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Maternal, Child & Women's Health (MCWH)

INTERNAL CIRCULAR

Date: 12 November 2019	File No: 29/9/P
To: CEOs OF ALL HOSPITALS AND CHCs WHICH PROVIDE CARE FOR CHILDREN, WOMEN IN LABOUR AND THEIR NEWBORN cc. Head Office Directors District Health Directors District Clinical Specialist Team Members	Circular No: G142/2019

Subject: Minimum Requirements For Audit Of Adverse Outcomes In Maternal, Perinatal And Child Care

1. Objective.

To reduce maternal, perinatal and child morbidity and mortality in KZN by ensuring that all health facilities comply with minimum requirements for audit of adverse outcomes in maternal, perinatal and child care.

2. Background.

The necessity of monitoring adverse incidents in maternal, perinatal and child care with a view to improving the quality of care and preventing recurrence has long been accepted in our Department of Health. The importance of such audit processes has been further emphasized by the creation of three national ministerial committees for reviewing maternal, perinatal and child mortality and morbidity, namely the NCCEMD, NaPeMMCo and CoMMiC. These committees draft national recommendations for improving the quality of maternal, perinatal and child care, which, once approved by the National Minister, are then disseminated to the Provinces for implementation.
Whilst national recommendations provide general guidance, it is also essential for each individual facility to perform regular and routine audit of its own maternal, perinatal and child-related adverse

events. This is so that facility-specific problems and deficiencies can be identified and addressed without delay.

Having functional audit processes for maternal, perinatal and child care at every facility has become all the more important and urgent in recent years due to the huge increase in the numbers of litigation claims made against the Department of Health. By far the biggest burden of litigation comes from claims relating to disabled children where the care around the time of birth is alleged to have been negligent. This makes it particularly important to include audit of all neonatal encephalopathy cases in the routine facility-based audit processes, which is something that may not have been done in the past.

Whilst all facilities in KZN probably do conduct maternal, perinatal and child audit at some level, there is no doubt a wide variability in the functionality of these processes. In particular, even where remediable gaps in care are identified, there may be failure to document an action plan to address the problem, or failure to follow through on the action plan.

In order to guide CEOs, this circular lists the minimum requirements for maternal, perinatal and child audit for all Department of Health Hospitals and Community Health Centres. Over and above these minimum requirements, more detailed audit and quality improvement programmes are encouraged where this is feasible to conduct and will add extra value.

3. Minimum Requirements For Maternal, Perinatal And Child Audit.

Definitions

- Debriefing – informal enquiry, with staff present at the time of the adverse incident, to clarify details of the incident and identify any health systems failure that requires immediate correction – e.g. medical officer did not come when called; no resuscitation trolley; stock outs of drugs or surgical supplies.
- Audit – formal systematic review of the adverse incident and the circumstances leading up to it, with staff caring for the patient during any period relevant to the adverse event. Avoidable / modifiable factors at any level in the health system must be identified.

Note: The debriefing and audit could be conducted at the same sitting if the relevant staff and records are available. However, the debriefing must be done soon after the adverse incident while more time may be required to prepare for the audit (e.g. both the obstetric and neonatal team need to be available to audit a neonatal death or neonatal encephalopathy case; information may need to be obtained from a referring facility).

Subject: Minimum Requirements For Audit Of Adverse Outcomes In Maternal, Perinatal And Child Care.

Maternal Death (death occurring anytime during pregnancy and within the first 6 weeks post-delivery)

- Every maternal death must be reported to the top facility management by the next working day.
- Debriefing of the staff present at the time of death must occur within the next working day.
- Every maternal death must be audited within a week.
- In addition to the "internal" facility audit, there is a legal requirement that every maternal death be notified to the Provincial Maternal Health Office for the purpose of the National Confidential Enquiry into Maternal Deaths.

Stillbirth (birth of a dead baby ≥500g)

- Debriefing of the staff present at the time of delivery must occur within the next working day.
- Every stillbirth must be audited within a week.
- Every stillbirth must be entered into the PPIP (Perinatal Problem Identification Programme).

Neonatal Death (baby born alive ≥500g, who dies within the first 28 days of life)

- Every neonatal death must be reported to the top facility management by the next working day.
- Debriefing of the staff present at the time of death must occur within the next working day.
- Every neonatal death must be audited within a week. This audit must involve a joint review by both the obstetric and the neonatal care teams at the facility.
- Every neonatal death must be entered into the PPIP.

Neonatal Encephalopathy cases (any case where a diagnosis of neonatal encephalopathy is made according to clinical findings; includes cases where the final outcome is death)

- Every case of neonatal encephalopathy must be audited. This audit must involve a joint review by both the obstetric and the neonatal care teams at the facility.
- Neonatal encephalopathy cases are not captured in PPIP unless the outcome is a neonatal death. There will therefore be a need for a separate monthly summary of the neonatal encephalopathy cases.

Child deaths (death of a child <13 years)

- Every child death must be reported to the top hospital management by the next working day.

Subject: Minimum Requirements For Audit Of Adverse Outcomes In Maternal, Perinatal And Child Care.

- Debriefing of the staff present at the time of death must occur within the next working day.
- Every child death must be audited within a week.
- Every child death in the paediatric ward (including neonates who die in the paediatric ward) must be entered into the Child PIP (Child Healthcare Problem Identification Programme).

PPIP (Perinatal Problem Identification Programme)

- One or more PPIP champions should be identified amongst the health workers at the facility. The PPIP champion must ensure that the PPIP database is kept up to date (monthly data entry is recommended and data must be backed up).
- PPIP data analysis of the most common causes of perinatal death and the most common avoidable factors contributing to those deaths with trends should be conducted at least every 6 months.

Child PIP (Child Healthcare Problem Identification Programme)

- One or more Child PIP champions should be identified amongst the health workers at the facility. The Child PIP champion must ensure that the Child PIP database is kept up to date (monthly data entry is recommended and data must be backed up).
- Child PIP data analysis of the most common causes of child death and the most common modifiable factors contributing to those deaths with trends should be conducted at least every 6 months.

Perinatal review meetings (PNRM) / Child mortality meetings

- These must be held at least monthly at hospital level. They can be a combined meeting or two separate meetings.
- The monthly meeting should include a summary of all the deaths that have been captured as listed above.
- The PNRM must additionally include a summary of the neonatal encephalopathy cases for the preceding month.
- Further guidelines for conducting the PNRM including preparation for the meeting are available in the National Maternity Care Guidelines 2016.

Action Plans

- If audit of any individual maternal death, stillbirth, neonatal death, child death or neonatal encephalopathy case identifies urgent actions that need to be taken to prevent recurrence, then an action plan needs to be drawn up. Similarly an action plan needs to be drawn up at

the end of every perinatal review meeting and child mortality meeting, and in response to the periodic analysis of PPIP and Child PIP data.

4. Special Considerations For Implementing The Minimum Requirements For Audit Of Adverse Outcomes In Maternal, Perinatal And Child Care

- **Action plan manager.** The audit processes described above will only be effective in improving care if the action plans are implemented. This means that it is important for any action to be followed up. Experience has shown that action plans drawn up in response to identified problems are often neglected or forgotten. Each action plan should therefore be allocated a manager whose responsibility it is to track whether the various actions in the plan are being implemented by those who are responsible for the individual actions. The action plan manager must continue tracking the action plan until all actions have been successfully completed. The quality assurance manager is ideally suited to this responsibility of tracking the action plans, but any other suitable manager could be allocated this task per action plan.

- **DCST Role.** Every District has a District Clinical Specialist Team (DCST) whose responsibilities include supporting and guiding the audit processes described above across the facilities in the District. For example, where the facility requires this, the DCST will be able to provide forms or templates for documenting the audit processes, and will be able to provide training or mentoring on use of the PPIP or Child PIP. The DCST should be represented at the facility perinatal review and child mortality meetings, and can guide the facility in preparing for these meetings.

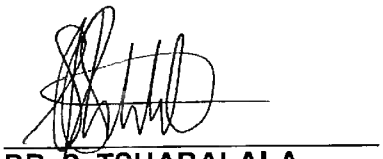
5. Confidentiality

The documentation regarding individual adverse events (maternal death forms, PPIP forms, Child PIP forms etc) is sensitive and must be kept confidential, and separate from the patient's case records. Details which would allow identification of individual cases (e.g. hospital number, patient name) should not be included in minutes of perinatal meetings or in any other communication that might have a wide distribution by email or in print. The patient or relatives have the right to access the medical records, but not the record of the audit process. Where complaints or litigation can be anticipated, a copy of the records of individual cases must be kept under lock and key in the offices of relevant managers.

Subject: Minimum Requirements For Audit Of Adverse Outcomes In Maternal, Perinatal And Child Care.

6. Recommendations

- All relevant managers at the facility, including the quality assurance manager, are to familiarize themselves with Minimum Requirements For Audit Of Adverse Outcomes In Maternal, Perinatal And Child Care.
- The CEO must take responsibility to ensure that the audit processes listed above take place in their facility.
- CEO to ensure that documentation is kept of these audit processes. This must include a record of all deaths (for example as captured in PPIP for perinatal deaths, and Child PIP for child deaths), a record of all neonatal encephalopathy cases, minutes of perinatal review meetings and child mortality meetings, a record of periodic PPIP and Child PIP data analysis and all action plans related to adverse outcomes in maternal, perinatal and child care.
- This documentation must be available to be shared with the District or Provincial managers when requested or required. Details of routine reporting requirements (format and frequency) for the various audit processes listed above are still to be finalized through discussions with districts and facilities and will be communicated in due course.
- Top facility management must always be represented at the facility perinatal review and child mortality meetings.
- A monthly data verification process for maternal, perinatal and child health indicators must occur to ensure that the facility DHIS data, PPIP and Child PIP data are all aligned and accurately represent the true statistics as recorded in the source documents (registers). This data verification can conveniently be done as part of the preparation for the monthly perinatal review and child mortality meeting.



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