn care (immediate assessment and stimulation, and neonatal resuscitation); care of healthy neonate (breastfeeding, chlorhexidine cord application, and clean postnatal practices); and care of the small neonate (thermal care, hospital care of preterm babies including kangaroo mother care, case management of severe neonatal infections, oral antibiotics for neonatal infections and oral rehydration solution for diarrhea).

Some interventions are required by all women in labour and newborns, while others are specifically intended for complicated cases. Comprehensive and Basic Emergency Obstetric Care services should encompass provision of all the signal functions entailed. All the direct obstetric complications are included in Emergency Obstetric Care and these are important for neonatal context as many maternal problems also result in complications in newborns.

Normal Care: Mother[iii]

1.1 The pregnant woman's general condition (labour and stage confirmed) and emergency signs are assessed immediately upon arrival and documented.

1.2 The progress of labour is regularly monitored using a partograph.

1.3 Every woman receives oxytocin immediately after birth of the baby, as part of active management of third stage of labour according to protocol.

*Immediate is defined as within 1 minute of delivery, before birth of the placenta.

Complications: Mother

1.4 Parenteral magnesium sulphate is administered for signs of pre-eclampsia and eclampsia according to a current evidence-based protocol.

---

[i] Graham WJ, Bell JS, Bullough CHW. Can skilled attendance at delivery reduce maternal mortality in developing countries? Safe Motherhood strategies: a review of the evidence 17 (2001): 97-130.

[ii] Bhutta ZA, Das JK, Bahl R, et al. for The Lancet Every Newborn Interventions Review Group and The Lancet Every Newborn Study Group. Can available interventions end preventable deaths in mothers, newborn babies and stillbirths, and at what cost? Lancet 2014, published online May 20. http://dx.doi.org/10.1016/S0140-6736 (14)60792-3.

[iii] WHO. Guidelines on maternal, newborn, child and adolescent health approved by the WHO guidelines review committee. Recommendations on maternal and perinatal health. 2013. WHO: Geneva.

1.5 Women in preterm labour receive appropriate interventions for both the woman and the baby according to evidence-based guidelines including use of antenatal corticosteroids for eligible mothers.[iv]

1.6 Women with delay in labour progress, or prolonged or obstructed labour receive appropriate interventions according to evidence-based guidelines.

1.7 Women with antepartum haemorrhage (APH) receive appropriate interventions according to evidence-based guidelines.

Immediate Newborn Care

1.8 Essential newborn care is provided according to current evidence-based guidelines.

1.9 Breastfeeding is initiated within one hour after birth[v].

Complications: Newborn

1.10 Newborn resuscitation is initiated without delay in the newborn not breathing spontaneously at birth:
- 1.10.1 The newborn receives additional stimulation.
- 1.10.2 Positive pressure ventilation with bag and mask is initiated within one minute after birth if no spontaneous breathing after additional stimulation.

Standard 2. Evidence-based safe postnatal care is provided for mothers and newborns.

Intent:
Postnatal care encompasses all issues pertaining to mother and baby from birth to 6 weeks (42 days)[vi]. The new WHO guidelines on postnatal care[vii] recommend timing of discharge from health facility after normal birth to be 24 hours after childbirth. Thus, the first postnatal care contact occurs within the facility. Later contacts may take place at the facility or within the home depending on national policies and guidelines. The immediate postnatal period is critical for watching out for maternal and neonatal complications and supporting breastfeeding. Pre-term and low birth weight babies require special care.

Routine Care Postnatal Care (Uncomplicated vaginal birth)

2.1 Healthy mothers and newborns stay in the facility and receive postnatal care (PNC) for at least 24 hours after birth

Complications: Postnatal (Mother and Newborn)

Mothers

[iv] World Health Organization.2015.WHO recommendations on interventions to improve preterm birth outcomes. WHO: Geneva.

[v] NEOVITA study group. Timing of initiation, patterns of breastfeeding, and infant survival: prospective analysis of pooled data from three randomized trials. Lancet Glob Health. 2016; 4:e266-267.

[vi] World Health Organization. 2010. WHO Technical Consultation on Postpartum and Postnatal Care. WHO: Geneva.

[vii] World Health Organization. 2013.WHO Recommendations on Postnatal Care of the Mother and Newborn. WHO: Geneva. ISBN 978 92 4 150664 9

2.2 Current evidence-based protocols are carried out for management of post-partum sepsis.[viii]
2.3 A current evidence-based protocol carried out for the management of post-partum hemorrhage[ix].

Newborns

2.4 Kangaroo mother care is initiated early in the first week of life for babies with birth weight <2000 g and clinically stable according to protocol[x].
  2.4.1 The infant is kept skin-to-skin with the mother in kangaroo position.
  2.4.2 The infant is supported for feeding breast milk.
  2.4.3 The mother receives additional support to establish breastfeeding.
2.5 A newborn with signs of complications is managed or referred for further management according to protocol.
2.6 Antibiotics are administered according to a current evidence-based protocol for management of suspected newborn sepsis.
2.7 Supportive care is provided to sick newborns according to the evidence-based protocols.

Standard 3: Fundamental human rights are observed and the experience of care is dignified and respectful.

Intent:
"A strong focus on respectful care as an essential component of quality of care"[xi]. Privacy and dignity must be observed and emotional support provided**.** Hospital staff needs to assure that the psychological, social, spiritual, and physical needs, cultural beliefs and practices of patients and families are respected, including newborns. Consequently, health care workers are responsible for conducting themselves in an ethical manner that justifies the public trust and protecting the patient's rights.
Experts have identified key drivers of patient satisfaction, which include responding to patient's special needs and concerns, keeping patients informed, involving them in decision-making regarding their care/treatment, and treating them with courtesy and respect. Therefore, hospital policies and practices need to support these desires and expectations of patients and families. In regard to pregnant women, having a companion of choice has been shown in systematic review to improve outcomes for women in labour[xii].

3.1 A process is in place for women and families to express concerns.

3.2 All women have informed choices in the services they receive, and the reasons for interventions or outcomes are clearly explained.

3.3 Every woman is offered the option to experience labour and childbirth with a companion of her choice.

[viii] World Health Organization. 2008. Managing Puerperal Sepsis. Midwifery Educational Modules, 2nd ed. WHO: Geneva ISBN 978 92 4 154666 9.
[ix] World Health Organization (WHO). WHO recommendations for the prevention and treatment of postpartum haemorrhage. Geneva (Switzerland): World Health Organization (WHO); 2012. 41 p
[x] Bergh A-M, Kerber K, Abwao S, et al. 2014. Implementing facility-based kangaroo mother care services: lessons from a multi-country study in Africa. BMC Health Services Research. 14:293. http://www.biomedcentral.com/1472-6963/14/293.
[xi] World Health Organization statement. The prevention and elimination of disrespect and abuse during facility-based childbirth. World Health Organization, Geneva, 2014
[xii] Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews. 2013;7:Art. No.:CD003766 doi:10.1002/14651858.CD003766.pub5

3.4 No woman or newborn is subjected to mistreatment such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services.

3.5 No woman or newborn is subjected to unnecessary or harmful practices during labour, childbirth and the early postnatal period
- 3.5.1 No unnecessary I/V line a routine
- 3.5.2 No episiotomy unless medically indicated.
- 3.5.3 No unnecessary cesarean section

Standard 4. A governance system is in place to support the provision of quality maternal and newborn care.

Intent:
Variable leadership and district level commitment is a common challenge in implementing quality improvement in MNC.[xiii] Consequently, leadership and management may lead to variations in outcomes of care. Leaders who are committed to improving and setting quality as a priority are more likely to create a culture in which quality improvement efforts succeed.[xiv] An environment that enables quality improvement is one that has a structure in place including policies and people to facilitate the resources, systems and processes. Other key elements include supporting team-based decision making, engaging the community in quality improvement [xvxvixvii] and using data to inform decisions.

4.1 Every health facility has managerial and clinical leadership collectively responsible for creating and implementing appropriate policies and plans to meet the needs of women, newborns and staff.

4.2 An effective quality improvement program is present, including:
- 4.2.1 Functional quality teams
- 4.2.2 QI action plans
- 4.2.3 QI mentoring/ coaching
- 4.2.4 Capturing and Use of data
- 4.2.5 Monitoring and evaluation

[xiii] Twum-Danso NAY, Akanlu JB, Osafo E, Sodzi-Tettey S, Boadu RO, Atinbire S, Adondiwo A, Amenga-Etego I, Ashagbley F, Boadu EA, Dasoberi I, Kanyoke E, Yabang E, Essegbey IT, Adjei GA, Buckle GB, Awoonor-Williams JK, Nang-Beifubah A, Twumasi A, McCannon CJ, Barker PM. A nationwide quality improvement project to accelerate Ghana's progress toward millennium development goal four: design and implementation process. 2012. Int J for Qual in Health Care; 1-11.

[xiv] Dixon-Woods M, McNicol S, Martin G. Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature. BMJ Qual Saf 2012; 1-9. Doi 10.1136/bmjqs-2011000760

[xv] Stover KE, Tesfaye S, Frew AH, Mohammed H, Barry D, Alamineh L, Teshome A, Hepburn K, Sibley LM. Building district-level capacity for continuous improvement in maternal and newborn health. J Midwifery Women's Health. 2014 Jan; 59 Suppl 1:S91-S100. doi: 10.1111/jmwh.12164.

[xvi] Lee AC, Lawn JE, Cousens S, Kumar V, Osrin D, Bhutta ZA, Wall SN, Nandakumar AK, Syed U, Darmstadt DL. 2009. Linking families and facilities for care at birth: what works to avert intra-partum related deaths? Int J Gynaeco Obstet. 107 Suppl 1, S65-85, S86-8.

[xvii] Marston C, Renedo A, McGowan CR, Portela A. 2013. Effects of community participation on improving uptake of skilled care for maternal and newborn health: a systematic review. PLoS 1, 8, e55102.

Standard 5. The physical environment of the health facility is safe for providing maternal and newborn care.

Intent:
The healthcare environment can place a mother and newborn at risk of developing an infection or sustaining an injury – contributing to mortality and morbidity.[xviii] Accordingly, attention needs to be given to several conditions: safe and sufficient water, basic sanitation and hygiene, effective management of healthcare waste and adequate ventilation[xixxx]. Increased bed numbers and lack of bed space contributes to infection transmission; therefore, bed management is issue that requires effective hospital-wide systems.[xxi] Patient identification is an international patient safety issue; correct patient identification is important for administering medications, blood, treatments, procedures and taking test samples. In the case of a newborn, it is important to ensure that the baby is correctly placed with its mother[xxii].

5.1 Services available are clearly displayed.

5.2 An infection prevention and control (IPC) program is in place to reduce health care -associated infections.
- 5.2.1 Infection prevention and control focal person
- 5.2.2 Formation of hygiene and IPC committee
- 5.2.3 Development of hygiene and IPC plan including water supply, excreta management and hand washing
- 5.2.4 Infection reporting system (surveillance); monitoring of caesarean section and neonatal sepsis rates
- 5.2.5 Hand hygiene monitoring
- 5.2.6 Adequate supplies in all clinical areas:
  - personal protective equipment
  - waste bins
  - soap and hand disinfectant
  - sharp containers
- 5.2.7 Adequate facilities and logistics for final waste management, e.g. incinerator, burial pit.

Standard 6. Qualified and competent staff are available in adequate numbers to provide safe, quality mother and newborn care.

Intent:
Facility leaders must ensure that the right number and mix of staff are available to meet the mission. In addition, the staff needs to be qualified and have the required experience for the job. The roles and responsibilities of each staff member need to be clearly defined and staff needs to be oriented to the

---

[xviii] Adams J, Bartram J, Chartier Y, editors. Essential environment health standards in health care. Geneva: WHO. 2008.

[xix] Velleman Y, Mason E, Graham W, Benova L, Chopra M, et al. 2014. From joint thinking to joint action: a call to action on improving water, sanitation, and hygiene for maternal and newborn health. PLoS med 11 (12): e1001771. doi.10.1371/journal.pmed.1001771

[xx] Benova L, Cumming O, Campbell OMR. 2014. Systematic review and meta-analysis: association between water and sanitation environment and maternal mortality. Tropical Med and International Health. doi. 10.1111/tmi.12275

[xxi] Hussein J. Mavalankar DV, Sharma S, D'Ambruoso. 2011. A review of health system infection control measures in developing countries: what can be learned to reduce maternal mortality? Globalization and Health. 7 (14). doi: 10.1186/1744-8603-7-14

[xxii] Farley DO. 2011. Evaluation of the WHO Patient Safety Solutions Aides Memoir. WHO: Geneva. Retrieved on 17 Mar 2015 at http://www.who.int/patientsafety/implementation/solutions/patientsafety/en/

hospital, their department, and job to ensure their competence. It is important that each staff member's performance be assessed regularly and their knowledge and skills continually upgraded.

6.1 Skilled birth attendants (SBA) are available on site 24 hours/7 days a week.
6.2 Staff has the qualifications, knowledge and skills to implement high impact MNH interventions.

Standard 7. Essential medications, supplies, and equipment are consistently available to provide mother and newborn care.

Intent:
Adequate numbers of medications and supplies are required to provide care and treatment and to perform testing procedures. When these supplies are not available, the patient is at risk of not receiving timely test results, treatments and perhaps, surgical interventions.
Medication use is a complex system of processes (selection, storage, prescribing, dispensing, administration, and patient monitoring) that has many risk points. Policies and procedures need to be implemented for safe storage and handling of medications. Studies have identified common causes of serious medication errors, such as use of abbreviations, look-alike/sound-alike medications and concentrated electrolytes.[xxiii][xxiv] Separating and labeling these medications are measures to reduce the potential for error. Health care practitioners may be proficient in using equipment, but may often lack the expertise to inspect and maintain the equipment. It is important to have staff with the required skills to inspect and maintain equipment to ensure that it is functional and safe. Standardization of supplies and equipment promotes efficiency and is a means of decreasing the potential for error. Accordingly, supplies need to be readily available, well organized, labeled and maintained in a standardized way as much as possible throughout the facility.

7.1 Medications are available, well-organized and within expiry date (using first expired/first out rules) and no stock outs within past 3 months.
- 7.1.1 Pharmacy
- 7.1.2 Maternal ward
- 7.1.3 Neonatal ward

7.2 Essential equipment and supplies are available to carry out the clinical protocols without interruption.

7.3 Diagnostic examinations for essential investigations are accessible for pregnant women, mothers and newborns.

Standard 8. Health Information systems are in place to manage patient clinical records and service data.

Intent:
Health information management is an important connection between doctors, patients, Ministry of Health, insurance providers, and others in the healthcare field, by maintaining, collecting, and analyzing health information. Proper collection, management and use of information within healthcare systems will determine the system's effectiveness in detecting health problems, defining priorities, identifying solutions and allocating resources to improve health outcomes.

[xxiii] WHO Collabourating Centre for Patient Safety Solutions. Look-alike, sound-alike medication names. Vol 1, solution 1. May 2007.
[xxiv] WHO Collabourating Centre for Patient Safety Solutions. Control of concentrated electrolyte solutions. Vol 1; solution 5. May 2007.

8.1 Registers are kept that contain complete data regarding:

- Admission, delivery and discharge times
- Outcome of the delivery, including still births
- Cesarean sections
- Gestational age
- Birth weight

8.2 Patients' medical records are thoroughly and accurately completed.

8.3 Critical data for key indicators is collected and validated (complete and accurate) related to labour, childbirth and the postnatal period.[xxv]

8.4 Accurate & complete health care data is submitted to the next level in a timely manner.

8.5 A birth[i] and death registration system is in place that is in line with ICD-10 coding (capturing of statistics).

8.6 Maternal and perinatal death reviews and response are regularly conducted and recommendations from reviews are implemented.

8.7 The data is analysed by users and routinely used to make clinical and management decisions.

Standard 9. Services for mother and newborn care are available to ensure continuity of care.

Intent:
Ineffective communication among caregivers is one of the most frequently cited categories of root causes of serious events that occur in healthcare facilities[xxvi]. In particular, communication was identified as contributing to delays in treatment, maternal and perinatal incidents. Patients often move between areas of diagnosis, treatment, and care on a regular basis and may encounter three shifts of staff each day—introducing a safety risk to the patient at each interval. The hand-over communication between units and between and amongst care teams might not include all the essential information, or information may be misunderstood. These gaps in communication can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm to the patient. Effective communication, which is clear, timely, accurate, complete and understood by the recipient, reduces error and results in improved patient safety. When patients are transferred to another facility, information about their condition, care and treatment is needed by the receiving medical team to provide ongoing care. When this information is not provided, the patient is at risk of misdiagnosis or treatment. Continuity further extends to the community and therefore, key stakeholders need to engage in discussions and decisions regarding improving maternal and neonatal health.

9.1 Communication and systems are in place to assure continuity of care for postnatal care follow-up, counselling and monitoring for mother and baby.

[xxv] Biswas A, Rahman F, Halim A, Eriksson C, Dalal, K. 2014. Maternal and Neonatal Death Review (MNDR): A Useful Approach to Identifying Appropriate and Effective Maternal and Neonatal Health Initiatives in Bangladesh. *Health*, **6**, 1669-1679. doi: 10.4236/health.2014.614198.

[xxvi] Joint Commission International. Sentinel Event Data 2004-2013. PowerPoint presentation. Retrieved on 16 Mar 2015 at http://www.jointcommission.org/assets/1/18/Root_Causes_by_Event_Type_2004-2Q2013.pdf

9.2 For every woman and newborn needing referral, the referral follows a pre-established plan that can be implemented without delay at any time.

9.3 Reliable communication methods are operational including mobile phone, landline or radio for referrals and consultation on complicated cases.

Appendix 2. EMEN Standards Assessment Tool

Please mark (√) if the task is performed correctly; mark (X) if it is not performed correctly.
Met: Perform the steps or tasks according to the standard procedure or guidelines
Not Met: Unable to perform the step or task according to the standard procedure or guidelines

EMEN Standards and Criteria for Quality in Maternity and Newborn Care					
	Assessment Questions	**Means of Verification**	**Scoring**		**Comments**
			Not Met 0	**Met 1**	
Standard 1. Evidence-based safe care is provided during labor and childbirth.					
Normal Care: Mother					
1.1 The pregnant woman's general condition (labour and stage confirmed) and emergency signs are assessed immediately upon arrival and documented.	1. Was the pregnant woman's general condition assessed within the first 30 minutes of arrival in the health facility? 2. Did a person trained in obstetric triage conduct an assessment of the woman's general condition and emergency signs? 3. Were the following assessment findings documented by a skilled birth attendant (SBA): • Blood pressure • Foetal heart sounds • Signs of bleeding • Rupture of membranes • Imminent delivery?	Observation Medical record review			
1.2 The progress of labour is regularly monitored using a partograph.	1. Are partographs filled out completely and correctly? Check for: • Blood pressure • Foetal heart rate checked	Medical record review: Partograph			

	hourly • Uterine contractions assessed every half hourly • Cervical dilatation every 4 hours • Descent • Molding • State of membranes or colour of the liquor • Outcome of the baby • Any medication or fluid given recorded (Source for list: AMDD, module 6, pg. 2) 2. Was the partograph started when the cervix was ≥ 4 cm? (Source: WHO Safe Childbirth Checklist, 2012)				
1.3 Every woman receives oxytocin immediately after birth of the baby, as part of active management of third stage of labour according to protocol. *Immediate is defined as within 1 minute of delivery, before birth of the placenta.	Do all women receive oxytocin immediately after birth of the baby?	Observation: Delivery Medical record review			
Complications: Mother					
1.4 Parenteral magnesium sulphate is administered for signs of pre-eclampsia and eclampsia according to a current evidence-based protocol.	1. Was a protocol present in the maternity ward for management of pre-eclampsia and eclampsia? 2. Was parenteral magnesium sulphate administered for signs of pre-eclampsia and eclampsia according to a current evidence-based protocol?	Medical record review or Case scenario/OSCE			
1.5 Women in preterm labour receive	Is either intramuscular (IM) dexamethasone	Medical record review or			

appropriate interventions for both the woman and the baby according to evidence-based guidelines, including use of antenatal corticosteroids for eligible mothers.	or IM betamethasone (total 24 mg in divided doses) given when preterm birth is imminent?	Case scenario/OSCE			
1.6 Women with delay in labour progress, or prolonged or obstructed labour receive appropriate interventions according to evidence-based guidelines.	Were women with prolonged or obstructed labour managed according to current evidence-based protocols? 1. Was an IV inserted & fluids administered to women experiencing prolonged or obstructed labour? 2. Were women with prolonged or obstructed labour immediately referred to a facility with c-section capabilities? 3. Were antibiotics administered to women with labour past 24 hours?	Medical record review Case scenarios/OSCE Document Review: • Perinatal mortality audits to assess action taken • Referral records			
1.7 Women with antepartum hemorrhage (APH) receive appropriate interventions according to evidence-based guidelines.	Were women with antepartum hemorrhage (APH) managed according to current evidence-based protocols? 1. Vaginal examination is not performed. 2. The patient is immediately referred where blood transfusions can be given safely. 3. An IV line is inserted and intravenous fluids are administered rapidly.	Medical record review Case scenarios/OSCE Document Review: • Perinatal mortality audits to assess action taken. • Referral records			
Immediate Newborn Care					
1.8 Essential newborn care is provided according to current evidence-based guidelines.	1. Were newborns dried immediately and thoroughly after birth? 2. Was spontaneous breathing assessed at birth? 3. Was the cord clamped and cut between 1 and 3 minutes of birth? 4. Was the baby put skin-to-skin to the	Observation of birth or OSCE			

	mother immediately after birth and provided with warmth? 5. Was the baby breastfed within one hour of birth when the feeding cues appeared?				
1.9 Breastfeeding is initiated within one hour after birth.	Was the baby breastfed within one hour of birth when the feeding cues appeared?	Medical record review Document review: clinic register Interview: mothers			
Complications: Newborn					
1.10 Newborn resuscitation is initiated without delay in the newborn not breathing spontaneously at birth: 1.10.1 The newborn receives additional stimulation. 1.10.2 Positive pressure ventilation with bag and mask is initiated within one minute after birth if no spontaneous breathing after additional stimulation. If no spontaneous breathing after effective ventilation, the newborn is referred immediately to appropriate level of care by appropriate means. Continuous positive airway pressure therapy is recommended for the treatment of preterm newborns with respiratory distress syndrome.	1. Was a protocol/algorithm present in the maternity/neonatal ward for neonatal resuscitation? 2. Did newborns receive additional stimulation if not breathing spontaneously at birth? 3. Was positive pressure ventilation with bag and mask initiated within one minute after birth if no spontaneous breathing after additional stimulation? 4. If no spontaneous breathing after effective ventilation, was the newborn referred immediately to appropriate level of care by appropriate means? AMDD staff interview questions: 5. Have you ever received instruction on how to resuscitate a newborn with bag and mask? 6. Have you provided this service in the past 3 months?	OSCE with use of model			

Standard 2. Evidence-based safe postnatal care is provided for all mothers and the newborns.					
Routine Care Postnatal Care (uncomplicated vaginal birth)					
2.1 Healthy mothers and newborn receive care in the Healthy mothers and newborns stay in the facility and receive postnatal care (PNC) for at least 24 hours after birth	Do healthy mothers and newborns receive postnatal care in the facility for at least 24 hours after birth?	Medical record review Interview: mothers			
Complications: Postnatal (mothers and newborns)					
Mother					
2.2 Current evidence-based protocols are carried out for management of post-partum sepsis.	Do healthy mothers and newborns receive postnatal care in the facility for at least 24 hours after birth?	Medical record review			
2.3 A current evidence-based protocol is carried out for the management of postpartum haemorrhage (PPH).	1. Was a protocol present in the maternity ward for management of PPH? 2. Were women with any of the following treated for PPH: • that required treatment for haemorrhage (Intravenous fluids, uterotonics or blood) • retained placenta • severe bleeding from lacerations (vaginal or cervical) • vaginal bleeding in excess of 500ml after childbirth • more than one pad soaked in blood in 5 minutes? (Source: Data Collector Manual, AMDD, pg. 36)	Medical record review			

	3 Were women with postpartum haemorrhage managed according to current evidence-based protocol?				
Newborn					
2.4 Kangaroo mother care (KMC) is initiated early in the first week of life for babies with birth weight <2000 g and clinically stable according to protocol. 3.4.1	1. Is the infant kept skin-to-skin with the mother in kangaroo position? 2. Is support for exclusive breastfeeding or other appropriate feeding provided? 3. Is there early recognition/response to illness? (Source: Lawn JE, Mawansa-Kambafwile J, Horta BL, Barros FC, Cousens S. Int. J. Epidemiol. (2010) 39 (suppl 1):i144-i154.doi:10.1093/ije/dyq031)	Medical record review			
2.5 A newborn with signs of complications is managed or referred for further management according to protocol.	1. Were protocols present in the maternity ward for management of newborn complications? 2. Was a referral policy and procedure present? 3. Are newborns with signs of complications managed or referred for further evaluation according to protocol?	Medical record review			
2.6 Antibiotics are administered according to a current evidence-based protocol for management of suspected newborn sepsis.	1. Was a protocol present in the maternity/neonatal ward for management of suspected newborn sepsis? 2. Were the risk factors for neonatal infection assessed, including: • membranes ruptured >18 hours before delivery • mother had fever >38ºC before delivery or during labour • amniotic fluid was foul smelling or purulent?	Medical record review			

	3. Were newborns with the following signs of infection treated according to current evidence-based guidelines: • diminished spontaneous activity • less vigorous sucking • apnea • bradycardia • temperature instability • respiratory distress • vomiting • diarrhea • abdominal distention • jitteriness • seizures • jaundice? (Diagnosis is clinical and based on culture results.) (Source: WHO. Managing Newborn Problems: A Guide for Doctors, Nurses and Midwives 2003)				
2.7 Supportive care is provided to sick newborns according to the evidence-based protocols.		Medical record review Case scenarios/OSCE Document Review: • Perinatal mortality audits to assess action taken. • Referral records			
Standard 3. Human rights are observed and the experience of care is dignified and respectful for every woman and newborn.					
3.1 A process is in place for women and families to express concerns.	Is there a policy and procedure for addressing patient concerns?	Manager or staff interview			

		Client interview			
3.2 All women have informed choices in the services they receive, and the reasons for interventions or outcomes are clearly explained.	Are women informed and understand their options and participate in decisions regarding their care, e.g. consent for cesarean section?	Client interview: Interview women who have undergone a caesarean section and ask them about the information that they received prior to surgery. Medical record review: Review records to determine if there is a signed consent for surgery – exception: emergency.			
3.3 Every woman is offered the option to experience labour and childbirth with a companion of her choice.	Are women offered an opportunity for a companion during labour, childbirth and immediate postnatal period?	Client interviews			
3.4 No woman or newborn is subjected to mistreatment such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services.	1. Are clear policies on rights and ethical standards developed? 2. Have staff received training in treating childbearing women with compassion and dignity? 3. Are community stakeholders involved in ending disrespect and abuse during childbirth? 4. Is there a process for identifying and reporting abuse? 5. Are preventative and therapeutic measures implemented? (Source: WHO statement: Prevention and elimination of disrespect and abuse during childbirth. 2014)	Document review: Rights & ethical standards, training records Staff interviews Management interviews Client interviews			

	6. Is a woman expected to pay a fee or buy supplies for a normal delivery? 7. In an obstetrical emergency, is payment required before a woman can receive treatment? (Source: AMDD, module 1, pg.9)				
3.5 No woman or newborn is subjected to unnecessary or harmful practices during labor, childbirth and the early postnatal period 3.5.1 No unnecessary I/V line a routine	1. Are women informed and understand their options and participate in decisions regarding their care, e.g. consent for cesarean section? 2. What are the general practices regarding the use of episiotomy and maintenance of IV line during labour?	Client interview Medical record review Observations			
3.5.2 No episiotomy unless medically indicated.					
3.5.3 No unnecessary cesarean section					
Standard 4. A governance system is in place to support the provision of quality maternal and newborn care.					
4.1 Every health facility has managerial and clinical leadership collectively responsible for creating and implementing appropriate policies and plans to meet the needs of women, newborns and staff.	Have policies been written for the following: • Commitment to improving access to services, e.g. ensuring that hospital fees do not create a barrier to access. • Support implementation of baby-friendly standards • Staff have authority to deliver essential care, including medications, according to standard protocols. • Patient rights are outlined • Use of companions during labour/delivery • Task-shifting in maternity and newborn wards?	Document review: hospital policies, budget, performance & annual reports Management interviews			
4.2 An effective quality improvement program is present, including: 4.2.1 Functional quality teams	Is an effective quality improvement program present, which includes:	Interviews: Management Interview and QI team members			

4.2.2 QI action plans	• Functional quality teams • QI actions plans • QI mentoring/coaching • Capturing and use of data • Monitoring and evaluation?	Document review: Meeting minutes and QI action plans			
4.2.3 QI mentoring/ coaching					
4.2.4 Capturing and use of data					
4.2.5 Monitoring and evaluation					
Standard 5. The physical environment of the health facility is safe for providing maternal and newborn care.					
5.1 Services available are clearly displayed.	Does the hospital have signage: • External signage provides guidance for the public to locate the hospital from the main roads and Y junctions to hospital; • Hospital signs include the name of the hospital and services provided; and, • Clear, visible internal signage that includes the names and directions for main hospital areas and services?	Observation: When driving to, entering & touring the hospital, observe whether directional signs are present and clear.			
5.2 An infection prevention and control (IPC) program is in place to reduce health care-associated infections.	1. Is there an IPC focal person? 2. Is PPE available in all clinical areas (gloves, goggles, fluid resistant aprons)?	Interview IPC focal person			
5.2.1 Infection prevention and control focal person	3. Are staff observed to be using PPE correctly?	Observation			

	4. Are puncture-proof sharps containers located in each clinical area that are at 5. waist height? 6. Are sharps containers no more than ¾ full? 7. Is there a concrete-lined sharp pit or incinerator for sharps disposal? 8. Is there a well ventilated, maintained & 9. protected placenta pit (fenced)? 10. Did staff wash their hands before and after examining a patient? 11. Do staff dry hands avoiding contamination (personal or disposal towels, or air dry)? 12. Do staff wear gloves when handling medical waste? 13. Is the delivery unit cleaned after each delivery? 14. Are functioning sinks with clean, running water available in clinical rooms/ wards/ treatment areas for hand washing (one per ward)? 15. Are sinks equipped with bar/liquid soap in clinical areas? 16. Are healthcare workers compliant with the hand hygiene "five moments"?	Review of documents: hand hygiene monitoring and infection surveillance records (data collection, infection rates). Staff knowledge test			
5.2.2 Formation of hygiene and IPC committee					
5.2.3 Development of hygiene and IPC plan including water supply, excreta management and hand washing					

5.2.4 Infection reporting system (surveillance); monitoring of caesarean section and neonatal sepsis rates					
5.2.5 Hand hygiene monitoring					
5.2.6 Adequate supplies in all clinical areas: • personal protective equipment • waste bins • soap and hand disinfectant • sharp containers					
5.2.7 Adequate facilities and logistics for final waste management, e.g. incinerator, burial pit.					
Standard 6. Qualified and competent staff are available in adequate numbers to provide safe, consistent and quality maternal and newborn care.					
6.1 Skilled birth attendants (SBA) are available on site 24 hours/7 days a week.	1. Does the maternity department have a staffing plan, which includes the number and categories of staff needed per shift? 2. When staffing levels do not meet the needs, is there a policy and procedure that describes actions to be taken, e.g. reassign staff, on-call staff? 3. Is the maternity staffing plan based on workload, e.g. nurse to patient ratio? 4. Has there been sufficient skilled birth attendants on site 24 hours/7 days a week for the past 3 months according to national norms?	Document review: • Staffing norms/plan • Review the duty roster to determine whether birth attendants are scheduled 24/7. Management interview: Discuss how the staffing plan is established based on workload measures.			
6.2 Staff has the qualifications, knowledge and skills to implement impact interventions.	Does the assigned facility staff have the qualifications, knowledge and skills to implement the high impact interventions:	Review documents: • staff training plans • staff records, e.g. certificates,			

	Normal Care: Mother • Obstetric triage/initial assessment • Partograph • Active management of the third stage of labour (AMSTL) • Breastfeeding counselling and lactation management **Complications: Mother** • Pre-eclampsia & eclampsia • Prolonged obstructed labour • PPH • Postpartum sepsis **Immediate Newborn Care** • Essential newborn care **Newborn Complications:** • Asphyxia/resuscitation • Small and sick newborns • KMC • Neonanatal sepsis	qualifications Skills demonstration Staff interview: *What are the actions taken during active management of the third stage of labour?* In the responses, immediate oxytocin and immediate ergometrine mean within one to two minutes of the birth of the baby. (This is an example of one question in Module 7 of the AMDD EmONC manual.)			
Standard 7. Essential medications, supplies and functional equipment and diagnostic services are consistently available for maternal and newborn care.					
7.1 Medications are available, well-organized and within expiry date (using first expired/first out rules) and no stock outs within past 3 months. 7.1.1 Pharmacy 7.1.2 Maternal ward 7.1.3 Neonatal ward	1. Are medications stored using first expired/first out rules? 2. Stock outs have **not** occurred within the past 3 months? 3. Are medications stored to prevent damage from light, heat, and water? 4. Are medications routinely available to	Check current available inventory of required medications (including emergency) Calculate the number of stock outs in past 100			

	carry out the high impact interventions (antibiotics, anticonvulsants, antihypertensives, and oxytoxics? (Source: AMDD, Module 3) **Normal Care: Mother** • Injectable uterotonic (oxytocin) in the delivery service area **Complications: Mother** • Injectable antibiotic for maternal sepsis; for infection prevention due to PROM (gentamicin and ampicillin or ceftriaxone) • Skin disinfectant • Intravenous solution with infusion set) Both plasma expander and D5W (for infusion with medicines) • Betamethasone/ Dexamethasone • Oxygen available with administration equipment • Magnesium sulphate • Antihypertensives **<u>Immediate Newborn Care</u>** • Chlorhexidine for cord care • Vitamin K1 • OPV & Hepatitis B vaccines **<u>Complications: Newborn</u>** • Oxygen available with administration equipment Antibiotics	days.			

7.2 Essential equipment and supplies are available to carry out the clinical protocols without interruption.	1. Is there an effective inventory management system, e.g. use of supply lists and stock cards? 2. Is there an effective equipment maintenance process? 3. Are all essential supplies available to carry out the high impact interventions? **<u>Normal Care: Mother</u>** • BP apparatus • Stethescope • Low reading thermometer • Foetoscope • Sterilization equipment **<u>CEmOC</u>** • Spinal needle • Blood typing • Cross match testing • Blood screening kits for HIV and hepatitis • Ultrasound in delivery service area **<u>Immediate Newborn Care</u>** • Soap for handwashing • Alcohol rub for hands • Sterile gloves • Cord clamps/sterile thread for tying the cord • Towels for drying babies • Suction apparatus • Infant scale	Observation: store room, pharmacy, wards, departments Document review: • procurement plan & process documents • stock outs • stock records • Inventory list • Inventory • Maintenance schedule/ records • Observation: equipment maintenance tags			

	Complications: Newborn • Neonatal bag & mask (2 sizes: 0 and 1) **Checklists and job-aids :** • Are job aides available to guide practitioners to implement the high impact interventions? **Normal Care: Mother** • Partograph Immediate care for newborn • Guidelines and job aids for safe birth practices for prevention of mother-to-child transmission (PMTCT) **CEmOC** • Guidelines for management of preterm labour • CEmOC guidelines **Immediate Newborn Care** • Guidelines for essential newborn care • Job aids for essential newborn care **Complications: Newborn** • Referral guidelines for newborns • Guidelines for ACS • Register where ACS administration is recorded • Job aids for KMC				

	<u>Emergency referral</u> • Referral transport • Stretcher • Referral slips **<u>Space & amenity provision</u>** • Bed per maternity patient • Functional latrine close to labour room and maternity wards • Rooming –in • Eclampsia room • KMC (beds/ward) • Newborn resuscitation table Sick newborn care unit (For CEmOC facilities only)				
7.3 Diagnostic examinations for essential investigations are accessible for pregnant women, mothers and newborns.	• Are the diagnostic kits and equipment available and in good working order? • List of Diagnostic tests available? • Are they free of cost?	Observation Document review: procurement plan & process documents, stock outs, stock records, • Inventory list • Inventory • Observation • Management interview • Maintenance schedule • Testing results			
Standard 8. Health information systems are in place to manage patient clinical records and service data.					
8.1 Registers are kept that contain complete data regarding: Admission, delivery and discharge times	Do the relevant registers contain complete data regarding selected items (see list under criteria and/or locally defined register items)?	Document review: Registers			

• Outcome of the delivery, including still births • Cesarean sections • Gestational age • Birth weight	**<u>Mother</u>** • Age • Residence/village • Admission, delivery and discharge times • PMTCT (if relevant) • Mode of delivery • Caesarean sections (elective or emergency) • Delivery attendant • Number of spontaneous vaginal deliveries, vacuum extraction, forceps • Total deliveries • Complications • Expected postpartum visit date **<u>Newborn</u>** • Apgar score • Gestational age • Sex • Birth weight • Outcome of the delivery: live births greater than or equal to 2.5kg • Still births • Low birth weight babies: • Total newborn outcomes for facility births • Infant feeding (breastfeeding initiation and at discharge) • Neonatal deaths occurring within the first 24 hours • Birth notification				

	Referrals • Referrals out due to obstetric indications • Referrals out due to newborn complications				
8.2 Patients' medical records are thoroughly and accurately completed.	Do the medical records contain all the following: • Reason for admission • Significant findings, including investigations • Procedures performed • Diagnoses made • Relevant protocol followed • Medications or other treatments • Patients condition at discharge • Follow-up instructions and all discharge medications that the patient is to take following discharge. Other items relevant to context or medical record type (e.g., HIV status in high prevalent area or partograph in maternity labour delivery record)?	Medical record review: Overall review of documentation			
8.3 Critical data for key indicators is collected and validated (complete and accurate) related to labour, childbirth and the postnatal period.	1. Has the data for key indicators been collected and validated (complete and accurate) related to labour, childbirth and the postnatal period? 2. Has the reports been signed off by the in-charge or information technology officer?	Document review: Comparison of monthly report to source data (registers or medical records)			
8.4 Accurate & complete health care data is submitted to the next level in a timely manner.	Is accurate and complete health care data submitted to the next level in a timely manner?	Document Review: Reports received at next level.			

8.5 A birth and death registration system is in place that is in line with ICD-10 coding (capturing of statistics).	Are births being notified to the CRVS authority?	Document Review: Registers and/or notification books			
8.6 Maternal and perinatal death reviews (MPDR) and response are regularly conducted and recommendations from reviews are implemented.	Are maternal and perinatal death reviews routinely conducted? Are recommendations from reviews implemented?	Document Reviews: MPDR meeting minutes and documentation			
8.7 The data is analysed by users and routinely used to make clinical and management decisions.	8.7a: Has the data been analyzed by users and used to make programme and management decisions? 8.7b Manager(s) have updated monthly or quarterly data charts or scorecards (last data not more than 3 months old) 8.7c Management meeting minutes reflect data review and action plans at least quarterly.	8.7a: Document review: data charts or scorecards; Manager interviews 8.7\b: Key informant interview – MNH Manager(s) 8.7c: Document Review: Management meeting minutes. Sample: last 12 months of management meeting minutes.			
Standard 9. Services are available to ensure continuity of care for all pregnant women, mothers and newborns.					
9.4 Communication and systems are in place to assure continuity of care for postnatal care follow-up, counseling and monitoring for mother and baby.	1. Are there communication and systems in place to assure continuity of care for postnatal follow-up, counselling and monitoring for mother and baby? 2. Do policies and procedures exist for	Document review: • Policies and procedures • Postnatal visit reports Observation of postnatal			

	communication and systems to assure continuity of care for postnatal follow-up, counselling and monitoring for mother and baby? 3. Is there a defined system to generate data on postnatal visits? 4. Is counselling provided regarding: • breast feeding • family planning • immunization • nutrition • Kangaroo mother care • Danger signs • Cord care & hygiene • Other country specific, (e.g insecticide-treated bed nets)	visits (delivery facility, home visits, clinic visits)			
9.2 For every woman and newborn needing referral, the referral follows a pre-established plan that can be implemented without delay at any time.	1. Is there an effective system for mothers and newborns requiring referral and transfer to a higher level of care? 2. Are mechanisms in place to facilitate timely access to referral care? 3. Are postnatal home visits available? 4. Are women's support groups available?	Document review: Referral policy and procedure Staff interview: referral processes			
9.3 Reliable communication methods are operational including mobile phone, landline or radio for referrals and consultation on complicated cases.	1. Is there a landline in the maternity area? 2. Is there a cell phone available to staff? 3. Is there a two way radio accessible to maternity staff? 4. Is the communication system routinely functional?	Observation: communication methods			

Appendix 3. Quality Awareness PowerPoint Slides

Appendix 4: QI Team Terms of Reference (Example)

Scope: Maternal and Newborn Care

Purpose:

To ensure that requirements to meet the maternal and neonatal standards and quality improvement processes are implemented and maintained

Responsibilities:

1. Co-ordinate and provide leadership for quality improvement activities in maternal and newborn care services.
2. Create awareness about the importance of quality improvement standards & processes.
3. Conduct internal assessments in the quality of services:
    a. Conduct accurate data collection on priority maternal, breastfeeding and newborn indicators.
    b. Analyse data collected and identify areas for improvement.
    c. Assist staff to develop quality improvement action plans.
    d. Actively monitor performance against the plan (PDSA cycle).
4. Review and share quality improvement actions undertaken during quarterly review meetings at the district and regional level.
5. Adapt existing maternal, newborn care policies, guidelines, procedures and protocols and ensure that they are available, accessible and utilised at the maternity and newborn care units.
6. Ensure adherence to the ten steps to successful breastfeeding.
7. Ensure interdisciplinary retrospective clinical case reviews are undertaken weekly.
8. Facilitate on-the-job training for all maternity and newborn care staff on quality improvement.
9. Review incident forms, track trends, investigate issues and implement PDSA cycle for improvements.
10. Provide monthly and annual quality reports to the hospital QI committee and management.

11. Evaluate the effectiveness of the quality team on an annual basis.

Accountability:

The maternal-newborn quality committee works under the authority of:

1. Hospital QI Committee
2. Hospital Management Team

Chairperson: Medical Director
Co-chairperson: Head of Maternity

Membership:

Committee/Team membership consists of at least 1-8 in the list below and may include additional members as noted.

1. Head of Maternity
2. Hospital Administrator
3. Midwife
4. Staff Nurse/Paediatric Nurse
5. Medical Doctor - maternity unit
6. Medical Doctor - neonatal unit
7. Pharmacist
8. Laboratory in charge
9. Community Representative

Quorum:

50% of core members in attendance +1.

Meetings:

As a minimum, every month; (set a day in a specific week for monthly meetings)

Agenda:

An agenda is shared 5 working days prior to the meeting through phone calls, whatsapp messages, emails and/or circulars.

Minutes:

Minutes of all meetings are emailed to all committee members including the Hospital Manager within 1 week and hardcopies provided to committee members that do not have e-mail access.

Linkages with other teams/committees:

The maternal and newborn quality team/committee reports quality activities and results to the facility quality committee. In addition, the team/committee has linkages with the following groups:

1. Infection Prevention and Control team
2. District QI team
3. Drug and Therapeutic Committee

Appendix 5. Meeting Minutes (Example)

Quality Team Meeting Minutes		Date: 5 Jan 2016	
Participants:			
Topic	**Discussion**	**Recommendations/ Actions**	**Follow-Up**
Patient Satisfaction Survey	• A questionnaire was distributed to 100 maternity patients being discharged from the hospital from Oct 1-Dec 31 2015; 54 responded. The main issue identified was rudeness of the clinical staff. • Various solutions to this problem were discussed.	1. Provide a refresher customer service training for all clinical staff and share the results of the survey with them. 2. Conduct a focused survey regarding staff rudeness after the training	Training targeted for March Collect data in July Report back to the committee in September

Appendix 6. List of Required Documents

Facility Policies	Policies and Procedures	Other Documents
1. Rights & ethics, e.g. confidentiality and privacy 2. Commitment to improving access to services, e.g. ensuring that hospital fees do not create a barrier to access. 3. Support implementation of baby-friendly standards 4. Staff have authority to deliver essential care, including medications, according to standard protocols. 5. Patient rights are outlined 6. Use of companions during labour/delivery 7. Task-shifting in maternity and newborn wards 8. Communication and systems to assure continuity of care for postnatal follow-up, counselling and monitoring for mother and baby	1. Patient complaints 2. Informed consent 3. Infection prevention & control 4. Medication management 5. Equipment maintenance 6. Hand-over processes 7. Referral and transfer processes	1. Quality Improvement Program 2. Infection Prevention & Control Program 3. Staffing plans 4. Job descriptions 5. Procurement plan 6. Admission, birth, death & c-section registers 7. Maternal & perinatal death reviews 8. Indicator data 9. Medical records

Appendix 7. Policy and Procedures Review Tool

Facility Policies	Yes	No	Comments
1. Rights & ethics, e.g. confidentiality and privacy			
2. Commitment to improving access to services, e.g. ensuring that hospital fees do not create a barrier to access.			
3. Support implementation of baby-friendly standards			
4. Staff have authority to deliver essential care, including medications, according to standard protocols.			
5. Patient rights are outlined			
6. Use of companions during labour/delivery			
7. Task-shifting in maternity and newborn wards			
8. Communication and systems to assure continuity of care for postnatal follow-up, counselling and monitoring for mother and baby			
Policies and Procedures (Standard Operating Procedures)	**Yes**	**No**	**Comments**
1. Patient complaints			
2. Informed consent			
3. Infection prevention & control			
4. Medication management			
5. Equipment maintenance			

6. Hand-over processes			
7. Referral and transfer processes			
8. Quality Improvement Program			
9. Meeting Minutes of QI teams			
10. Staffing plans			
11. Job descriptions			
12. Procurement plan			
13. Admission, birth, death & c-section registers			
14. Maternal & perinatal death reviews			
15. Indicator data			
16. Medical records			

Appendix 8. Guidance to Develop Policies and Procedures

Purpose

To provide guidance in the development and management of policies and procedures (P&Ps)

Policy Statement(s)

1. Policies and procedures are written according to the format, approval process, and management of policies and procedures as outlined in this procedure.

2. Policies and procedures are reviewed and revised at least every two years and when there are changes to the policy or procedure.

Definitions

Coding: The process of assigning alphanumeric characters (letters with numbers) to a policy/procedure to guide in locating the policy

Index: An alphabetical listing of all policies and procedures maintained at the beginning of the P&P manual

Management: As applied to this policy, management of policies and procedures is the typing, storage, distribution, maintenance of a revision schedule, and ensuring policy owners are notified when a policy needs revision.

Policy and Procedure Manual: A collection of hardcopies of approved policies and procedures and supporting forms.

Policy: Statements that give direction to the organization on behavioral expectations, guidance on decision making, and parameters of authority

Policy Owner: The individual who developed and is responsible for maintaining the policy and procedure

Procedure: A list of steps to carry out an activity or perform a technical skill.

Responsibilities

Administrator:

- Reviews and approves all hospital-wide policies and procedures.
- Assures that each policy and associated procedures have been appropriately reviewed.
- Assures hospital-wide compliance.

Department Heads:

- Initiates, revises, reviews and approves all department-specific policies and procedures and assures compliance.
- Communicates all policies and procedures to department staff.
- Assures compliance with all policies and procedures.
- Maintains an ongoing monitoring procedure for timely review and update of policies and procedures.

Hospital staff:

- Recommend new policies/ procedures and revision to existing policies/proce dures to their department directors.
- Participate in policy and procedure development when requested.
- Comply with all policies and procedures.

Secretary to Administrator:

- Assigns hospital-wide policies and procedures numbers, and distributes new and revised policies and procedures.
- Makes sure all P&Ps are according to the standardized template and properly coded
- Obtains approval signatures of new and revised P&Ps
- Places hard copies of all P&Ps in the P&P manual
- Places an electronic copy in the P&P file on the shared drive
- Notifies policy owners when a policy needs revision
- Maintains an alphabetical index of all P&Ps

Equipment/Forms Required

Policy and Procedure Template
Relevant policy and procedure manual

Procedure

1. The need for a P&P is determined by the Quality team as may be required by law and/or for good practice.
2. The Team Leader assigns the policy owner.
3. The policy owner writes a draft of the P&P using the Policy and Procedure template.
4. Policies and procedures are prepared in the following manner:
   - 4.1 **Title:** Select a title that is accurate and short, which helps the reader identify what the contents are so that it can be easily accessed when needed.
   - 4.2 **Policy code/number**: Assign a code (policy category and number) so that it can be filed in a logical manner in the appropriate manual/section. See coding below
   - 4.3 **Policy owner:** Identify the person who writes the P&P and is responsible for revising it
   - 4.4 **Department:** Write in the department name for which this policy/procedure applies.
   - 4.5 **Applies to:** Indicate who the P&P applies to, e.g. all staff, nurses etc.
   - 4.6 **Effective date:** Indicate the date that the P&P will be put into effect.
   - 4.7 **Revision dates:** Each time a P&P is revised, enter the date the change was approved.
   - 4.8 **Approvals: Names/Titles** - Identify who needs to approve the P&P. The first signature will be the policy owner. The approvals will follow the chain of command with the highest ranking individual signing last.
   - 4.9 **Signatures/dates:** The approvers sign and date the P&P
   - 4.10 **Notes:** Indicate any information that may modify the P&P in any way or help those who the P&P applies to understand and implement the P&P
   - 4.11 **Purpose:** Indicate the reason that this policy/procedure is needed.
   - 4.12 **Policy Statement(s): –**Write one or more statements that defines limits of authority, and/or identifies responsibility and accountably for carrying out the P&P
   - 4.13 **Definitions –** Define terms to clarify understanding for the reader (when needed) – Many P&Ps will not require definitions.
   - 4.14 **Equipment/Forms -** List all equipment or forms required to carry out the procedure.
   - 4.15 **Procedure**
     a. Write the step-by-step procedure (Note: drawing a flow chart may be helpful).
     b. If steps are carried out by different people during the process, indicate who is responsible for each step.
     c. Limit sentences to 15 words or less when possible.
     d. Avoid using time-sensitive information, e.g. instead of referring to a specific person, use their position title.
     e. Have one or two employees who will be using the policy/procedure to review it to determine whether it is clear and accurate.
   - 4.16 **References –** List references if there is a specific source for the policy/procedure, e.g. a law/regulation or citation from the literature.
   - 4.17 **Footer –** Include the name of the P&P, the date of originating, and date of last revision. Enter the page number in the middle of the bottom of the page in the format of "X of Y", e.g. page 1 of 5.
5. The policy owner sends the policy to all committee members 1 week prior to meeting
6. The policy owner places the P&P on the meeting agenda for discussion and communication prior to finalization.
7. Once discussed and agreed, the policy owner sends the electronic version to the administrative secretary.

8. The administrative secretary reviews the P&P to determine that it is in the proper format, obtains the signatures of the policy owner, and others required.
9. The administrative secretary makes a hard copy for the manual, and places an electronic copy under P&P Manual.
10. P&P is approved and signed by the policy owner, the immediate supervisor of the policy owner.
11. The individuals responsible for approval of a policy sign the P&P in the space provided in the approval section of the P&P.
12. Upon approval, the policy owner develops and implements a plan to disseminate and communicate the policy/procedure.
13. The policy owner evaluates the effectiveness of the communication and implementation process.

Classification of P&Ps

Policies and procedure will be classified and grouped as:

Grouping	**Number prefix**	**Responsible Position**
Administrative	ADM	Administrator
Human Resources	HR	Human Resources Director
Patient Centered Care	PCC	Clinical Medical Officer
Infection Prevention and Control	IPC	Infection Control Focal Person
Environmental safety	ES	Administrator
Quality and Safety	QIS	Quality Improvement Focal Person

Numbering/Coding

1. Designate each topic with a prefix to be used; for example, policies that cover administrative policies and procedures are ADM.
2. Assign numbers to each policy and procedure in the order you have organized them. Make sure to use as many digits as necessary for the sake of uniformity. This will also prove beneficial when adding new policies later. For example, the first policy under the Administrative prefix might be designated policy number ADM-001.
3. Cross reference policies and procedures using their number designations.

Storage of P&Ps

Hard copies of finalized P&Ps are maintained in a P&P manual located in the relevant department.

Revisions

1. The administrative secretary maintains a log in an Excel format indicating the list of the P&Ps, the policy owner and the date from revision.
2. One month prior to the date for revision the administrative secretary notifies the policy owner by an e-mail that the P&P is due for revision.
3. The policy owner:
   2.1 Reviews the P&P to determine if any revisions are required.

Appendix 9. Treatment Guidelines/Clinical Protocol Review Tool

Date of Assessment:
Name of Assessor:
Name of Health Facility:

Instructions: Place a check (√) whether the protocol is present or not.
If the protocol is present, check to see if it is a current evidence-based protocol (referenced within past 5 years) or not.
Enter the date that the last review/revision. Note any additional comments.

Clinical Protocols	Present		Current evidence-based protocol		Date of last revision	Comments
	Yes	No	Yes	No		
1. Maternity admission assessment						
2. Monitoring of labour (partograph)						
3. Active management of third stage of labour						
4. Prolonged or obstructed labour						
5. Bleeding during labour						
6. Pre-eclampsia and eclampsia						
7. Immediate newborn care						
8. Newborn resuscitation						
9. Routine newborn postnatal care						
10. Newborn with signs of complications						
11. Routine maternal postnatal care & counselling						
12. Management of post-partum sepsis						

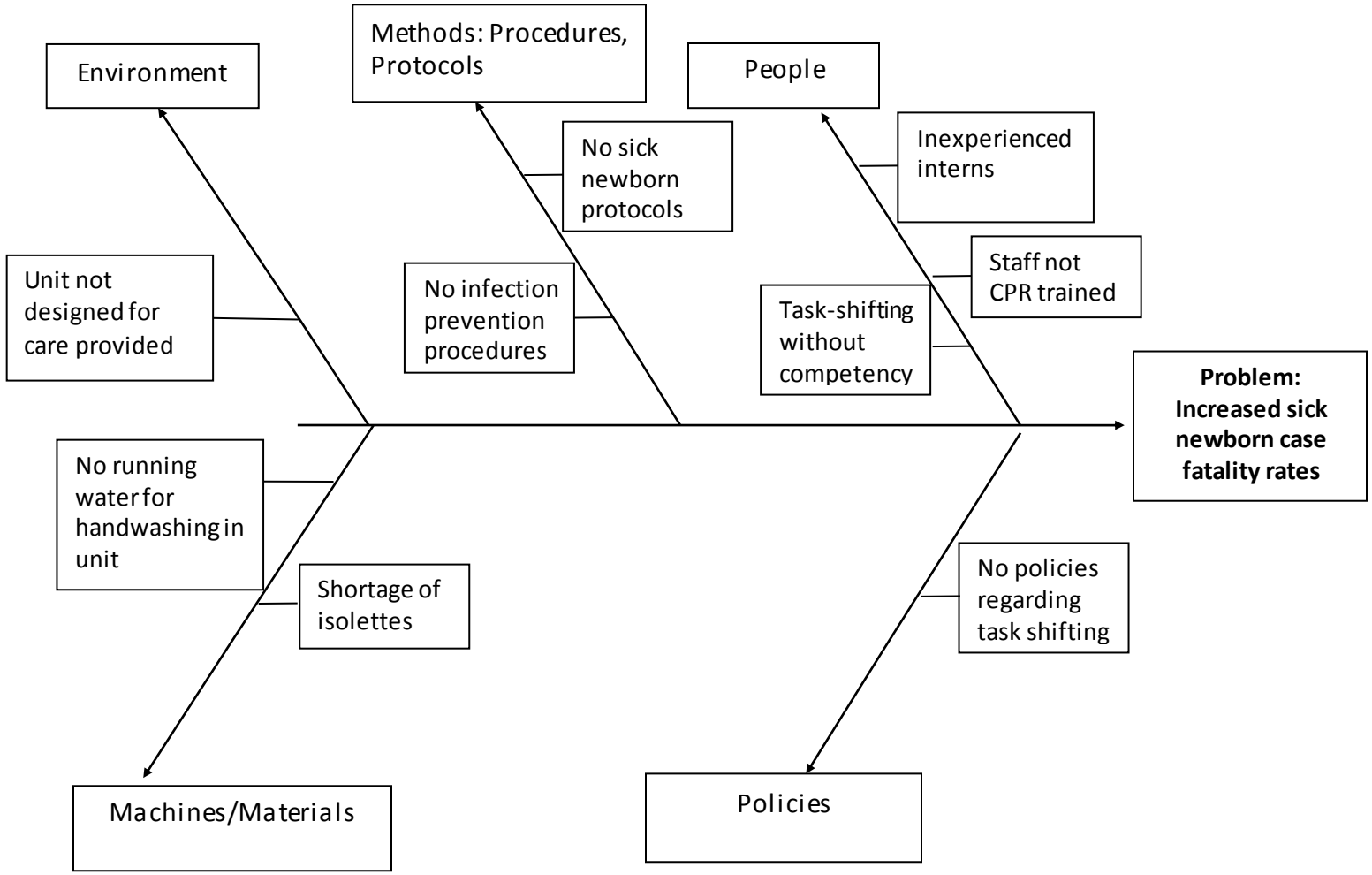
13. Management of post-partum hemorrhage						
14. Management of suspected newborn sepsis						
15. Preterm and low birth weight (LBW) babies						
16. Kangaroo Mother Care						

Appendix 10. Cesarean Section Surgical Site Infection Flow Chart

Flow charts allow the team to review each step in a process. In this example, the team was concerned about high post cesarean section infection rates. The beginning and end of a process is represented in circles and each step in-between is placed in a square. The example shows a high-level flow chart with columns under each step. The secondary flow chart (in the columns) includes interventions that may contribute to the development of a surgical site infection. The QI team reviews each of the interventions to consider which of these might be impacting the c-section surgical site infection rate at at their facility. The team then prioritizes the potential causes and identifies solutions to improving practice. At that point, the PDSA cycle is initiated.

Pre-op	Surgical Prep	Theatre	Ward	Discharge
Assessment to determine need for c-section	Surgical skin prep	Surgical scrub compliance	Surgical site care	Patient/family education regarding wound care and signs of infection
Determine antibiotic allergies		Appropriate peri-operative antibiotic prophylaxis	Handwashing compliance	
Bathe with antiseptic soap (when possible)		Ventilation – air exchanges, screens on windows	Isolation practices (when necessary)	
		Maintenance of surgical barrier and techniques	Dressing trolley cleaning & disinfection	
		Disinfecting respiratory therapy equipment		
		Sterilization of instruments & linen		

Appendix 11. Fishbone Diagram (Cause and Effect Analysis) Example



A **Fishbone Diagram** is another option to conduct an analysis of the root cause.

- Draw the diagram with a process arrow to the effect and draw a box around it, as shown above.
- Decide what the major categories of the causes are (i.e., people, machines, measurement, materials, methods, environment, policies, etc.).
- Label categories important to your situation. Make it work for you.
- Brainstorm all possible causes and label each cause under the appropriate category.
- Analyze causes and eliminate trivial (minor) ideas.
- Rank causes and circle the most likely ones for further consideration and study.
- Investigate the circled causes.

Appendix 12. Monitoring Activity Worksheet (Example)

NAME of HEALTHCARE FACILITY

Monitoring Activity

Topic: Medical Record Completeness	**Unit/Department:** Maternity

Background/Purpose

x High volume population
x High risk population
x Problem identified

□ New policy/procedure
□ New form

Why is monitoring this activity important? The hospital is striving to meet the EMEN standards; in that endeavor, various standards need to be met related to documentation. A medical record review showed incomplete documentation for several areas that involved both physicians and nurses.

Indicator (s)

Proportion of pregnant women admitted in labour who received an initial assessment by a skilled birth attendant (SBA)

Numerator: Pregnant women admitted in labour who received an initial assessment by a SBA
Denominator: Total number of pregnant women admitted in labour

Proportion of women for whom a partograph was completed correctly. (Source: adapted the Draft WHO Standard HFA Modules and Indicators)

Numerator: Number of partographs in which all required elements are documented (aggregated per element)

Denominator: Total number of partographs reviewed.

Methods

Data collection:

The method of data collection is a patient record review (closed and open review)

Sample size: Minimum 30 records

Data Collectors

The Committee members, composed of a multidisciplinary team (physician, midwife, nurse), conduct medical records review every first and third Tuesday of each month at 1:00 – 2:30 PM in the Medical Record Department.

A permanent (consistent) group of data collectors are selected who are knowledgeable about the medical record and have been trained in the data collection methodology. The collectors must be computer literate in EXCEL. Collectors may be nurses, midwives, physicians; and these individuals must be diligent in meeting this monthly accountability. The Department Chairman nominates

representatives from each department.

The Medical Record Department Head is responsible for training the data collectors. A sample of five records are selected each month for a quality check. Any differences in scoring need to be reviewed with the individuals who originally scored the record and the results of these audits should be reported to the Medical Record Committee as they may need to take additional actions, e.g. training.

Time frame

Data is collected every month. Data collection begins on the first day of each month; and ends on the last day of each month

Data Gathering

Abstract Coder:

1. Retrieve, randomly select*, and list the medical record numbers from the current month's medical record list, ensuring that all services are represented and the physicians' cases are equitably distributed.
2. Pull the records.
3. Place a medical record review form in each record.
4. Write the physician's code number and the diagnosis on the data collection form under "Type of Patient Record".
5. Place a tag on the top of the medical record folder indicating who is required to review each record (for you to place a check mark on each provider once the record has been completed).
6. Keep the records aside on a shelf with a labeled paper indicating "medical record review files" and the review date.

*Random selection can be achieved by selecting every second or third record from the list.

Secretary:

7. Email all reviewers 2 days ahead of the scheduled review date.
8. Inform the department secretary to remind them once again in the morning of the scheduled medical record review.

Data Aggregation

The Abstract Coder and/or a Secretary compiles the data. They are properly trained on how to count and tabulate the data manually using a blank review tool.
Once completed, each tallied entry is reviewed for accuracy, and then entered into the computer's EXCEL file that has been programmed to calculate the percentage per indicator and the overall percentage of compliance.

Analyzing and Reporting Data

Reports:

Reports for the previous month's inpatient, outpatient, and emergency records reviewed are sent to the Medical Record Committee, Quality Focal Person and the Hospital Director on the 10th day of the month.

The Hospital Director distributes the information to the appropriate individuals. For instance, the data related to physicians is forwarded to the Clinical Director; nursing data is forwarded to the Director of Nurses.

Analysis:

The results of the medical record review are analyzed/interpreted by the appropriate groups (physicians, nurses, other health care professionals). Actions are taken based on this analysis.

At what meetings will the results be shared?

Appendix 13. Communication Plan (Example)

Who needs the information?	What are the message(s)?	How will they be delivered?	Who will deliver them?	When will they be delivered?
District Health Team (DHT)	• DHT can support by learning QI methods & assisting with the baseline assessment	Monthly Meeting	UNICEF staff	March 10, 2016
Hospital leaders & maternity management	• Same as above • Implementation process • Track EMEN indicators regularly	• Meeting • EMEN Standards	UNICEF staff	March 13, 2016
Clinical staff	• Implementation process • Roles and responsibilities	• Meeting • EMEN Facilitation manual	Hospital and maternity management	March 14, 2016
Community Health Committee	• Community can assist in meeting the standards	Monthly Meeting	DHT & hospital leaders	March 18, 2016

TEMPLATES

Template 1. MCH Quality Improvement 2016-17 Dashboard Report

NAME OF HOSPITAL

LOCATION

Enter the percent achieved for indicators 1-9 for each quarter; enter the maternal, neonatal, stillbirth and c-section rates at the end of the year (4th quarter)

Quarterly reports due on March 31, June 30, October 31 and December 31. RED = below target GREEN = meets target

INDICATORS	2016 3rd Q	2016 4th Q	2017 1st Q	2017 2nd Q	2017 3rd Q	2017 4th Q
1. Birth registration						
2. Essential newborn care						
3. Antenatal corticosteroid use						
4. C-section surgical site infections						
5. Newborn resuscitation						
6. Treatment neonatal sepsis						
7. Handwashing						
8. Patient satisfaction						
9. Documentation of partograph						
Maternal Mortality Rate						
Neonatal Mortality Rate						
Stillbirth Rate						
C-section rate						

Template 2. Meeting Agenda

Date:

Venue:

Meeting Roles
Host:
Facilitator:
Timekeeper:
Refreshments:
Note-taker:
Delegates for absent members:

Meeting Objectives:

1.
2.
3.
4.

Next Meetings dates and places:

Agenda:

Time	Item	Type of Action	Decision Required

Template 3. Assessment Scoring (Excel Sheet)

Every Mother Every Newborn Assessment Tool				
Standards and Criteria				
Instructions: Enter scores for each question on the assessment tool in the cells, using the key below: **Scoring Key:** 0 = no, the element does not meet the criterion 1 = yes, the element fully meets the criterion		**Baseline** **DATE:**	**DATE:**	**DATE:**
		Score	**Score**	**Score**
Labour and Childbirth				
Standard 1	**Evidence-based safe care is provided during labour and childbirth.**			
	Normal Care: Mother			
1.1	The pregnant woman's general condition & emergency signs are assessed upon arrival.			
1.2	The progress of labour is regularly monitored using a partograph.			
1.3	Every woman receives oxytocin immediately after birth of the baby.			
	Complications: Mother			
1.4	Parenteral magnesium sulphate is administered for signs of pre-eclampsia and eclampsia.			
1.5	Women in preterm labour receive appropriate interventions for both the woman and the baby according to evidence-based guidelines including use of antenatal corticosteroids for eligible mothers.			
1.6	Women with delay in labour progress, or prolonged or obstructed labour receive appropriate interventions according to evidence-based guidelines.			
1.7	Women with ante-partum haemorrhage (APH) receive appropriate interventions according to evidence-based guidelines.			
	Immediate Newborn Care			
1.8	Essential newborn care is provided according to current evidence-based guidelines.			
1.9	Breastfeeding is initiated within one hour after birth.			
	Complications: Newborn			
1.10.	Newborn resuscitation is initiated without delay in the newborn not breathing spontaneously at birth.			
1.10.1	The newborns receives additional stimulation.			
1.10.2	Positive pressure ventilation with bag and mask is initiated			
Total	Highest Possible = 12	0	0	0
	Percent achievement	**0.0%**	**0.0%**	**0.0%**
Postnatal Care				
Standard 2	**Evidence-based safe postnatal care is provided for all mothers and the newborns.**			
	Routine Postnatal Care			

2.1	Healthy mothers and newborns stay in the facility and receive postnatal care (PNC) for at least 24 hours after birth			
	Complications: Postnatal (mother and newborn)			
	Mothers			
2.2	Current evidence-based protocols are carried out for management of post-partum sepsis.			
2.3	A current evidence-based protocol carried out for the management of post-partum hemorrhage.			
	Newborns			
2.4	Kangaroo mother care is initiated early in the first week of life for babies with birth weight <2000 g and clinically stable: a) skin to skin, b) infant supported for breast feeding, 3) mother receives additional support.			
2.4.1	The infant is kept skin-to-skin with the mother in kangaroo position.			
2.4.2	The infant is supported for feeding breast milk.			
2.4.3	The mother receives additional support to establish breastfeeding.			
2.5	A newborn with signs of complications is managed or referred for further management.			
2.6	Antibiotics are administered for management of suspected newborn sepsis.			
2.7	Supportive care is provided to sick newborns.			
Total	Highest Possible = 10	0	0	0
	Percent achievement	**0.0%**	**0.0%**	**0.0%**
	Patient Rights			
Standard 3	**Human rights are observed and the experience of care is dignified and respectful for every woman and newborn.**			
3.1	A process is in place for women and families to express concerns.			
3.2	All women have informed choices in the services they receive, and the reasons for interventions or outcomes are clearly explained.			
3.3	Every woman is offered the option to experience labour and childbirth with a companion of her choice.			
3.4	No woman or newborn is subjected to mistreatment such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services.			
3.5	No woman or newborn is subjected to unnecessary or harmful practices during labour, childbirth and the early postnatal period.			
3.5.1	No unnecessary I/V line a routine			
3.5.2	No episiotomy unless medically indicated.			
3.5.3	No unnecessary cesarean section			
Total	Highest Possible = 9	0	0	0
	Percent achievement	**0.0%**	**0.0%**	**0.0%**
	Governance			
Standard 4	**A governance system is in place to support the provision of quality maternal and newborn care.**			
4.1	Every health facility has managerial and clinical leadership collectively responsible for creating and implementing appropriate policies and plans to meet the needs of women, newborns and staff.			
4.2	An effective quality improvement program is present.			
4.2.1	functional quality teams			
4.2.2	QI action plans			
4.2.3	QI mentoring/coaching			

4.2.4	capturing & use of data			
4.2.5	monitoring and evaluation			
Total	Highest Possible = 7	0	0	0
	Percent achievement	**0.0%**	**0.0%**	**0.0%**
	Physical Environment			
Standard 5	**The physical environment of the health facility is safe for providing maternal and newborn care.**			
5.1	Services available are clearly displayed.			
5.2	An infection prevention and control program is in place to reduce health care-associated infections.			
5.2.1	Infection prevention and control focal person			
5.2.2	Formation of hygiene and IPC committee			
5.2.3	Development of hygiene and IPC plan including water supply, excreta management and hand washing			
5.2.4	Infection reporting system (surveillance); monitoring of caesarean section and neonatal sepsis rates			
5.2.5	Hand hygiene monitoring			
5.2.6	Adequate supplies in all clinical areas: PPE, waste bins, soap/disinfectant, sharps container			
5.2.7	Adequate facilities and logistics for final waste management, e.g. incinerator, burial pit.			
Total	Highest Possible = 9	0	0	0
	Percent achievement	**0.0%**	**0.0%**	**0.0%**
	Qualified and Competent Staff			
Standard 6	**Qualified and competent staff are available in adequate numbers to provide safe, quality mother and newborn care.**			
6.2	Skilled birth attendants (SBA) are available on site 24 hours/7 days a week.			
6.3	Staff has the qualifications, knowledge and skills to implement high impact MNH interventions.			
Total	Highest Possible = 2	0	0	0
	Percent achievement	**0.0%**	**0.0%**	**0.0%**
	Medications, Supplies, Equipment & Diagnostic Services			
Standard 7	**Essential medications, supplies, functional equipment and diagnostic services are consistently available to provide mother and newborn care.**			
7.1	Medications are available, well-organized and within expiry date and no stock outs within past 3 months.			
7.1.1	Pharmacy			
7.1.2	maternity ward			
7.1.3	neonatal ward			
7.2	Essential equipment and supplies are available to carry out the clinical protocols without interruption.			
Total	Highest Possible = 5	0	0	0
	Percent achievement	**0.0%**	**0.0%**	**0.0%**
	Health Information Systems			

Standard 8	**Health Information systems are in place to manage patient clinical records and service data.**			
8.1	Registers are kept that contain complete data .			
8.2	Patients' medical records are thoroughly and accurately completed.			
8.3	Critical data for key indicators is collected and validated related to labour, childbirth and the postnatal period.			
8.4	The data is analysed by users and routinely used to make clinical and management decisions.			
Total	Highest Possible = 4	0	0	0
	Percent achievement	**0.0%**	**0.0%**	**0.0%**
Continuity of Care				
Standard 9	**Services for mother and newborn care are available to ensure continuity of care.**			
9.1	Communication and systems are in place to assure continuity of care for postnatal care follow-up, counselling and monitoring for mother and baby.			
9.2	For every woman and newborn needing referral, the referral follows a pre-established plan that can be implemented without delay at any time.			
9.3	Reliable communication methods are operational including mobile phone, landline or radio for referrals and consultation on complicated cases.			
Total	Highest Possible = 3	0	0	0
	Percent achievement	**0.0%**	**0.0%**	**0.0%**
Overall Achievement of Standards		**0.0%**	**0.0%**	**0.0%**

Template 4. Policy and Procedure

<table>
<tr><td rowspan="4">LOGO

Name of Facility
Address</td><td colspan="3">Title:</td></tr>
<tr><td>Policy code/number:</td><td>Effective date:</td><td>Revision date:</td></tr>
<tr><td>Department:</td><td colspan="2">Applies to:</td></tr>
<tr><td>Responsible person:</td><td>Approvals:
Names/titles</td><td>Signatures/dates:</td></tr>
<tr><td colspan="4">Purpose:

Policy Statement(s):

Definitions:

Equipment/Forms:
1.

Procedure:

1.

References:
1.</td></tr>
</table>

Template 5. Clinical Record Review Tool

Instructions:
Each month, select at least 30 patient records from the maternity department and the associated newborn record. Include records of women and newborns that experienced a normal delivery, experienced complications and those that were transferred. Review the records as a team of at least 3 including a midwife, nurse and physician.

Column one identifies the standard number and topic; column two lists the documentation requirements. This document is designed for the review of three (3) records. For each medical record reviewed, enter the medical record number (MR#) and for Normal Vaginal Delivery (NVD), C-Section (CS), Assisted Delivery (AD) and other diagnosis for obstetric complications and newborn complications (DX) and then, for each requirement indicate with a checkmark whether the documentation was present (Y), not present (N) or not applicable (NA). For further clarity of the expectation, refer to the assessment tool.

To complete this form, several additional documents are needed as follows:

- Informed consent policy and procedure
- Medical and nursing assessment policies and procedures
- Policy and procedure of care
- Protocols
  - Newborn Resuscitation
  - Pre-Eclampsia and Eclampsia
  - Post-partum Hemorrhage
  - Prolonged and/or Obstructed Labour
  - Newborn Complication

Standard	Documentation Requirement	Medical Record # Dx:			Medical Record # Dx:			Medical Record # Dx:			Comments
		Y	N	NA	Y	N	NA	Y	N	NA	
Standard #1 The health facility provides evidence-based safe care during labour and childbirth for the mother and the newborn	Were the following assessment findings documented at the time of admission Check for danger signs: • bleeding vaginally • convulsing now or history • looking very ill • unconscious • in severe abdominal pain • headache and visual disturbance • severe difficulty breathing • Sever • Severe vomiting.										
	• Foetal heart sounds										
	• Blood pressure										
	• Temperature										
	• Abdominal assessment										
	• Obstetric history										
	• Medical and surgical history										
	• Pelvic examination										
	Partograph										
	• Name of client										
	• Age										
	• Gravida/Para										
	• Time of Admission										
	• State of membranes										
	• Foetal heart rate every half an hour										

	• Colour of the liquor										
	• Molding at each cervical examination										
	• Partograph started with the cervix was ≥ 4 cm										
	• Blood pressure every 4 hour or more frequently if indicated										
	• Maternal pulse rate every half hour										
	• Cervical dilatation every four hour										
	• Descent of head every four hour										
	• Uterine contractions assessed every half an hour										
	• Hour and time documented correctly										
	• Temperature every 4 hour										
	• Protein, acetone, and volume: Record when urine is passed										
	• Physician order for medication or fluid										
	• Medication or fluid given recorded										
	• Medication used: Oxytocin for active management of third stage of labour										
	• Outcome of the baby										
Pre-term Labour	Is either intramuscular (IM) dexamethasone or IM betamethasone (total 24 mg in divided doses) given when preterm birth is imminent?										
Prolonged or obstructed	Were women with prolonged or obstructed labour managed according to current evidence-based protocols?										
	Was an IV inserted & fluids administered to women experiencing prolonged or obstructed labour?										

	Women with prolonged or obstructed labour immediately referred to a facility with c-section capabilities?										
	Were antibiotics administered to women with labour past 24 hours?										
Standard #2 Evidence-based safe postnatal care is provided for all mothers and the newborns.	**Routine Care Postnatal Care (Uncomplicated vaginal birth)**										
	Are the postnatal assessment sheets for mother and her newborn completed? Mother: - Vaginal bleeding - uterine contraction - fundal height, - temperature and heart rate (pulse) routinely during the first 24 hours starting from the first hour after birth. - Blood pressure should be measured shortly after birth. - If normal, the second blood pressure measurement should be taken within six hours. - Urine void should be documented within six hours MONITOR MOTHER EVERY 15 MINUTES and MONITOR MOTHER AT 2, 3 AND 4 HOURS, THEN EVERY 4 HOURS: Baby: - stopped feeding well, - fast breathing (breathing rate ≥60 per minute), - severe chest in-drawing, - no spontaneous movement,										

	- fever (temperature ≥37.5 °C), low body temperature (temperature) - Jaundice within 24 hours										
	Complications: Postnatal (mothers and newborns)										
	Women with postpartum haemorrhage managed according to current evidence-based protocol Look for the cause of bleeding and manage accordingly. In case of atonic uterus: - Massage uterus and expel clots - Give oxytocin and - Give Misoprostol if oxytocin is not available or bleeding does not respond oxytocin - Give ergometrine if bleeding persists (DO NOT give if eclampsia, pre-eclampsia, hypertension or retained placenta (placenta not delivered). - If heavy postpartum bleeding persists despite uterine massage, oxytocin/ergometrine treatment and removal of placenta. - If bleeding persists, apply aortic compression and transport woman to hospital. (ref: PCPNC 2015)										
	Were women with any of the following										

	treated for PPH: • that required treatment for haemorrhage (intravenous fluids, uterotonics or blood) • retained placenta • severe bleeding from lacerations (vaginal or cervical) • vaginal bleeding in excess of 500ml after childbirth more than one pad soaked in blood in 5 minutes										
	newborn with signs of complications										
	Newborns with signs of complications managed or referred for further evaluation according to protocol?										
	Were the risk factors for neonatal infection assessed, including: • membranes ruptured > 18 hours before delivery • mother had fever > 38ºC before delivery or during labour • amniotic fluid was foul smelling or purulent?										
	Were newborns with the following signs of infection treated according to current evidence-based guidelines:										
Standard #3 Human rights are observed and the experience of care is dignified and respectful for every woman and newborn.	If the woman had a c-section, is there a signed consent for surgery (exception: emergency)?										
Standard # 4 A governance	Meeting minutes of QI teams										

system is in place to support the provision of quality maternal and newborn care.	QI action plans										
Standard # 5 The physical environment of the health facility is safe for providing maternal and newborn care.	Hand hygiene monitoring and infection surveillance records (data collection, infection rates).										
Standard #6 Qualified and competent staff are available in adequate numbers to provide safe, consistent and quality maternal and newborn care**.**	When staffing levels do not meet the needs, is there a policy and procedure that describes actions to be taken, e.g. reassign staff, on-call staff?										
	Review the duty roster to determine whether birth attendants are scheduled 24/7										
	Staffing norms/plan										
	Staff training plans										
	Staff records, e.g. certificates, qualifications										
Standards # 7 Essential medications, supplies and functional equipment and diagnostic services are consistently available for maternal and newborn care.	Are medications stored using first expired/first out rules?										
	Stock outs occurred in the last three months: Calculate the number of stock outs in past 100 days.										
	Procurement plan & process documents										
	Stock outs										
	Stock records										
	Inventory list										
	Maintenance schedule/ records										

Standard # 8 Health information systems are in place to manage patient clinical records and service data.	Do the relevant registers contain complete data regarding selected items (see list under criteria and/or locally defined register items)? **<u>Mother</u>** • Age										
	• Residence/village										
	• Admission, delivery and discharge times • PMTCT (if relevant)										
	•										
	• Mode of delivery										
	• Caesarean sections (elective or emergency)										
	• Delivery attendant										
	• Number of spontaneous vaginal deliveries, vacuum extraction, forceps										
	• Total deliveries										
	• Complications										
	• Expected postpartum visit date •										
	<u>Newborn</u> • Apgar score										
	• Gestational age										
	• Sex										
	• Birth weight										
	• Outcome of the delivery: live births greater than or equal to 2.5kg										
	• Still births										

	• Low birth weight babies:										
	• Total newborn outcomes for facility births										
	• Infant feeding (breastfeeding initiation and at discharge)										
	• Neonatal deaths occurring within the first 24 hours										
	• Birth notification **<u>Referrals</u>** • Referrals <u>out</u> due to obstetric indications										
	• Referrals <u>out</u> due to newborn complications										
	Do the medical records contain all the following: • Reason for admission										
	• Significant findings, including investigations										
	• Procedures performed										
	• Diagnoses made										
	• Relevant protocol followed										
	• Medications or other treatments										
	• Patients condition at discharge										
	• Follow-up instructions and all discharge medications that the patient is to take following discharge.										
	• Other items relevant to context or medical record type (e.g., HIV status in high prevalent area or partograph in maternity labour delivery record)?										
	Has the data for key indicators been										

	collected and validated (complete and accurate) related to labour, childbirth and the postnatal period?										
	Has the reports been signed off by the in-charge or information technology officer?										
	Data charts or scorecards										
	Management meeting minutes										
Standard # 9 Sufficient dugs, supplies and equipment are available to provide mother and newborn care.	Policies and procedures for continuity of care										
	Postnatal visit reports										
	Referral policy and procedure										

Template 6. The 5 WHYs Worksheet (Root Cause Analysis)

Define the Problem: *(Insert one of the top prioritized student needs)*

Why is it happening? *(Identify each as a concern, influence or control.)*

1. → Why is that? ↓

2. → Why is that? ↓

3. → Why is that? ↓

4. → Why is that? ↓

5. → Why is that? ↓

Caution: *If your last answer is something you cannot <u>control</u> go back up to previous answer.*

**(Provided as a free template by The IPL L*

Template 7. Quality Improvement Action Plan

Name of the health facility_____ Date_____

Standard # and gap identified	Solutions	Actions Next Steps	Resources Required	Responsible Person	Deadline

Template 8. Monitoring Activity Worksheet

NAME of HEALTHCARE FACILITY	
Monitoring Activity	
Topic:	**Unit/Department:**

Background/Purpose

□ High volume population
□ High risk population
□ Problem identified
□ New policy/procedure
□ New form

Why is monitoring this activity important?

Indicator (s)

Operational definition:

Numerator:
Denominator:

Methods

Data collection:
- □ Patient record review
- □ Observation
- □ Questionnaire
- □ Survey
- □ Focus group
- □ _____

Sample size: _____
Method for selecting sample:

Process for data collection:
Who is going to collect the data?

How is the data to be collected?

Time frame:
Data collection will begin:

How often will data be collected?

Data collection will end:

Analyzing and Reporting Data

Analysis

Who will compile the data?

What method of analysis will be used?

Reports

Who will write the report of the findings?

Who needs a copy of the report?

At what meetings will the results be shared?

Template 9. PDSA Worksheet for Testing Change

Aim: (overall goal you wish to achieve)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	**Person responsible**	**When to be done**	**Where to be done**

Plan

List the tasks needed to set up this test of change	**Person responsible**	**When to be done**	**Where to be done**
		.	

Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**

Do **Describe what actually happened when you ran the test**

Study **Describe the measured results and how they compared to the predictions**

Act **Describe what modifications to the plan will be made for the next cycle from what you learned**

http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet