CHAPTER 3
FACILITATING THE QUALITY IMPROVEMENT PROCESS

INTRODUCTION

Within a few weeks of the introductory meeting, you should begin the QI process at your facility, helping the team use the tools provided in the toolbook that accompanies this manual. This chapter walks you through the four steps of the QI process, suggesting tools and techniques appropriate to each step. At the end, a section explains how to establish the ongoing, cyclical nature of the process and integrate it into the work environment at the facility. This is illustrated by a timeline for QI activities.

The QI process consists of four steps. You will guide the team through:
- Information gathering and analysis
- Developing an action plan
- Implementing solutions
- Evaluating progress and following up

The process and tools provided will help you and the staff address all the components of service that influence quality: clinical standards, managerial and logistical aspects, room-by-room readiness for emergencies, and rights and needs of clients and staff.

Your role as team leader is to ensure that the team examines these aspects of care in a constructive and systematic way, so that gaps identified are analyzed and lead to solutions, solutions lead to constructive action, and action leads to improvements in service. In addition, by "learning through doing," staff will experience the benefits of a team approach, not only to improving quality of service, but to improving their own performance in routine delivery of EmOC services. Your behavior and the type of leadership you demonstrate are important to every step of the QI process.
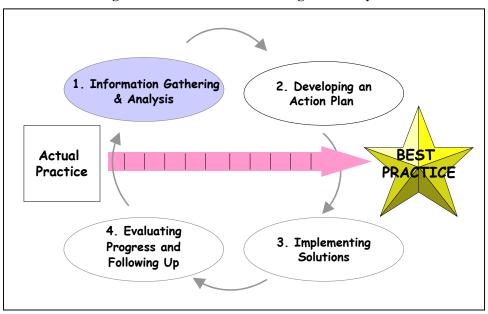
STEP 1: INFORMATION GATHERING AND ANALYSIS

Figure 8: Information Gathering and Analysis

Purpose

To assess the gap between actual and desired practice in the services involved in facility readiness and response to, and clients' rights in, obstetric emergencies.

Participants

In general, all levels of staff involved in providing a service should also be involved in the QI of that service. The exact makeup of participants will depend upon the tools being used at the time.

Tools (included with instructions in the toolbook)

➢ Primary tool: EmOC assessment
➢ Additional tools:
  • Client/family interview
  • Client flow analysis
  • Registers and records assessment
  • Brief case review guidelines

Other possible tools (not in the toolbook) could include a variety of community assessments (e.g., CARE's FEMME Community Assessment, EngenderHealth's Community COPE). If your facility is already using QI tools, you can adapt them to the process described here if you wish.

Process

Information gathering and analysis go hand in hand. You are never merely gathering information about services; you are also naturally going through a process of analyzing the strengths and

problems you find. To explain more clearly what happens during assessment activities, information gathering and analysis are discussed separately in this section, even though in practice you will find that they are always linked together. The chief objective is to stimulate dialogue and problem solving, not simply checking items off a list.

Information Gathering

Ideally, you should begin information gathering with the EmOC assessment tool. Organized into sections corresponding to the clients' and staff's rights and needs, it covers all aspects of EmOC, from facility readiness to staff response, when an emergency arises. Where these findings reveal issues needing closer analysis, the team uses additional, more specific tools from the toolbook. For example, if delays are found to be a problem, the team might use the client flow analysis tool to identify where and why these delays occur. If women's dissatisfaction with services seems to be an issue, the client/family interview tool will help staff gather information directly from women and their families. All tools are listed at the end of this chapter, as well as in the toolbook, which explains how to use them and how each one fits into the QI process.

Information gathering is carried out in small working groups. Depending on what is being assessed and how many staff are participating, each group may be responsible for a particular part of the assessment. For example, several working groups could each take two or three rights sections of the EmOC assessment, while another group conducts client interviews. (If the number of participating staff is fewer than five, it may not be feasible, or necessary, to break into working groups.) Working groups should consist of a mix of different levels of staff, but be sure to assign some staff to each working group who will be able to answer the more technical or medical questions. For the EmOC assessment tool, each working group should identify a note taker and a scorer.

Your role is to see that team members are clear about the purpose of their part in information gathering and that both strengths and weaknesses are recorded. Here are some specific steps you, as facilitator, can take:

- *Read the instructions* for each assessment tool being used and familiarize yourself with each question in the instrument.
- *Make copies* of the tool for each working group and provide pens and pencils, as needed.
- *Decide on a date* for conducting the assessment. Consult with facility management and EmOC staff to determine when the activity will least disrupt the services. Decide on a plan to handle emergencies during information-gathering activities.
- *Identify* who will be in each working group and inform them of the time and place for their activity.
- *Remind key department heads and other staff* that the activities will take place on a particular date.
- *Organize a preparatory meeting* to review the instruments' contents and how to use them. It might be beneficial to invite department heads or other hospital administrators to this meeting, so they will know what to expect in this step of the QI process.

Analysis

While in their small working groups for information gathering, the staff begins developing an action plan by analyzing findings from their assessment to identify problems, root causes, and to

develop solutions. The working groups will then be prepared to present the results of their analyses to the larger group for discussion and integration into an overall action plan for EmOC services. Specifically, staff will:

Define the problem:
- A problem is the difference between the actual situation (as found from assessment tools) and the desired situation (as defined by clinical standards and in the shared vision developed earlier; see Chapter 2).
- Team members must agree this is a problem.
- State the problem as specifically as possible (e.g., "Drugs in emergency kit in maternity ward are missing or out of date," rather than "The maternity ward is not adequately prepared for obstetric emergencies").
- Put problems in terms of processes and systems, not the fault of individuals.
- Identify problems that are feasible for staff to address.
- Discuss the effect of the problem on staff and clients.

Identify root causes:
- A root cause is the underlying reason or reasons a problem exists—at the level that an individual can have an effect on the problem. Root causes should be put in terms of specific, concrete issues that lend themselves to doable solutions. In addition, there can be more than one root cause for a problem.
- To identify root causes, use the "multiple whys" method (Figure 9). By asking "Why?" at least three times and "Are there any other causes?," the team will get closer to the underlying reasons a problem exists at the facility and will find it easier to arrive at an effective solution.

> *Note:* The idea behind the "multiple whys" technique is to draw out the "what, where, when, and who" of the problem. Behind the "why" could be other questions, such as "When is this a problem?" "Who is involved in this activity?" and "Which aspect of the blood transfusion process is an issue here?"

Figure 9: Multiple Whys

Finding:	There is a long delay between the time a complication arises on the maternity ward and the time an appropriate provider arrives on the scene.
Why?	Ward staff do not know which providers are on call and how to reach them.
Why?	There is no duty roster with this information posted in the client-care areas.
Why?	This information is available only in the matron's office, which she keeps locked when she is not in.

Recommend solutions:
- Have staff offer, discuss, and agree upon solutions.
- Solutions should address root causes.
- Have staff look at successful practices in other parts of the facility for possible solutions.

- Most solutions should be ones that staff can implement themselves with available re-sources.
- Some solutions may need to be divided into multiple steps.

Identify by whom and by when:
- The team should identify the person who can most easily implement an action based on his or her knowledge of a procedure, process, or task. Use actual names, not titles.
- The designated individual does not have to implement the solution alone but rather be responsible for ensuring that it gets done. When solutions are divided into multiple steps, different team members can be assigned to particular tasks (see Figure 14).
- The same person should not be responsible for carrying out too many solutions. Probe to find out who else can be responsible for different solutions.
- Although some solutions may need outside resources, senior staff or external organizations should be named as little as possible. The objective is to motivate team members to change their own practices and use existing resources more efficiently before requesting additional resources.
- The time allowed for implementation of solutions should be realistic.

The note taker should use the draft action plan format below (Figure 10) to record team agreements. It will be presented for comments to the larger group during the action plan meeting.

Figure 10: Action Plan Format: Draft Action Plan

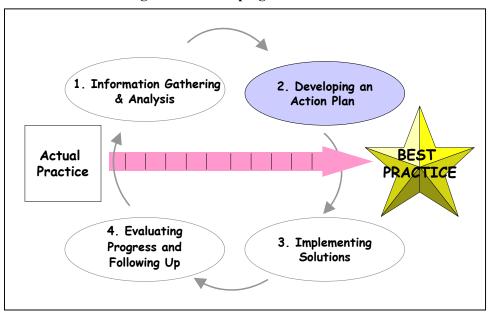| Problem	Root Cause(s)	Solution	By Whom	By When	Status

STEP 2: DEVELOPING AN ACTION PLAN

Figure 11: Developing an Action Plan

Purpose

To develop one consolidated action plan that will serve as the guide you and the staff will use to improve quality of EmOC service delivery, through discussion of the working groups' draft "mini action plans."

Participants

The meeting to develop a consolidated action plan should include all staff who participated in information gathering and, if appropriate, representatives from other services who will be involved in carrying out solutions included in the action plan. Depending on the solution and the organization of EmOC services, these additional participants may include representatives from laboratory, blood bank, or maintenance services.

Tools

➢ Action Plan Format

The consolidated action plan is recorded using the same format as the one used by working groups developing draft mini action plans (see Figure 12).

Figure 12: Action Plan Format: Consolidated Action Plan

Problem	Root Cause(s)	Solution	By Whom	By When	Status

Process

Together in this meeting, you will develop one consolidated action plan for all staff to implement. During this meeting, you and the staff will pull together the action plans from each working group, combine and refine problems and root causes, eliminate duplication, confirm responsibilities and timelines, and prioritize the order of implementation. To accomplish this successfully, you should ensure that staff follow these six steps:
- Identify problems.
- Find root causes.
- Develop feasible solutions.
- Decide who will take responsibility for implementation.
- Decide when they will accomplish the task.
- Prioritize actions by problem importance and solution feasibility.

As you can see, most of these steps are the same as those done earlier in the smaller working groups. The last step, *prioritization*, is crucial and is usually done during the group decision making that occurs during the action plan meeting.

As team leader, you should remember *how* teams arrive at an action plan is just as important as *what* problems and solutions are listed. Use your leadership and communication skills (see Chapter 4) to make the process a positive one for all staff. Every meeting is an opportunity for team building.

Steps in Developing an Action Plan

Define the problem:
- A problem is the difference between the actual situation (as found from assessment tools) and the desired situation (as defined by clinical standards and in the shared vision developed earlier; see Chapter 2).
- The team must agree this is a problem.
- State the problem as specifically as possible (i.e., "Drugs in emergency kit in maternity ward are missing or out of date," rather than "The maternity ward is not adequately prepared for obstetric emergencies").
- Put problems in terms of processes and systems, not the fault of individuals.
- Identify problems that are feasible for staff to address.
- Discuss the effect of the problem on staff and clients.

Identify root causes:
- To identify root causes, use the "multiple whys" method (Figure 13). By asking: "Why?" at least three times and "Are there any other causes?," the team will get closer to the underlying reasons a problem exists at the facility and will find it easier to arrive at an effective solution.

Develop solutions:
- Have staff offer, discuss, and agree upon solutions.
- Solutions should address root causes.
- Have staff look at successful practices in other parts of the facility for possible solutions.

- Most solutions should be ones that staff can use themselves with available resources.
- Some solutions may need to be divided into multiple steps.

Figure 13: Multiple Whys: Developing a Consolidated Action Plan

Finding:	There is a long delay between the time a complication arises on the maternity ward and the time an appropriate provider arrives on the scene.
Why?	Ward staff do not know which providers are on call and how to reach them.
Why?	There is no duty roster with this information posted in the client-care areas.
Why?	This information is available only in the matron's office, which she keeps locked when she is not in.
Why?	The matron is not aware of the importance of having the duty roster posted in the maternity ward.

Identify by whom and by when:
- The team should identify the person who can most easily implement an action based on his or her knowledge of a procedure, process, or task. Use actual names, not titles.
- The designated individual does not have to implement the solution alone, but rather be responsible for ensuring that it gets done. When solutions are divided into multiple steps, different team members can be assigned to particular tasks (see sample action plan, Figure 14).
- The same person should not be responsible for carrying out too many solutions. Probe to find out who else can be responsible for different solutions.
- Although some solutions may need outside resources, senior staff or external organizations should be named as little as possible. The objective is to motivate staff to change their own practices and use existing resources more efficiently before requesting additional resources.

Prioritize actions by problem importance and solution feasibility:
Some actions will be obvious choices to prioritize because they are either critical to preserving lives and health or very easy to accomplish.

The group can consider these questions in establishing priorities:
- Does this problem pose a danger to clients or staff? (If the answer is "yes," this needs to be assigned the highest priority and be addressed immediately.)
- Will the proposed change result in fewer delays in access to EmOC for clients?
- Is it possible to address this problem with existing resources (staff, time, money)?
- Will the solution be relatively easy to accomplish?
- How much time will these changes take to implement?
- Can staff do this without external assistance?

Figure 14: Sample Action Plan

Problem	Root Cause(s)	Solution	By Whom	By When	Status
Delay between occurrence of complications and arrival of appropriate provider	Staff do not know who is on call. No duty roster is posted in client-care areas.	Post current duty roster in all client-care areas. During next staff meeting, inform staff about posting duty roster in all client-care areas.	F. Castano, matron head sister	July 5, 2003 July 15, 2003 (next staff meeting)	
Incomplete emergency drug kits/ some expired drugs	Staff do not check kits regularly for completeness and expiration dates.	Assign staff in each client-care area to check emergency drugs weekly.	M. Rivera, nurse-midwife	July 10, 2003	
Electric suction machine not functioning	Machine needs repair but site lacks necessary spare parts. No repair and maintenance system exists.	Order spare parts. Staff person will check maintenance on a regular basis.	Mr. Palenque, cleaner	August 1, 2003 monthly	
Delivery room tables and floors not cleaned after each delivery	Staff knowledge of infection prevention (IP) is poor.	On-site orientation to IP is given.	Dr. Segura, team leader	August 15, 2003	

Next, consider the following while prioritizing:
- Problems and solutions with many "yes" answers to the above questions should be given a high priority.
- Picking problems with easy solutions to do first makes for some "quick wins"—successes that boost morale and give staff energy to tackle harder issues.
- When the priority given to each problem has been decided, assign dates for implementing the solution.

Tracking activities (optional):
- *Make visible the invisible.* Tracking some quantifiable aspect of changes team members have agreed upon will help them see if their efforts are starting to make a difference. Before you conclude the action plan meeting, discuss with the team picking one or two activities to track for the next several months (for example, over the next two action plan meetings). Examples of activities to track might include:
  - One or two questions from the EmOC assessment that staff consider key could be chosen as quality indicators to track over time.

- If the procedure to call and collect EmOC clinical staff members at night has been changed, keeping track of how much time elapses between notifying the night nurse in charge and when treatment begins would show a trend toward a shorter delay.
    - If one of the activities to improve emergency response is to ensure that emergency drug kits are complete, all drugs' current contents and expiration dates could be noted weekly for several months.
- You take responsibility for designing a simple tracking sheet. (You can do this after the meeting, during the implementation step.) In the second example above, the tracking sheet would list the required contents for kits in each location (maternity ward, OR, delivery room, etc.), with space provided to check the presence of each drug and its expiration date. Assign someone to record data and decide whether and where tracking sheets are to be posted.
- Just a few activities listed in the action plan should be tracked, to avoid an overly cumbersome process.

Meeting wrap-up:
- Review with the team how follow-up will be handled and what to do if staff assigned responsibility for an action are having problems.
- Congratulate staff for their hard work and commitment to finding solutions for problems and taking responsibility for carrying them out. Point out how they worked as a team, listening and discussing equally.
- Explain that while this action plan will be written up and posted, there will never be a "final" action plan. Rather, the action plan will change with each information-gathering activity.
- Show the action plan to YOUR supervisor and other administrators, as appropriate.
- Post the final action plan in an area where staff can see it. Add observations frequently to note progress, to show that you are watching.
- Use staff meetings or a specifically scheduled meeting for a progress report.
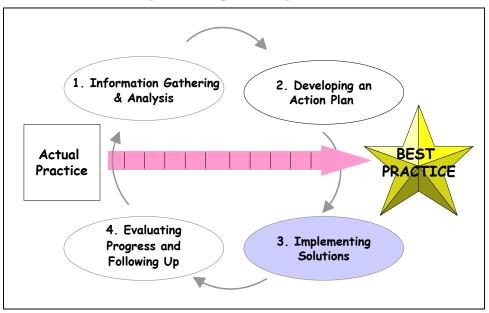
STEP 3: IMPLEMENTING SOLUTIONS

Figure 15: Implementing Solutions

Purpose

To take the actions agreed upon in the action plan and to track progress or full completion of the activity.

Participants

The people named in the action plan have primary responsibility for implementing the solution, but often they will be coordinating/training other staff to take action.

Tools

The tools required for this step depend on what actions were agreed to in the action plan. If you are tracking indicators, for example, you will use the tracking sheet you developed. Also, you and the team can use the "Status" column of the action plan to record progress on each problem along the way.

Process

The main activity is for staff to carry out their individual roles and responsibilities according to the action plan, in addition to their daily duties.

Although the steps in implementation are the least specific of any in this manual, this step in the QI process may be the most challenging one for you as the team leader. Implementing solutions challenges staff to adapt and change, and your leadership in the initial stages of the process—through encouragement, coaching, and constructive feedback—is particularly important to support their adopting new practices. Many of the skills and techniques you will need are discussed in Chapter 4, Using Facilitative Leadership and Communication Skills.

- As team leader, you will be responsible for coordinating the implementation of the action plan. Here are some issues to consider:
  - Has the individual or team completed writing the action plan, and have they put it in a place where it is visible and accessible to staff?
  - Are the people assigned responsibility for implementing the action plan recommendations meeting their deadlines?
  - Do people assigned responsibility turn to you or other team members if they are having difficulty implementing the actions?
  - Are staff at all levels providing needed support to the people assigned responsibility?
  - If there is a separate QI committee (e.g., a small group of volunteers who make the action plan accessible to all staff, follow up on the action plan with those responsible for implementation, set meeting schedules, organize following QI activities, etc.), are staff communicating the status of the action plan activities to the QI committee?
  - Are managers providing support as needed to carry out the actions?

- If the answer to any of these questions is "no" or "not very well," there are some things you can do to improve the situation:
  - Provide more guidance yourself or encourage more staff support to complete assigned tasks.
  - Readjust unrealistic timelines.
  - Involve others if the original person responsible is deemed inappropriate.
  - Explore together with the team alternative root causes and solutions to the problem.
  - Rethink a solution that has turned out not to be feasible.

When changes to the original plan seem necessary, the team should come together to reach consensus on changes to be made. All staff involved in developing the action plan need to be informed when alterations are made to it.

Tracking Activities
If you have decided to track activities, design a simple tracking sheet early in the implementation period and assign one team member to record the data. Check in on the team member to see if he or she needs assistance with this.
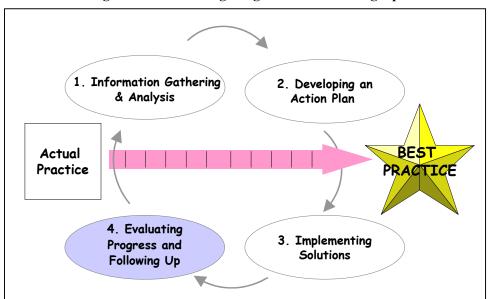
Figure 16: Evaluating Progress and Following Up

Purpose

On a regular basis, to lead staff through a review of progress they have made in implementing the action plan, an evaluation of whether actions they have taken are making desired changes in quality of service, and decision making regarding which assessment activities are necessary for further information gathering and analysis.

Participants

Review of progress will be ongoing, ranging from informal, individual discussions to agenda items for staff or hospital-administration meetings. Participants, therefore, will vary according to the type of meeting; but in general, all staff involved in carrying out tasks in the action plan should be full participants in any review and evaluation meetings. In the annual EmOC assessment, participants may also include visiting supervisors involved in medical monitoring (see Chapter 5). It is important to use the team approach in the review and evaluation process.

Tools

➢ For informal review during follow-up action plan meetings, the action plan format, tracking tools, and other information-gathering tools, as appropriate
➢ For annual evaluation, the EmOC assessment tool

Process

Bring the team together to review the action plan, assess progress made on implementation, and decide on follow-up steps. This can be done at routine staff meetings, meetings of a QI committee, or at an action plan development meeting. Specific steps in this process include
• Reviewing action plan progress, including what worked and what did not work
• Revising the action plan
• Deciding on follow-up assessment/information-gathering activities (step 1, again)

- Here are some important questions to address:
  - Is the action plan posted where staff can see it? Is it an updated version? Has it been helpful to post the action plan and observations?
  - Are the people assigned responsibility for implementing the action plan meeting their deadlines?
  - Have people assigned responsibility turned to you or other team members when they have difficulty in implementation? Have they been helped?
  - Are staff at all levels, including management, providing needed support to the people assigned responsibility?
  - If there is a separate QI committee, are staff communicating the status of action plan activities to the QI committee?
  - How are the members doing as a team? What is working well, and what can they change?
- If the answer to any of these questions is a "no" or "not very well," there are some things you can do to improve the situation:
  - Provide more guidance yourself or encourage more staff support to complete assigned tasks.
  - Adjust unrealistic timelines.
  - Involve others if the original person responsible is deemed inappropriate.
  - Explore with the team alternative root causes and solutions to the problem.
  - Rethink a solution that has turned out not to be feasible.
- If you are tracking activities, review tracking sheets and discuss trends:
  - Distribute or display tracking sheets (graphs, tables, totals, etc.), so all staff can see the data.
  - Discuss findings since last measures were taken. Ask why counts are going up/down /staying the same.
  - *Success?* Keep up the good work. *Obstacles, no progress?* What changes should be made?

Evaluation is an important component of improving the quality of service. It is a means of assessing whether you are achieving what you set out to achieve, of demonstrating to others the progress you have made, and of identifying possible adjustments you might wish to make.

While *reviewing progress and process* should be done frequently, *evaluating results* is best done on an annual basis. Scoring the EmOC assessment annually will allow time for scores to reflect changes that staff have implemented. If the score is calculated more frequently, change may not be noticeable, and this may dampen staff's enthusiasm for the process. We recommend that scored assessment be done in the same month each year.

The EmOC assessment tool used in the information-gathering step is well suited for an annual evaluation of the quality of service (see the toolbook for more detail). Used in evaluation, the EmOC assessment enables you to calculate a score that can be used as a baseline the first time and then over time, compared with scores from previous assessments.

As an annual event, EmOC evaluation is a powerful way for you and the staff to:
- Evaluate the current status of EmOC
- Identify areas for improvement and develop a (new) action plan to implement any improvements

- Celebrate progress on key indicators
- Provide a simple method of measuring staff achievements over time

Suggestions for facilitating the evaluation process:
- Schedule the annual EmOC review at a time when all staff who are involved in the QI process can participate. You should again organize working groups to collect data according to the EmOC assessment tool and other tools, as appropriate.
- Consider who else should attend the evaluation meeting. Suggestions are supervisors and specialists involved in medical monitoring (see Chapter 5).
- In addition to this annual review, EmOC data should be saved to facilitate other evaluations, as needed. Institutions and donors frequently conduct evaluations of services. Use the data from the EmOC assessment and tracking sheets for selected indicators for an objective and effective evaluation meeting.
- Celebrate improvements and successes.
- Communicate success to others.

Integrating the Quality Improvement Process into the Work Environment

The purpose of this section is to help you keep the QI process going on a regular basis, so that the four steps will become routine, and changes made will show positive long-term effects on care. Thus, it is crucial that these steps—information gathering and analysis, developing an action plan, implementing solutions, and evaluating progress and following up—be done on an ongoing basis; they should become *your and the staff's* tool for continually managing EmOC services in a positive and effective way.

Big events important to QI are scheduled annually or semiannually, while smaller, more informal events, such as regular meetings of EmOC or maternity ward staff, are held several times a month. While more formal meetings are important to take stock of real improvements in service delivery, small, frequent meetings are critical to integrating improved communication, better team work, and staff-lead problem solving into the daily work environment. These behaviors do not happen automatically; your leadership and coaching will be essential to maintaining staff performance throughout the years. (See Chapters 3 and 4 for information about organizing effective meetings and for facilitative supervision and communication skills.)

Even if present staff learn to work in this way, transfers and vacancies will necessitate a constant reintegration of personnel to the EmOC team and to the QI steps. The cyclical nature of the QI process provides an effective mechanism to orient new staff. The annual EmOC evaluation, for example, is an opportunity for you to acquaint newly arrived staff with the shared vision of EmOC services at the facility and the information-gathering process. Regularly held staff meetings will demonstrate how staff conduct case reviews, discuss service-delivery issues, gather relevant information, problem solve together, and then assign responsibility for implementing a solution. If you succeed in conducting meetings in this way, you and the staff will discover that problems can be avoided, work made more efficient, and staff morale improved.

Making a Timeline for Quality Improvement

To facilitate the regular use of the four QI steps, you might want to make a timeline to coordinate various QI activities. By making your own timeline, you will see how regular staff meetings
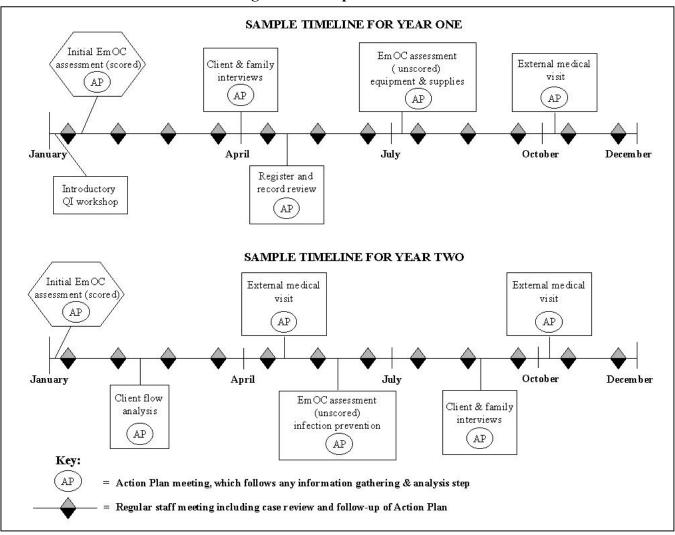
Figure 17: Sample Timeline

SAMPLE TIMELINE FOR YEAR ONE

Initial EmOC assessment (scored) — AP
Client & family interviews — AP
EmOC assessment (unscored) equipment & supplies — AP
External medical visit — AP

January · April · July · October · December

Introductory QI workshop
Register and record review — AP

SAMPLE TIMELINE FOR YEAR TWO

Initial EmOC assessment (scored) — AP
External medical visit — AP
External medical visit — AP

January · April · July · October · December

Client flow analysis — AP
EmOC assessment (unscored) infection prevention — AP
Client & family interviews — AP

Key:
AP = Action Plan meeting, which follows any information gathering & analysis step
◆ = Regular staff meeting including case review and follow-up of Action Plan

(weekly/monthly), periodic case reviews, QI/action plan meetings, medical monitoring visits, a complications review or death audits, a records review, and an EmOC annual assessment will fit together to ensure a continuous QI process. A sample timeline that covers activities over a two-year period appears in Figure 17.

Description of Emergency Obstetric Care Quality Improvement Tools

The following is a brief description of the tools contained in the toolbook.

EmOC Assessment

The EmOC assessment tool consists of several guides organized around the Rights Framework for Quality Emergency Obstetric Care. Each section contains questions about service appropriateness, timeliness, and adherence to established standards. Different guides assess the readiness of each room or area to support EmOC services, as well as cleanliness and organization; availability and functionality of utilities, equipment, supplies, and drugs; and adherence to clients' rights to confidentiality, dignity, and other essentials. The EmOC assessment can be scored to yield a quality

measure (QM) for tracking progress in each of these areas (recommended annually). It can also be used without scoring, as a periodic, overall assessment of quality.

Client/Family Interview
Staff conduct semi-structured, informal discussions with EmOC clients or family members to learn about their perspectives on service quality. Through these confidential discussions, staff gather information about clients' opinions about access to care and information, dignity and comfort, privacy and confidentiality, informed choice, freedom to express opinions, and continuity of care.

Registers and Records Assessment
Staff review facility registers or logs and individual client records to determine whether they contain information important to tracking obstetric emergencies and maternal deaths and if record keeping is being done correctly and completely.

Client Flow Analysis (CFA)
Staff follow emergency clients from arrival at the facility gate through key points in their visit to gather information about client waiting time. Staff use CFA data to identify and analyze the causes of delays.

Brief Case Review Guidelines
During staff meetings, providers discuss complicated cases using case histories, records, and laboratory results in order to learn from outcomes and to determine whether system problems interfered with provision of quality care.

Additional Measures of Quality

Tracking Methods for Selected Activities
The purpose of tracking is to see progress made to improve services, particularly when staff input helped to bring about the changes. One way to do this is to display the progress on the action plan itself. Another way is to track selected activities, as discussed in Chapter 3, and report on them in staff meetings. Encourage staff to develop additional ways of informing one another about progress and problems.

External Investigation of Maternal Deaths (Death Audit)

Although external investigation (audit) can refer to audit of services, standards, or complicated cases, this document focuses on external investigation, by a local committee of experts, of maternal deaths. (Maternal death is defined as death during pregnancy or within 42 days of termination of pregnancy.) This audit may already exist in your area and can be used as input to the QI process.