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CHAPTER 2
EMOC ASSESSMENT

PURPOSE AND DESCRIPTION

The purpose of the EmOC assessment is to enable staff to:

- Assess the quality of EmOC services against established standards, including the current state of readiness for and response to obstetric emergencies at the facility.
- Identify areas for improvement to be included in the development of an action plan for QI.
- Establish a baseline against which progress can be measured.
- Measure their achievements periodically in a simple way.

The EmOC assessment is organized according to the Rights Framework for Quality Emergency Obstetric Care, as discussed in the introductory QI meeting. Each guide in the tool includes questions based on standards and guidelines or the "best practices" generally accepted for EmOC.

There are two ways to use this tool:

- ***With scoring:*** Conduct the EmOC assessment completely and compute the scores to establish a *baseline*. Thereafter, conduct and score it once a year for an *annual QI score* so that staff can measure progress in their improvement efforts over time. The last page of the EmOC assessment is an assessment summary sheet for use when scoring.

  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.

- ***Without scoring:*** Conduct the EmOC assessment periodically during the year, using all or selected guides, depending on service improvement needs. In this way, the tool serves as a flexible means of gathering information for QI. The tool can be used along with other QI approaches the facility may already be using, such as COPE or Appreciative Inquiry.

Using the EmOC tool should be the first information activity in the QI process. Begin this step within one month of the introductory QI meeting.

ESTIMATED TIME FRAME

The preparatory meeting should take about one hour, and the assessment activity will take about half a day (depending on staff's busyness), although the exact time frame will depend on the size of your site.

PREPARING FOR THE EMOC ASSESSMENT

Since this assessment is often the first team-led activity in the QI process, it is important for the team leader to prepare staff in advance and to keep facility management well informed of the process. Suggested steps for the team leader to follow:

- ***Select participants:*** The participants for the EmOC assessment team are clinical and support staff who either are directly mobilized for obstetric services or who support emergency services.
- ***Read*** through the instructions on how to conduct the EmOC assessment and be familiar with the questions in the tool.
- ***Determine*** whether staff will be scoring the tool or not. If they are not calculating QI scores, decide which particular guides will be used during this round of information gathering.
- ***Decide on a date*** to conduct the assessment. Consult with site management and selected clinical and support staff to determine when this is least likely to disrupt services. Have a plan to cover emergencies while staff are conducting the assessment.
- ***Inform participants*** of the time, place, and time frame for the initial meeting and subsequent assessment activities.
- As the date draws closer, ***remind*** key department heads and staff that the assessment will be taking place.
- ***Organize times and places*** for the following meetings:
  - The *preparatory meeting* with team members to describe the process, review the instructions, and establish small working groups if desired. Other on-site staff, not directly involved in the assessment, can be included if appropriate.
  - The *information-gathering and analysis meetings,* during which team members actually conduct the assessment. There may be more than one meeting if several small working groups are conducting the assessment. The leader may not be able to attend each one.
  - The *action plan meeting*, during which all small working groups get together to integrate information from all assessment activities into one overall action plan. (See Chapter 3 of the QI Leadership Manual for how to integrate EmOC assessment findings into action plan development.)
  - *A debriefing for site management* or other interested groups, such as the pediatrics department, on the findings and the action plan developed.
- ***Ensure seating arrangements*** that are comfortable and allow for maximum participation at all meetings.
- ***Review*** how to facilitate meetings as described in Chapter 4 of the QI Leadership Manual.
- ***Prepare materials for team members*****,** such as sufficient copies of the EmOC assessment forms, pens or pencils, and spare flipchart paper for draft action plans. If they are scoring the EmOC assessment, they will also need a calculator to add the scores and two large sheets of graph paper.
- ***Prepare flipcharts*** required for explaining the EmOC assessment and cover them up until they are needed in the discussion. (See Chapter 2 of the QI Leadership Manual).

USING THIS TOOL IN THE QI PROCESS

Conducting the EmOC Assessment: Information Gathering and Analysis

- ***Organize groups:*** Depending on how many people are participating, the team leader should divide staff into small teams and give each team two or three of the guides to complete. Teams should consist of a mix of different levels of staff, but they should include some staff who will be able to answer the more technical or medical questions. Each team will identify a scorer and a note taker.
- ***Answer questions in the guides:*** Team members jointly review each of the questions and answer them either "yes" or "no" through discussion among themselves, staff interviews, or direct observation. If some aspect of the tool is truly "not applicable," team members should write "N/A" in the margin, so that later it is clear that this question was not simply omitted in error. **Every** question must have either a "yes" or "no" answer or a " not applicable" indicator.
  - *Discuss and review standards:* Many of the questions on the guides can be answered in the assessment meeting. During the discussion, the team should review and clarify standards as needed by looking at the local and/or national standards or other appropriate sources.
  - *Interview and observe if needed:* If team members cannot answer a question, they should try another way of finding the answer by asking another staff member or by checking or observing something themselves. For example, if the team is unsure about whether the operating room staff follow infection prevention procedures correctly, the team can discuss the process with the operating room staff, observe what they do, and decide together whether they are doing it correctly.
  - *Answer all questions:* Assessment teams should answer all the questions, except those that pertain to services or procedures they do not provide and cannot foresee providing in the future. For example, at a small clinic, staff may not be able to carry out such procedures as cesarean sections, so some questions on the guide would be "not applicable." On the other hand, if the question is about a service or procedure that is not currently provided, but is something that team members agree might be possible in the future, they should answer the question. They might be tempted to answer "not applicable," but the team leader should encourage them to resist the temptation. The answer may be "no" the first time, but "yes" the next time, and then they will see progress.
  - *Answer all bullets:* If a question has a bulleted list of items, all items must be present or all actions must be done in order to answer "yes." If one or more items in the bulleted list are answered "no," circle those items to keep track of what was missing. These items, then, would be something to address in the action plan meeting.
  - *Add questions:* When conducting the EmOC assessment without scoring, team members may add questions to a guide that they think are important to quality service.
- ***Find root causes:*** If something is not being done, team members should determine why it is not being done. Analyzing root causes, the staff should focus on gaps in systems and processes and not blame the individuals. What is the root cause of the problem? They can use the technique of "multiple whys," described in Chapter 1 of the toolbook, to help in this process.

- ***Reach consensus:*** For each guide, the objective is to come to a consensus on whether something is being done. When the team reaches consensus, the scorer marks the answer to the question. The note-taker takes notes on issues brought up in the discussion. If the team cannot reach consensus, then the issue should be brought up in the action plan meeting, during which everyone involved in the EmOC assessment can have input.
- ***Prepare a master copy****:* Once information gathering and analysis are completed, the team prepares one master copy of responses to the EmOC assessment. The findings should be recorded on flipchart paper using an action plan format.

If the team is *not* scoring the questions, please skip the subsection below, "When Scoring the EmOC assessment," and go directly to DEVELOPING AN ACTION PLAN. If the team *is* scoring, continue first with the section below and then with the rest of the instructions.

When Scoring the EmOC Assessment

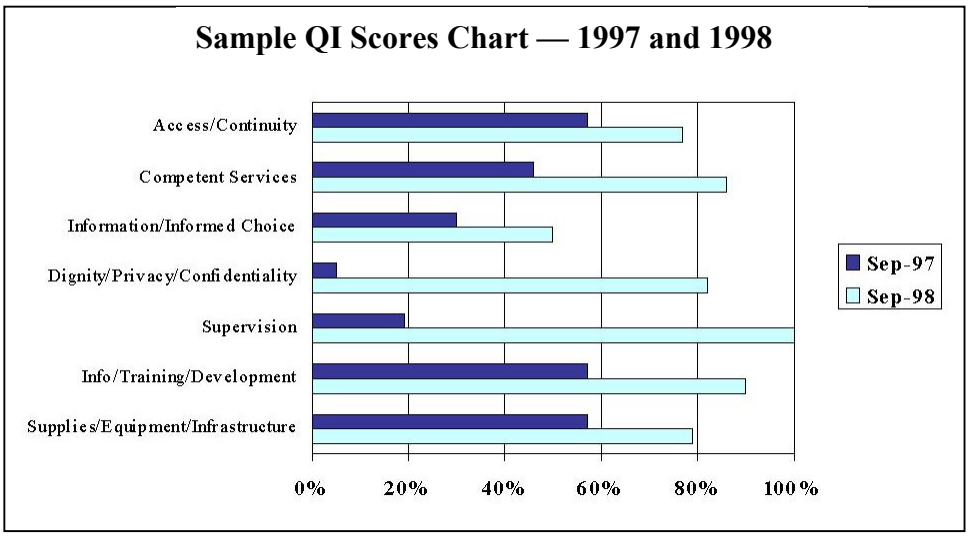
- *Calculate QI scores:* Once a year, team members should calculate a score for each guide in the assessment tool by counting the number of "yes" and "no" answers for each section. Scoring is as follows:
  - Add the number of times "yes" is answered in a section. (Reminder: If a question has a bulleted list of items, all items must be present or all actions must be done in order to answer "yes.")
  - Add the number of times "no" is answered.
  - Total the "yes" and "no" answers. Do not include questions you have determined are "not applicable."
  - Divide the number of "yes" answers by the total number of questions answered (again, do not include those deemed "not applicable") and multiply by 100 to get a percentage score. Use a calculator if necessary.
  - Below is an example of a tally sheet (Figure 6) . In this example, all the questions were answered on the Access and Continuity Guide, but on the Competent Care Guide, four of the questions were "not applicable," so the total is less than 70.

Figure 6: Summary Sheet Example

Indicators	"Yes" Answers A	"No" Answers B	Total Answers C	% "Yes" Score (A ÷ C) x 100
I. Access and Continuity	10	6	16	62.5%
II. Competent Care	44	22	66	66.6 %

- *Prepare a graph:* Team members then prepare a simple bar graph of the scores on the indicators. The graph may be roughly drawn on newsprint or on large sheets of graph paper. List the indicators along the side, and have a scale between zero and 100 along the bottom. Mark the score for each indicator, draw the bar, and shade it in. This visual representation of the team members' activity will help them compare scores from each quality area.

Figure 7: Sample Year-by-Year Graph of QI Scores



- *Prepare a year-by-year graph:* If the EmOC assessment has been scored before, team members can also prepare a year-by-year bar graph representing the changes between year one and year two; years one, two, and three; etc., for each of the indicators. This creates a visual presentation of progress made in improving quality of service over the years. The graph presented above (Figure 7) is an example of a year-by-year graph of QI scores. The team leader should keep copies of all graphs and the master copy of the EmOC assessment for future reference.

Developing an Action Plan

- ***Develop an action plan*** to address the problems identified from the EmOC assessment. This can be done initially in the small assessment teams and then brought together in the final action plan meeting for presentation and discussion. The entire group may have useful suggestions or findings from other assessment tools to integrate into the action plan. Problems and resources from other departments may also influence solutions.

  Team members must find a solution for each root cause of a problem identified. They should prioritize solutions, taking into consideration such issues as client and/or staff safety and the ease with which a solution can be carried out using existing resources. The team would then assign a person responsible for implementation and completion dates that reflect each item's priority. These steps are described in detail in Chapter 3 of the QI Leadership Manual.

  Figure 8 shows a sample action plan drawn from an EmOC assessment that team members would present to the larger group.

Figure 8: Sample Action Plan from an EmOC Assessment

Problem	Root Cause(s)	Solution	By Whom	By When	Status
Delay between occurrence of complications in delivery room and arrival of appropriate provider on the scene	• Staff in delivery room do not know who is on call. • No duty roster is posted in client-care areas. • Head sister keeps duty roster in her room.	Post duty roster in all client-care areas.	F. Castano, administrator	July 30, 2003	

Implementing Solutions

- ***Implement solutions*** as agreed upon in the action plan. Suggestions for facilitating implementation are in Chapters 3 and 4 of the QI Leadership Manual.
- The team leader or members of the QI Committee can periodically ***check in with staff*** assigned to a particular intervention on the action plan to determine their progress and provide support as needed.

Evaluating Progress and Following Up

- ***Review the action plan*** during routine staff meetings to determine progress and to discuss any modifications or additional support needed.
- ***Measure progress*** with annual assessments using the EmOC assessment and making graphs of the QI scores from year to year.
- ***Use the results*** to get external support when needed and to communicate success to staff, other departments, managers, stakeholders, the community, etc.

EMOC ASSESSMENT FORMS

Note: References to "MNH" in this tool are to *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors* (WHO, Department of Reproductive Health and Research, 2000)—also known as the "MNH Guide." The international standards from the MNH Guide referenced throughout this tool are meant to serve as a guiding principle in assessing quality of services; however, it is recognized that your facility may be using local and/or national standards and that they may differ from those referenced. If this is the case, staff are encouraged to review and clarify the referenced standards, as needed, by looking at the local and/or national standards or other appropriate sources.[*]

Reminder: If a question has a bulleted list of items, all items must be present or all actions must be done in order to answer "yes." If one or more items in the bulleted list are answered "no," answer "no" to the entire question, and circle those items to keep track of what was missing. These items, then, would be something to address in the action plan meeting.

Clients' Rights to Access to Services and Continuity of Care

Emergency obstetric care (EmOC) clients have a right to access services without facing barriers involving cost, hours of services, location, or physical or social barriers. Labor and delivery services, including the ability to handle complications, should be available 24 hours a day, 7 days a week.

EmOC clients have a right to the services, supplies, referrals, and follow-up necessary to obtain care.

		Yes	No
1.	Do clients and their families get from the entrance to each of the following areas easily and rapidly 24 hours a day, 7 days a week without encountering physical barriers (e.g., locked gates or grills): • Emergency-evaluation area? • Neonatal ward? • Maternity ward?		
2.	Do all staff, including ancillary staff in other departments, know where to direct women in labor to be assessed?		
3.	Do staff minimize procedural barriers to care for clients (e.g., requirements that clients obtain a male family member's permission to receive the service or have specific documents)?		
4.	Do obstetric clients with complications receive care immediately without encountering financial barriers (e.g., having to first pay for services or purchase supplies or drugs)?		
5.	Do all clients have access to EmOC services at your facility, regardless of their socio-demographic characteristics (e.g., age, marital status, social, or ethnic background)?		

continued

[*] A revised edition of the guide was published at the time this manual and toolbook went to press. If any changes to the standards are reflected in the 2003 edition, the tools in this toolbook may be adapted, as needed.

Clients' Rights to Access to Services and Continuity of Care *(continued)*

		Yes	No
6.	Are all obstetric clients evaluated within 15 minutes of arrival at your facility to determine if emergency care is needed, 24 hours a day, 7 days a week?		
7.	Do clients have access to labor and delivery services 24 hours a day, 7 days a week?		
8.	Are staff available to immediately recognize and initially manage (or stabilize and refer) each of the following conditions 24 hours a day, 7 days a week: • Postabortion complications? • Antepartum, intrapartum, or postpartum hemorrhage? • Hypertensive emergency, preeclampsia, or eclampsia? • Obstructed or prolonged labor? • Sepsis or infection (of the uterus, perineum, intravenous [IV] sites, incisions)? • Shock? • Ectopic pregnancy? • Neonatal asphyxia?		
9.	Do women and neonates have access to administration of IV fluids 24 hours a day, 7 days a week?		
10.	Do women and neonates have access to cardiopulmonary resuscitation (CPR) 24 hours a day, 7 days a week?		
11.	Do clients have access to each of the following basic EmOC services 24 hours a day, 7 days a week: • Injection of antibiotics? • Injection of magnesium sulfate (or diazepam if unavailable) for eclampsia? • Injection of oxytocin or ergotamine? • Assisted delivery (vacuum and forceps)? • Manual removal of placenta? • Uterine evacuation? • Repair of cervical tear?		
12.	Do clients have access to each of the following comprehensive EmOC services 24 hours a day, 7 days a week: • Blood transfusion? • Cesarean section?		
13.	Do clients have access to laboratory services 24 hours a day, 7 days a week?		
14.	Are all necessary supplies (e.g., gloves, IV fluids, oxygen), drugs (e.g., anesthesia, narcotics), and equipment available to clients 24 hours a day, 7 days a week without barriers (e.g., locked doors or cabinets or unavailable keys)?		

continued

Clients' Rights to Access to Services and Continuity of Care *(continued)*

		Yes	No
15.	Is there a referral facility or provider serving as backup in case of an emergency beyond your facility's capability (e.g., the need for a surgical procedure, a bowel or bladder injury, uncontrollable bleeding) 24 hours a day, 7 days a week?		
16.	Do staff at your facility do each of the following: • Provide or arrange transportation to a referral facility for emergency clients who cannot be treated? • Communicate with the referral facility staff to inform them about the referral?		
17.	Do staff complete client records with information essential for continued care of clients (e.g., diagnosis, complications, treatments, follow-up plan)?		
18.	When clients return for follow-up care, can staff easily retrieve their records?		
19.	Do all clients receive follow-up care at appropriate intervals (i.e., 24 hours, 48 hours, one week and four to eight weeks postpartum), either at your facility or through community-based care?		
20.	Before discharging postpartum clients, do staff provide each of the following: • Sexual and reproductive health counseling (e.g., family planning counseling, including for postabortion clients)? • Referrals for the client to other health services? • Pain control, as needed (e.g., for postabortion complications or postcesarean section)? • Referrals for neonatal services?		
Additional questions that you think are important: (DO NOT INCLUDE IN SCORING)			

Comments:

_____

_____

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_____

Your RIGHT TO ACCESS AND CONTINUITY Score

A. Add the number of times you answered "yes" in this section. _____
B. Add the number of times you answered "no" in this section. _____
C. TOTAL "yes" and "no" answers (A + B) _____

Clients' Right to Competent Care

Emergency obstetric care (EmOC) clients have a right to competent care that is safe, effective, and delivered promptly and skillfully in accordance with guidelines by trained staff who are skilled in routine care, management of complications and emergencies, and infection prevention.

		Yes	No
Promptness of care			
1.	For emergency clients, do staff immediately (within five minutes) perform all of the following (as needed): • Alert other labor ward clinicians? • Maintain the airway? • Assist breathing? • Stabilize circulation?		
2.	Do staff immediately (within five minutes) place a functional large bore (14–16 gauge) intravenous (IV) and give 2 L of normal saline for all clients with each of the following conditions: • Hemorrhage? • High pulse? • Low blood pressure? • Obstructed labor? • Sepsis?		
3.	Do staff immediately (within 30 minutes) perform each of the following (as needed): • Type blood? • Cross and transfuse blood (or refer to a facility that can do so)? (MNH S 23–29)		
4.	Do staff initiate surgical procedures (e.g., assisted delivery, cesarean section, uterine evacuation) within two hours of recognition of complication?		
5.	For postpartum hemorrhage, do staff perform (or refer) surgical interventions (e.g., bilateral uterine-artery ligation, hysterectomy, uterine-rupture repair) within two hours of recognition? (MNH P 95–108)		
6.	If unexpected surgical complications occur (e.g., bladder injury, bowel injury, excessive bleeding, uterine perforation), is a qualified provider always available on-site, on call, or by referral (within two hours)?		
Monitoring and evaluation			
7.	Do staff monitor all clients with an obstetric complication (e.g., hemorrhage, eclampsia, uterine rupture, obstructed labor, genital-tract sepsis) at least every 15 minutes for the first two hours of diagnosis?		
8.	Do staff keep an observation chart (including blood pressure, pulse, temperature, urine output) for all clients with obstetric complications (e.g., hemorrhage, eclampsia, uterine rupture, obstructed labor, genital-tract sepsis)?		

continued

Clients' Right to Competent Care *(continued)*

		Yes	No
Monitoring and evaluation *(continued)*			
9.	Do staff monitor clients immediately postdelivery or postsurgery for fever, vital sign instability, excessive bleeding, or uterine firmness: • Every 15 minutes for two hours? • Every four hours for at least 24 hours?		
10.	For all clients with hemorrhage or sepsis, do staff do each of the following: • Place a urine catheter to monitor output if needed? • Watch clients for signs of shock? (MNH S-1)		
11.	For all clients with hemorrhage or sepsis, do staff evaluate blood for coagulopathy by using a bedside clotting test (i.e., to check for either the failure of a clot to form after 7 minutes or for a soft clot that breaks down easily)? (MNH S-2)		
12.	Are all reproductive-age clients with abdominal pain evaluated to exclude ectopic pregnancy?		
13.	Before discharging postpartum clients, do staff check each of the following: • Clients' stability (bleeding, infection of uterus and perineum, uterine firmness, vital signs)? • Clients' ability to walk, eat, urinate, and repeat postpartum instructions?		
Normal labor MNH C-57–76			
14.	During active phase of labor, do staff do each of the following: • Monitor clients' vital signs (to look for warning signs) at least every 30 minutes? • Monitor labor progress at least every four hours? (MNH C-57)		
15.	During the second stage of labor, do staff ensure that • Clients are never left alone? • All deliveries are conducted by a skilled attendant?		
16.	Do staff practice active management of placental delivery (e.g., controlled cord traction, immediate oxytocin, uterine massage)? (MNH C-73)		
17.	Is administration of IV fluids performed to standards (e.g., proper infection prevention)? (MNH C-30)		
18.	Are vaginal-, perineal-, and cervical-laceration repair performed to standards (e.g., with anesthetic, antiseptic, absorbable suture, multiple layers)? (MNH P-73, 81, 83)		

continued

Clients' Right to Competent Care *(continued)*

		Yes	No
Normal Labor *(continued)*			
19.	Do staff ensure that each of the following neonatal services are performed to standards immediately postdelivery: • Neonatal resuscitation? (MNH S-141) • Cord care? • Eye care? • Thermal protection? • Appropriate vaccinations? • Breastfeeding-friendly counseling?		
Obstructed or prolonged labor MNH S-64–67, P-27–35			
20.	Do staff use a partogram or a labor chart to do each of the following: • Document labor progress? • Identify abnormal labor? (MNH C-65)		
21.	Do staff recognize and manage "inadequate uterine activity" (defined as fewer than three contractions in 10 minutes lasting less than 40 seconds) with oxytocin? (MNH S-64–67)		
22.	Do staff recognize obstructed labor (defined as when labor is arrested for more than two hours) and deliver the baby within two hours of diagnosis by assisted delivery or cesarean section?		
23.	Is assisted delivery (vacuum or forceps) performed to standards? (MNH P-27–35)		
24.	Is cesarean section performed to standards? (MNH P-47–52)		
Hemorrhage MNH S 13, 17–34			
25.	For antepartum hemorrhage at more than 37 weeks, do staff rule out placenta previa and then deliver the baby immediately?		
26.	For postpartum hemorrhage, is oxytocin or methergine given immediately after excluding uterine inversion?		
27.	Postpartum, do staff immediately evaluate and immediately treat all cases of continuous slow bleeding or sudden bleeding?		
28.	Are all cases of suspected ectopic pregnancy treated to standards with blood, laparotomy, and partial salpingectomy as needed? (MNH S-13, P-109)		
29.	Is administration of oxytocin or ergotamine performed to standards (e.g., with proper dilution and monitoring)?		
30.	Is manual removal of the placenta performed to standards, including the use of all of the following: • Anesthetic? • Antibiotic? • Antiseptic? • High-level disinfected [HLD]/sterile gloves? (MNH P-77)		

continued

Clients' Right to Competent Care *(continued)*

		Yes	No
Hemorrhage *(continued)*			
31.	Is blood transfusion performed to standards, including all of the following: • Confirming that blood is meant for that client? • Screening for HIV/hepatitis/syphilis? • Monitoring? • Responding to transfusion reactions? (MNH C-23–29)		
Preeclampsia, eclampsia MNH S-35–50			
32.	Are all clients with severe preeclampsia delivered within 24 hours of diagnosis by induction or cesarean section? (MNH S-47)		
33.	For all clients with preeclampsia or eclampsia, is blood pressure: • Monitored closely (at least every hour)? Controlled with antihypertensives for DP >110 mm Hg? (MNH S-46)		
34.	For all clients with severe preeclampsia and eclampsia, are each of the following obtained at least once: • Bleeding time? • Clotting time? • Platelet count?		
35.	Are all clients with eclampsia delivered within 12 hours of onset of convulsions by induction or cesarean section? (MNH S-47)		
36.	Are all clients with eclampsia treated with magnesium sulfate (or diazepam if unavailable)?		
37.	Are all clients being treated with magnesium sulfate monitored for magnesium toxicity (e.g., respiratory rate, urine output, reflexes)?		
38.	Is administration of magnesium sulfate (or diazepam if unavailable) for eclampsia performed to standards? (MNH S 44–46)		
Sepsis or infection MNH S 99–114			
39.	Do staff make all efforts to avoid unnecessary procedures that can increase the risk of infections (such as frequent vaginal exams, routine IV, routine uterine exploration after delivery, shaving)?		
40.	Do staff strictly maintain a sterile field during invasive procedures (such as cesarean section, laparotomy, injections, IV, urethral catheter insertion)?		
41.	Do staff treat all clients with clinical evidence of intrauterine infection (e.g., fever, foul amniotic fluid) as soon as it is diagnosed rather than waiting until postdelivery?		
42.	For genital-tract sepsis (e.g., perineal/wound infection, septic abortion, uterine infection), are broad-spectrum antibiotics (e.g., combination ampicillin/gentamycin and metronidazole) used?		

continued

Clients' Right to Competent Care *(continued)*

		Yes	No
Sepsis or infection *(continued)*			
43.	For genital-tract sepsis (including septic abortion), is volume status restored aggressively and immediately?		
44.	For genital-tract infections, is necrotic tissue removed?		
45.	Is administration of antibiotics performed to standards? (MNH C-35)		
Postabortion complication MNH S 9–13			
46.	For incomplete abortion and septic abortion, is uterine evacuation performed within two hours of diagnosis?		
47.	For septic abortion, are antibiotics started before uterine evacuation? (MNH S-9)		
48.	Is tetanus toxoid 0.5 mL IM given in each of the following cases: • For unhygienic conditions/procedures (e.g., incomplete abortion, septic abortion, unclean delivery, genital-tract infection)? • To unimmunized clients? (MNH S-51)		
49.	Is uterine evacuation performed to standards? (MNH P-61–68)		
Anesthesia MNH C-37–46, P 1-10			
50.	Do staff use local anesthesia whenever it is possible and safe to do so? (MNH C-38)		
51.	For local anesthesia, do staff know how to recognize signs of overdose? (MNH C-42)		
52.	For overdose from anesthesia, do staff know how to respond by: • Performing cardiopulmonary resuscitation (CPR)? • Administering drug antidote for narcotics, as needed? (MNH C-42)		
53.	Is administration of local and regional anesthesia performed to standards (e.g., with proper dosing and monitoring)? (MNH P 1–10)		
Complication rates			
54.	Is the incidence of hemorrhage and organ trauma caused by cesarean section less than 5%?		
55.	Is the incidence of uterine perforation from uterine evacuation less than 1%?		
56.	Is the incidence of uterine inversion following facility deliveries less than 5 %?		
57.	Is the incidence of infection less than 10% for each of the following procedures: • Cesarean section? • IV insertion? • Urethral catheter insertion?		
58.	Is the incidence of tetanus after hospital procedures 0%?		

continued

Clients' Right to Competent Care *(continued)*

		Yes	No
Infection prevention MNH C-17–20, 47–53			
59.	Do staff wash their hands with soap and running water: • Before each clinical procedure? • After each clinical procedure? • Before and after client contact? (MNH C-17)		
60.	Does your facility have each of the following protective wear items for staff in all client-care areas: • Aprons? • Caps? • Eyewear? • Face masks? • Shoe covers/boots? • Gloves (exam and HLD/sterile)?		
61.	Do staff change gloves when they become contaminated (i.e., between clients and with the same client if the gloves become contaminated)?		
62.	Is sterility maintained to the greatest extent possible in vaginal and manual uterine procedures (e.g., bimanual uterine compression, forceps, manual removal of placenta, vacuum, vaginal delivery) by use of each of the following: • HLD/sterile gloves? • Antiseptic prep? • Noncontamination? (MNH C-22)		
63.	Do staff vigorously rub hands together with antiseptic and water for 3–5 minutes before cesarean sections and laparotomies? (MNH C-48)		
64.	Is the surgical/procedure site (e.g., for abdominal incisions, injections, IV insertion, urethral catheter insertion, uterine evacuation) prepared from the center outward with an appropriate antiseptic solution (e.g., alcohol, cetrimide-based solution, iodine-based solution)? (MNH C-22)		
65.	If there is a break in the sterile field (such as a hole in a glove) during a procedure, do the assistants point it out and help to reestablish the sterile field?		
66.	Between clients, do staff clear medical waste and wipe down tables and contaminated surfaces with 0.5% chlorine solution in each of the following areas: • Delivery room? • Examination rooms? • Operating room?		

continued

Clients' Right to Competent Care *(continued)*

		Yes	No
Infection prevention *(continued)*			
67.	During steam sterilization, do staff measure temperature, pressure, and time according to manufacturers' instructions?		
68.	Are instruments decontaminated immediately after use in 0.5% chlorine solution for 10 minutes?		
69.	Do staff dispose of sharps in a puncture-resistant, leak-proof container in each client-care area? (MNH C-20)		
70.	Do staff use a system that ensures that medical waste (including placentas and sharp containers) is eventually safely buried or burned? (MNH C-20)		
Additional questions that you think are important: (DO NOT INCLUDE IN SCORING)			

Comments:

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_____

Your RIGHT TO COMPETENT CARE Score

A. Add the number of times you answered "yes" in this section. _____
B. Add the number of times you answered "no" in this section. _____
C. TOTAL "yes" and "no" answers (A + B) _____

Clients' Rights to Information and Informed Choice

Emergency obstetric care (EmOC) clients have a right to accurate, appropriate, and understandable information about their diagnosis, treatment and options if any exist, postdischarge care, and warning signs. This should be delivered through counseling and materials that are available throughout the health care facility.

EmOC clients have a right to the information and support they need in order to make informed decisions about their care. However, in case of emergency, the client should be stabilized first without delaying for the purpose of obtaining informed consent.

		Yes	No
1.	Are there local-language signs from all of the entrances directing clients to each of the following: • Emergency-evaluation area? • Labor and delivery rooms? • Neonatal ward?		
2.	When clients are stable, do staff inform all clients and their families about the diagnosis, need for treatment and procedures, and possible outcomes?		
3.	On discharge, do staff tell clients and their families about warning signs that need medical attention for mothers (e.g., fever, heavy bleeding, severe pain) and neonates (e.g., difficulty breathing, fever, jaundice, lethargy, poor feeding or sucking)?		
4.	On discharge, do staff inform clients with postabortion complications about warning signs that need medical attention (e.g., fever, foul-smelling discharge, heavy bleeding, pain)?		
5.	On discharge, are clients and their families informed about where mothers and/or neonates can access medical attention 24 hours a day, 7 days a week?		
6.	Do staff provide clients and their families with written and/or pictorial information in a language that they understand regarding each of the following: • Postdischarge care? • Warning signs? • Where to seek attention?		
7.	Do staff speak a language that clients understand, or are interpreters available?		
8.	In emergency situations where client is unstable, are lifesaving procedures performed to stabilize client even if informed consent cannot be obtained?		
9.	When clients are stable, do staff perform counseling and obtain informed consent for all procedures?		
10.	Are clients and their families informed that they have the right to refuse the specified treatment without sacrificing the right to other services (e.g., anesthesia, blood transfusion, cesarean section)?		

continued

Clients' Rights to Information and Informed Choice *(continued)*

Additional questions that you think are important: (DO NOT INCLUDE IN SCORE)			

Comments:

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Your RIGHT TO INFORMATION AND INFORMED CHOICE Score

A. Add the number of times you answered "yes" in this section. _____
B. Add the number of times you answered "no" in this section. _____
C. TOTAL "yes" and "no" answers (A + B) _____

Clients' Rights to Privacy, Confidentiality, Dignity, Comfort, and Expression of Opinion

Emergency obstetric care (EmOC) clients have a right to privacy and confidentiality during physical examinations, clinical procedures, and counseling, as well as in the handling of their personal information and medical records.

EmOC clients have a right to consideration for their feelings, modesty, and comfort, along with respect for their opinions and decisions. This is one of the most important aspects of quality. If clients and their families are not treated with respect, they are unlikely to seek care even in emergencies.

		Yes	No
1.	Do each of the following areas offer clients visual and auditory privacy from other clients and staff: • Examination rooms? • Labor and delivery rooms?		
2.	Do staff keep exposure to a minimum duration and amount during each of the following procedures: • Vaginal exams? • Vaginal deliveries? • Cesarean sections?		
3.	Do staff respect clients' wishes about whether or not to provide information to partners and family members (in emergency cases, this may not be possible)?		
4.	Do staff refrain from discussing clients with people who are not directly involved in the clients' care?		
5.	When client records are not in use, do staff store them in a secure place (e.g., with access strictly limited to authorized staff)?		
6.	Are each of the following client-care areas clean and comfortable: • Examination rooms? • Female/maternity wards? • Labor and delivery rooms? • Toilets? • Waiting areas?		
7.	Does your facility provide each of the following services for clients and those who accompany them: • Clean drinking water? • Handwashing facilities? • Toilets?		
8.	Do staff ensure that clients are comfortable during labor and delivery and procedures (including treatment of postabortion complications) by offering each of the following: • Pain medications? • Emotional support?		

continued

Clients' Rights to Privacy, Confidentiality, Dignity, Comfort, and Expression of Opinion *(continued)*

		Yes	No
9.	Do staff clean labor and delivery beds and mattresses with 0.5% chlorine solution immediately after each client?		
10.	Do staff provide counseling and emotional support to clients and their families in case of complications (e.g., destructive fetal operations, maternal death or complication, miscarriage, neonatal death or abnormality)?		
Additional questions that you think are important: (DO NOT INCLUDE IN SCORING)			

Comments:

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Your RIGHT TO PRIVACY, CONFIDENTIALITY, DIGNITY, COMFORT, AND EXPRESSION OF OPINION Score

A. Add the number of times you answered "yes" in this section. _____

B. Add the number of times you answered "no" in this section. _____

C. TOTAL "yes" and "no" answers (A + B) _____

Staff's Rights to Facilitative Supervision and Management

Emergency obstetric care (EmOC) staff need supervision and management that value and encourage quality improvement (QI) and give staff the support they need to provide quality services to their clients.

		Yes	No
1.	Do off-site supervisors or technical experts visit the facility regularly to do each of the following: • Assess services? • Recognize success? • Work with staff to solve problems?		
2.	Do on-site supervisors regularly assess services (e.g., observing infection prevention, observing services, reviewing registers and records)?		
3.	Do on-site supervisors regularly mentor staff (e.g., providing staff with constructive feedback, recognizing staff efforts and accomplishments)?		
4.	Do on-site supervisors review emergency protocols with staff through periodic rehearsals and drills?		
5.	Do on-site supervisors and staff routinely review available service data (e.g., QI assessments, registers, and statistics) to identify and discuss ways to improve services?		
6.	Do on-site supervisors hold regular staff meetings (at least monthly) to do each of the following: • Share problems that staff are experiencing? • Share recommendations? • Update staff and get their input on how to facilitate the care of EmOC clients?		
7.	Do on-site supervisors encourage staff to respect and collaborate with their colleagues (including community health workers, ancillary staff, and staff from other departments)?		
8.	Do on-site supervisors encourage staff to respond to client feedback on the quality of services?		
9.	Do staff have up-to-date written job descriptions with clear expectations?		
10.	Do on-site supervisors organize work shifts so that staff are fully occupied and well utilized during the entire time they are working?		
11.	Do on-site supervisors ensure that staff are assigned clear responsibilities for each of the following, 24 hours a day, 7 days a week: • Obstetric evaluation? • Management of labor, delivery, and postpartum care? • Management of complications? • Performance of clinical procedures (including cesarean sections and uterine evacuation)? • Stabilization and referral for complications that cannot be managed on-site?		

continued

Staff's Rights to Facilitative Supervision and Management *(continued)*

		Yes	No
12.	Is there a system to ensure transport to a referral facility for clients with complications that cannot be managed on-site, 24 hours a day, 7 days a week?		
13.	Is there a system to ensure access to blood supply (including donation and/or storage), 24 hours a day, 7 days a week?		
14.	Do on-site supervisors ensure that staff are assigned clear responsibilities daily for checking each of the following in each client-care area: • Equipment? • Supplies? • Drugs?		
15.	Is a functional system in place to maintain and repair the facility daily for each of the following: • Cleaning? • Electrical problems (e.g., exposed or unsafe wiring)? • Plumbing problems (e.g., leaky or blocked drains, sinks, toilets)? • Structural problems (e.g., broken ceiling, chipping paint)?		
16.	Does the facility maintain registers that capture all of the following information: • Postabortion complications? • Ectopic pregnancy? • Duty calendar? • Obstetric complications? • Postpartum admissions? • Pregnancy-related procedures and surgeries? • Neonates born before arrival?		
17.	Does the facility keep and post a statistics chart with monthly information on each of the following: • Number of total deliveries? • Number of cesarean sections? • Number of maternal deaths? • Number of neonatal deaths?		
18.	Does the facility keep track of and share with staff statistics on each of the following: • Hemorrhage and organ trauma (from cesarean section)? • Infection (from cesarean section, intravenous [IV] insertion, urethral catheter insertion)? • Uterine perforation (from uterine evacuation)?		
19.	Is there a mechanism to identify complicated cases for review (e.g., specific columns in the registers to record complications and final diagnosis, as well as a system to flag these charts for review)?		

continued

Staff's Rights to Facilitative Supervision and Management *(continued)*

		Yes	No
20.	Are cases with poor outcomes (i.e., neonatal or maternal morbidity or mortality) regularly reviewed (e.g., by examination of records and labs, as well as discussion of such cases and recommendations for the future at staff meetings)?		
Additional questions that you think are important: (DO NOT INCLUDE IN SCORING)			

Comments:

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Your RIGHT TO FACILITATIVE SUPERVISION AND MANAGEMENT Score

A. Add the number of times you answered "yes" in this section. _____
B. Add the number of times you answered "no" in this section. _____
C. TOTAL "yes" and "no" answers (A + B) _____

Staff's Rights to Information, Training, and Development

Emergency obstetric care (EmOC) staff need knowledge, skills, and ongoing training and professional-development opportunities to remain up-to-date in their field and to continually improve the quality of the services they deliver.

Note: "Sufficient number" means enough number of staff to provide the service 24 hours a day, 7 days a week, so that there is always staff with the skills (either on-site or available to come in) to attend to clients in a timely manner (within two hours).

		Yes	No
1.	Are current EmOC guidelines and protocols available and accessible to staff (on wall charts or in writing)?		
2.	Does the facility provide regular updates (at least quarterly) and training sessions to increase staff knowledge and skill in all aspects of EmOC (including infection prevention)?		
3.	Is a sufficient number of staff trained to respond to emergencies (e.g., performing cardiopulmonary resuscitation [CPR]; asking/shouting for help; stabilizing clients with intravenous [IV]; using emergency equipment, supplies, and drugs)?		
4.	Are staff trained to perform the following examinations as their job requires: • Pelvic examination? • Fetal assessment (growth, heart rate, pregnancy dating)? • General physical (breast, cardiac, distal pulse, lung, skin)? • Vital signs (blood pressure, heart rate, respiratory rate)?		
5.	Is a sufficient number of staff trained to manage labor and delivery (including dysfunctional labor)?		
6.	Is a sufficient number of staff trained in the management, stabilization, and/or referral of the each of the following complications: • Postabortion complications? • Antepartum hemorrhage? • Genital-tract sepsis? • Obstructed labor? • Uterine rupture? • Postpartum hemorrhage? • Preeclampsia, eclampsia, high blood pressure?		
7.	Is a sufficient number of staff trained to perform each of the following procedures: • Bimanual uterine compression? • Correction of uterine inversion? • Vaginal-, perineal-, and cervical-laceration repair?		
8.	Is a sufficient number of staff trained to perform administration of antibiotics?		
9.	Is a sufficient number of staff trained to perform administration of oxytocin or ergometrine?		

continued

Staff's Rights to Information, Training, and Development *(continued)*

		Yes	No
10.	Is a sufficient number of staff trained to perform administration of magnesium sulfate (or diazepam if unavailable) for eclampsia?		
11.	Is a sufficient number of staff trained to perform manual removal of placenta?		
12.	Is a sufficient number of staff trained to perform uterine evacuation?		
13.	Is a sufficient number of staff trained to perform assisted delivery (vacuum or forceps)?		
14.	Is a sufficient number of staff trained to perform cesarean section?		
15.	Is a sufficient number of staff trained to perform blood transfusion?		
16.	Is a sufficient number of staff trained to perform neonatal resuscitation (so that during every delivery there is a staff member with these skills available immediately)?		
17.	Are all staff trained in infection prevention as required for their job?		
18.	Is a sufficient number of staff trained either to perform or to promptly refer each of the following procedures: • Surgical correction of hemorrhage? • Repair of uterine rupture? • Hysterectomy?		
19.	For clients with complications that the facility cannot manage, do staff know how to refer and arrange for transportation to a higher-level facility 24 hours a day, 7 days a week?		
20.	Are all staff oriented and/or trained on the facility's policies and protocols regarding client relations (e.g., involving partners, family members and traditional birth attendants [TBAs], and supporting nonharmful traditional practices)?		
Additional questions that you think are important: (DO NOT INCLUDE IN SCORING)			

continued

Staff's Rights to Information, Training, and Development *(continued)*

Comments:

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Your RIGHT TO INFORMATION, TRAINING, AND DEVELOPMENT Score

A. Add the number of times you answered "yes" in this section. _____

B. Add the number of times you answered "no" in this section. _____

C. TOTAL "yes" and "no" answers (A + B) _____

Staff's Rights to Supplies, Equipment, and Infrastructure

Emergency obstetric care (EmOC) staff need reliable inventories of supplies, instruments, and working equipment and the infrastructure necessary to ensure the uninterrupted delivery of quality services.

Room-by-room walk-through to determine if the following rooms are ready for an EmOC client in terms of equipment, drugs, supplies, and infrastructure:

- *Facility in general*
- *Emergency-evaluation area (any area where emergency evaluation is performed (e.g., an emergency room, a room in the labor and delivery ward, a treatment room)*
- *Labor and delivery rooms*
- *Operating room*
- *Female/maternity ward*
- *Facility entrance and waiting areas*
- *Change/scrub room*
- *Pharmacy*
- *Lab and blood bank*
- *Staff lounge*
- *Instrument-processing and autoclave room*
- *Housekeeping room*

		Yes	No
Facility in general			
1.	Are walls, paint, plumbing, electrical wires, and sockets intact and well kept?		
2.	Does the facility have a reliable supply (including back-up) of clean water AND electricity such that services have not been interrupted in the past six months for lack of water, lighting or electricity?		
3.	Is there a functional system for repair and maintenance of equipment (e.g., anesthesia machine, autoclave, oxygen cylinder, suction machine) such that services have not been interrupted in the past six months?		
4.	Is there a functional system for monitoring and reordering of drugs and supplies (e.g. inventory) such that services have not been interrupted in the past six months?		
5.	Is all of the following basic examination equipment available in or accessible to the emergency-evaluation area, labor and delivery rooms, operating room, and female/maternity ward 24 hours, 7 days a week: • Examination table? • Adjustable light? • Blood pressure apparatus and stethoscope? • Fetoscope? • Speculum? • Weighing scale?		

continued

Staff's Rights to Supplies, Equipment, and Infrastructure *(continued)*

		Yes	No
Facility in general *(continued)*			
6.	Are all of the following basic supplies available in or accessible to the emergency-evaluation area, labor and delivery rooms, operating room, and female/maternity ward 24 hours, 7 days a week: • Antiseptic solutions (cetrimide, chlorhexidine, gluconate, iodine solution or iodophors, "spirits")? • Dressing supplies (bandages, adhesive tape)? • Hypodermic needles and syringes (10–20 cc)? • IV infusion set and fluids (tubing, needles)? • Scalpel blades? • Soap? • Spare bulb and spare batteries for room lights and flashlight, endotracheal (ET) tubes? • Suture and suture needles? • Urethral catheter and bag?		
7.	Are all of the following basic obstetric drugs available in or accessible to the emergency-evaluation area, labor and delivery rooms, operating room, and female/maternity ward 24 hours, 7 days a week: • Analgesics (acetaminophen, acetyl salicylic acid, morphine, paracetamol, pethedine)? • Anesthetics (general, local)? • Anticonvulsants (magnesium sulfate, diazepam)? • Antihypertensives (hydralazine, labetalol)? • IV solutions? • Oxytocics (ergotamine, misopristol, oxytocin)?		
8.	Are all of the following items for infection prevention available in or accessible to the emergency-evaluation area, labor and delivery rooms, operating room, and female/maternity ward 24 hours, 7 days a week: • Surgical gloves? • Utility gloves? • Bucket with chlorine (0.5%) for decontamination? • Sharps-disposal containers? • Waste buckets (for medical and other waste)?		
9.	Is an emergency trolley or cart (Figure 9) accessible to each of the following areas 24 hours, 7 days a week: • Emergency-evaluation area? • Labor and delivery rooms? • Operating room? • Female/maternity ward?		

continued

Staff's Rights to Supplies, Equipment, and Infrastructure *(continued)*

		Yes	No
Facility in general (continued)			
10.	Are all necessary emergency supplies (see Figure 9) available in or accessible to each of the following areas 24 hours, 7 days a week: • Emergency-evaluation area? • Labor and delivery rooms? • Operating room? • Female/maternity ward?		
11.	Are all necessary general emergency drugs (see Figure 9) available in or accessible to each of the following areas 24 hours, 7 days a week: • Emergency-evaluation area? • Labor and delivery rooms? • Operating room? • Female/maternity ward?		
12.	Are all necessary obstetric emergency drugs (see Figure 9) available in or accessible to each of the following areas 24 hours, 7 days a week: • Emergency-evaluation area? • Labor and delivery rooms? • Operating room? • Female/maternity ward?		
13.	Is all of the equipment necessary for neonatal resuscitation (see Figure 9) available in or accessible to each of the following areas 24 hours, 7 days a week: • Emergency-evaluation area? • Labor and delivery rooms? • Operating room? • Female/maternity ward? • Neonatal ward?		
Facility entrance and waiting areas			
14.	Do the facility entrance and waiting areas contain all of the following: • Wheelchair? • Trolley? • Stretcher? • Local-language signs to the emergency-evaluation area?		

continued

Staff's Rights to Supplies, Equipment, and Infrastructure *(continued)*

		Yes	No
Change/scrub room			
15.	Is the change/scrub room ready for use with all of the following: • Surgical attire? • Lighting? • Handwashing sink and running water? • Soap? • Scrub brushes? • Storage for staff's belongings?		
Pharmacy			
16.	Is the pharmacy ready for an EmOC client with all of the following: • Available staff? • All basic obstetric drugs? • Emergency drugs (see Figure 9)? • Antibiotics? • Antiemetics? • Antimalarials?		
Lab and blood bank			
17.	Is the lab and blood bank ready for cross matching and providing blood for an EmOC client with all of the following: • Available staff? • Blood bags? • Reagents? • Specimen-collection tubes? • Running water? • Microscope? • Refrigerator?		
Staff lounge			
18.	Is the staff lounge area ready for staff to use with all of the following: • Chairs? • Tables? • Drinking water? • Sink and running water? • Safe storage?		

continued

Staff's Rights to Supplies, Equipment, and Infrastructure *(continued)*

		Yes	No
Instrument-processing and autoclave room			
19.	Is the instrument-processing and autoclave room ready for processing and sterilizing instruments and supplies with all of the following: • Working autoclave? • Deep utility sink and running water? • Brushes? • Detergent? • Chlorine? • Basins? • Utility gloves?		
Housekeeping room			
20.	Is the housekeeping room ready with all of the following: • Deep utility sink and running water? • Mops? • Buckets? • Sponges? • Detergent? • Chlorine? • Utility gloves?		
Additional questions that you think are important: (DO NOT INCLUDE IN SCORING)			

Comments:

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Your RIGHT TO SUPPLIES, EQUIPMENT, AND INFRASTRUCTURE Score

A. Add the number of times you answered "yes" in this section. _____
B. Add the number of times you answered "no" in this section. _____
C. TOTAL "yes" and "no" answers (A + B) _____

Figure 9: Emergency Trolley Equipment, Drugs, and Supplies

Emergency trolley/cart carrying all *equipment, drugs, supplies* listed below:

Emergency Equipment

Ambubag (manual resuscitator), face mask, tubing, oxygen nipple
Battery-operated backup light (flashlight)
Blanket
Emesis basin
Foley catheter (size 16 or 18), drainage bag
Mouth gag
Nonflexible (size 18) and flexible suction catheters
Oral airways (two sizes: 90 mm and 100 mm), nasal airways (two sizes) nasopharyngeal airways (two sizes: 28 and 30)
Oxygen cylinder with flow meter, flow valve, volume meter, cylinder key, tubing (easily movable, i.e., on a stand with wheels), oxygen, key
Sphygmomanometer (blood pressure apparatus)
Stethoscope
Tourniquet
Laryngoscope with spare bulb and spare battery)*
Endotracheal tubes (7 or 7.5 mm internal diameter)*
Stylet for endotracheal tube*
Syringe (5 cc) (to inflate endotracheal tube cuff with air)*

Emergency Supplies

Adhesive tape
Antiseptic solutions
Gauze sponges
Hypodermic needles, hypodermic syringes
IV fluids and IV infusion sets with large caliber (14–16 gauge) needles and tubing
Water for injection
Knife blade
Lubricant for intubation
Oxygen
Suture needles, suture, chromic gut 3.0 and 2.0 on atraumatic needles
Surgical gloves

Emergency Drugs

General emergency drugs:

- Adrenaline
- Atropine sulfate
- Dextrose
- Diazepam
- Diphenhydramine (Benadryl) or phenergan
- Ephedrine
- Flumazenil or physostigmine (needed only if using benzodiazepines, such as diazepam)
- Lidocaine
- Naloxone (needed only if using narcotics)

Obstetric emergency drugs:

- Ergotamine (injection)
- Labetalol or hydralazine (injection)
- Magnesium sulfate (injection)
- Misopristol (tablets) (if available)
- Oxytocin (injection)

Neonatal Resuscitation Equipment

Firm surface for resuscitation
Neonatal IV fluid dispenser
Neonatal ambubag (manual resuscitator), face mask (neonatal size), tubing (neonatal size), oxygen nipple (neonatal size)
Battery-operated backup light (flashlight)
Blanket
Nonflexible and flexible suction catheters (neonatal size)
Oral airways (neonatal size), nasal airways (neona-tal size), nasopharyngeal airways (neonatal size)
Stethoscope
Laryngoscope with spare bulb and spare battery*
Endotracheal tubes (neonatal size)*
Syringe (5 cc) (to inflate endotracheal tube cuff with air)*

* Appropriate only when staff trained in intubation are present.

Facility Summary Sheet

Name of facility _____

Date of EmOC Assessment (month and year)_____

Fill in the total scores from the preceding previous pages for each client right or staff right.

1. Transfer the number of times you answered "yes."
2. Transfer the number of times you answered "no."
3. Add the "yes" and "no" answers. *Remember: Do not include any questions answered "not applicable" in the total.*
4. Divide the "yes" answer by the total, and multiply by 100 to get a percentage "yes" score.

Indicators	"Yes" Answers A	"No" Answers B	Total Answers C	% "Yes" Score (A÷C) x 100
I. Access and Continuity				
II. Competent Care				
III. Information and Informed Choice				
IV. Privacy, Confidentiality, Dignity, Comfort, and Expression of Opinion				
V. Facilitative Supervision and Management				
VI. Information, Training, and Development				
VII. Supplies, Equipment, and Infrastructure				