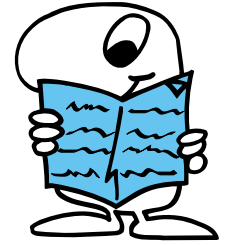


## Initiative for Sub-District Support



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# 4 Key Components of a Successful Perinatal Audit Process

File for quick reference

## The Issue

All available evidence points to the importance of an effective audit process in improving the quality of maternal health services and lowering the Maternal Mortality and Perinatal Mortality Rates. The audit process can be located at the district or the sub-district level, and usually takes place in the District Hospital. What are the key steps to implementing an effective audit process? This publication aims to answer this question by looking at the following four crucial activities which comprise an effective perinatal audit process:

### 1. Review of each perinatal and maternal death within 24 hours of the death

#### Purpose of the review:

- To ensure the accurate and complete record of information while the details are still fresh in the memories of all involved
- A preliminary assessment of:
  - The primary cause of death
  - The final cause of death
  - Preventable factors

This review should be carried out by the midwife and doctor in charge of the maternity unit. To ensure completeness of the data collection we recommend the use of the form in Appendix A.

### 2. Preparatory review meeting

The quality of this preparatory review is critical to the level of accountability and to the value of the subsequent Perinatal Review Meeting (PRM). There is insufficient time at a PRM to carry out review of the outcomes of all the pregnancies in one month. Therefore preparatory review meetings need to be carried out and a summary prepared for presentation to the PRM. This is the responsibility together of the midwife collecting the data and the doctor and midwife in charge of the maternity services in the sub-district. This meeting is held a few days before the monthly PRM.

At the preparatory review meeting the following is done:

- The perinatal statistics for the month are reviewed and interpreted. Included in this review will be an analysis of changing trends in the Key Indicators and also the indications for all caesarean sections. The statistics reviewed should be recorded on the form in Appendix B
- Each maternal and perinatal death is studied to determine the primary and final causes of death
- Each maternal and perinatal death is studied carefully to detect preventable factors (missed opportunities) and to ascertain how to improve future management. It is useful to classify preventable factors under the following headings:

- Health Worker related: where doctor or midwife did/did not do something which had a direct influence on the perinatal death (e.g. no action taken to treat syphilis in pregnancy)
  - Administration related: where something that is the responsibility of the health authority was not available (e.g. no fax to send back blood results)
  - Patient related: where a woman by doing/not doing something contributed to the perinatal death (e.g. not booking)
- The above information for each maternal and perinatal death should be recorded and prepared in table form for presentation at the Perinatal Review Meeting
  - Usually it will not be possible to spend sufficient time on each perinatal death at the monthly PRM, so one or two should be selected for detailed presentation. The criteria for selection of perinatal deaths to be presented at the PRM are:
    - contains factors that are directly/indirectly preventable by the service
    - has educational value
    - the issue has not been reviewed recently
  - The case studies chosen for presentation at the PRM should form the basis of a more detailed discussion of the obstetric topic that they illustrate
  - The protocols of management should be reviewed to decide whether any up-dating is necessary
  - Twice a year a summary of the primary and final causes of maternal and perinatal deaths and their preventable factors should be presented to the Perinatal Review Meeting for review and considered action
  - Twice a year a survey of patient satisfaction and also of staff satisfaction should be conducted and the results of these should be presented at the PRM

### 3. Monthly Perinatal Review Meeting (PRM)

#### The purpose of the PRM:

- To review the perinatal statistics for the month under review
- To review the causes and preventable factors in the perinatal deaths
- To determine corrective action
- To advance the education and learning of health workers in the maternal health services by reviewing one or two perinatal deaths in detail
- To review all maternal deaths

#### Who should attend the PRM?

- Doctors and midwives working in the antenatal clinic, maternity and the neonatal nursery in the hospital or community health centre
- midwives in charge of clinics in the sub-district
- representative from the hospital management
- community health facilitators (CHF) who supervise and train the community health workers (CHWs)
- social worker
- Midwives from all outlying clinics may not be able to attend, but there does need to be a mechanism of providing information for those unable to attend (e.g. through circulation of the minutes of the meetings)

#### How to attract attendees?

It has to be made clear that accountability through attendance and participation is not an option but is the professional responsibility of health workers involved in maternity services. Quality participation only occurs if the organisers ensure that the meeting is attractive and meets the expectations of all the participants.

This means that all contributions are welcomed and valued and that no witch hunting takes place. Probing discussion has to be based on an acceptance of each other's integrity and best intentions and a readiness by all to build on the stories of successes as well as failures.

The PRM is meant to be primarily an educational experience for all the participants. It is a team building exercise and **not** a disciplinary hearing.

## Time

This meeting should be scheduled for once a month on a set day, with a duration of at least one and a half hours. If the meetings are to be valuable each participant needs to give attendance at the PRM their top priority and make sure that they attend. Draw up a schedule for the year and stick to it.

## Conducting the meeting

The effectiveness of the Perinatal Review Meeting (PRM), and therefore its sustainability, is dependent on the skill and experience of the chairperson. For this reason, when PRMs are being commenced for the first time, it is a good idea for an outside trainer to offer to chair the first few meetings. However, as soon as possible, the local chairperson should be encouraged to take over, with guidance from the trainer. The following guidelines will assist the new chairperson.

➤ **Provide an agenda for the meeting.** This will usually take the following form:

- Presentation of statistics, using the form in Appendix B, for the month under review - by the midwife who collected the statistics for that month
- Discussion of the statistics  
The chairperson can ask a number of questions. Examples of these are:

*Have the figures been analysed? (e.g. developed into rates; compared across time; compared with other sub-districts; compared booked and unbooked cases)*

*What do the figures mean?*

*What do they say about the quality of the service?*

- Brief discussion of a summary of each of the perinatal deaths using the information recorded on the form in Appendix A.
- Case presentation
- Discussion of the case presentation

The chairperson can ask some questions to stimulate discussion. Examples are:

- *Is the information sufficient (i.e. documentation of sufficient assessments, findings, decisions to enable adequate discussion of the case)?*
- *Does the documentation indicate accurate findings and decisions?*
- *What interpretations can we make about the primary cause of death, the final cause of death,*

*preventable factors (related to health worker, administration, family)?*

- *What decisions need to be made about future practice?*

- Probe all preventable factors. Keep asking 'but why?' until you get to the root of each problem
- Consider carefully how to deal with problems and plan corrective action
- In addition to reviewing clinical problems, probe whether the patient has received quality counselling and that adequate follow-up has been instituted
- Take time to discuss the lessons that arise from the case studies presented

Review decisions taken as recorded in the minutes of the last meeting

- Provide all present with relevant photocopies, graphs and labour graphs. If these can be circulated 24 hours before the PRM then participation in discussion is greatly improved
- Provide up to date information on the topics being discussed. It might be possible to have a consultant present who can provide this, otherwise someone should be chosen to do some reading on the subject, for presentation at the next PRM
- Keep minutes and check whether decisions taken at previous meetings have been carried out. **It is important that lessons learnt result in an improved service**
- Keep a list of items that need further research. Assign topics to pairs of members present and set a date for their report back.

#### CHALLENGES TO BE MET:

- **How to bridge the gap when there is limited mutual respect between doctors and nurses?**

This calls for an intention from **both** professional groups to develop that respect based on an understanding of mutual dependence and appreciation for each other's role. Where problems arise, these need to be settled by discussion on the same day and not left to escalate. To this end chairing of the PRM should rotate among doctors and nurses.

- **How to review the indications for caesarean section and at the same time retain a good, supportive relationship between doctors and midwives?**

Doctors often feel the insecurity of limited experience in the face of what feels like excessive criticism from midwives of long standing. This can only be resolved on the basis of a spirit of acceptance of each other's professional integrity. At the end of the day, one person has to take responsibility for the final clinical decision, and that has to be the doctor. Where relationships are good, it should be possible to reflect on these decisions in a supportive way that always seeks improved practice by the whole team.

#### 4. Quarterly or 6-monthly epidemiological analysis of perinatal and maternal deaths

- It is not likely that there will be sufficient maternal and perinatal deaths to make possible a study of trends on a monthly basis. This is best done quarterly or six-monthly. The information to be reviewed should include the following:

- The primary causes of maternal and perinatal deaths
- The final causes of maternal and perinatal deaths
- The preventable causes of these deaths.

The information can either be analysed and presented in tables and graphs using pen and paper, or the Perinatal Problem Identification Programme (PIIP) computer software can be used. If the PIIP is to be used, it will be essential to study the relevant literature and to obtain the software programme.

#### LITERATURE

- The Perinatal Problem Identification Programme software and manual. This is prepared by the MRC Maternal and Infant Health Care Strategies Research Unit.
- Obstetrics in Peripheral Hospitals by Jon Larsen. Published by DEPAM, 1998
- Perinatal Education Programme. Manual 1, Maternal Care.

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Please feel free to contact us and to visit our website at [www.hst.org.za](http://www.hst.org.za)

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This Kwik Skwiz is published by the Health Systems Trust and funded by the Kaiser Family Foundation

*Designed and printed by The Press Gang – Tel: 031 307 3240*