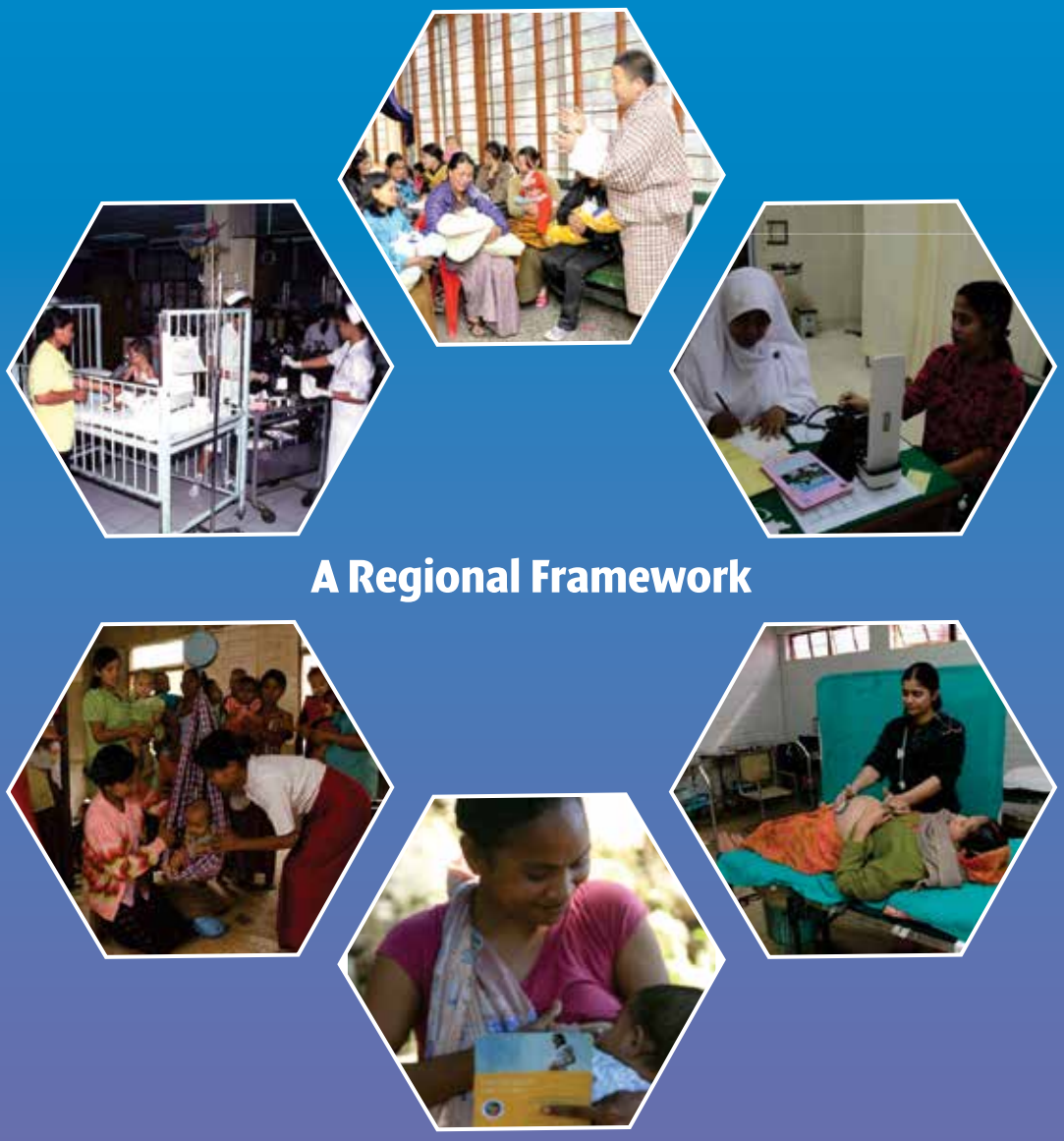
Assessment Tool for Hospital Care

Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health in South-East Asia Region



A Regional Framework

World Health Organization
Regional Office for South-East Asia

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for Hospital Care

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Introduction

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Introduction

Available statistics on the causes of maternal, newborn and child mortality highlight the fact that most of the deaths are as a result complications during and following pregnancy and/or childbirth; or from severe illnesses in children that require optimal care at health facilities. Much of the maternal deaths that occur in high burden countries result mainly from five morbidities: severe bleeding, high blood pressure, sepsis, unsafe abortion and obstructed labour; and the leading causes for child deaths being neonatal causes (preterm complications, birth asphyxia and neonatal infections), pneumonia, diarrhoea, malaria, and malnutrition. These deaths are 'mostly preventable' because the necessary medical interventions exist and are well known. However, the main obstacles are lack of access and poor quality of care provided in hospitals during pregnancy, childbirth and early postnatal period for the mothers and newborns, and poor case management of severely ill children who are under five years of age.

This generic assessment tool is to be used to evaluate the quality of care for mothers, babies and children in hospitals, based on standards derived from the WHO Pocket book of Hospital Care for Children and the WHO Integrated Management of Pregnancy and Childbirth (IMPAC). The aim is to aid Ministry of Health, key stakeholders and partners who are involved in quality of care improvement process, to carry out comprehensive assessments of maternal, neonatal and paediatric health care provided at facility level in a systematic way. Ultimately, this is to contribute to identifying gaps in key areas of maternal, newborn and child health care that need to be improved.

1. Structure of the tool

The tool attempts to be comprehensive but not exhaustive in addressing areas that are important to provide appropriate standard of care for mothers, babies and children admitted in hospitals. The assessment tool provides some prioritization recognizing that some aspects of patient care are essential. It helps hospitals to prioritize these essential aspects first and other areas, though important, may be addressed later. The key priority areas with the highest impact on improving quality of care include triage, hygiene (including hand-washing); availability of emergency and first line drugs; availability of updated standard treatment guidelines; emergency care and assessment; and management of common and routine conditions. Before use in a country, the assessment tool should be reviewed by health professionals for its consistency with national standards and guidelines, such as an essential drug list, or prevalence of diseases and adapted where necessary.

The tool includes sections with:

1) Brief questionnaires with yes or no answers, and space for written comments from observations or interviews;

2) Checklists for availability of services, equipment, drugs and supplies;
3) Structured forms for scoring of case management observations based on accepted standards of care and criteria;
4) Summary forms for each clinical case management observations and overall summary for the assessment;
5) Structured table for prioritizations and a framework for an action plan;
6) Structured interviews for health professionals, caregivers or mothers.

The assessment tool is organized in such a way, so as to facilitate dialogue with various stakeholders in the hospital during the hospital visit. These different sections are structured as follows:

1.1 Module A - General Section

This is the first section of the tool, which looks at the general hospital information on the basic infrastructure and layout of the facility and hospital support systems including overall staffing. This information is usually collected prior to the hospital visit and the questionnaires are sent by post or email to the participating hospital. The areas that are assessed in this section are:

- Lay out
- Infrastructure
- Staffing
- Hospital statistics
- Health information system and medical records
- Essential drugs and blood products
- Laboratory
- Guidelines and auditing

1.2 Modules B, C and D - The Continuum of Care

This section of the tool has three modules- a module on maternal care B; a neonatal module C and a paediatric module D. Each of these modules can be assessed separately on different occasion as well as together in one cycle. Each of the modules has the following subsections:

- Emergency care
- Wards
- Infection control and supportive care
- Essential drugs, equipment and supplies
- Case Management
- Monitoring and follow-up

The quality of medical care provided in the facility to pregnant women and new mothers, newborns and children are assessed in the case management sections and are based on the accepted standards of care.

1.3 Annexes - Interview questionnaires

There are 3 structured questionnaires to be administered during the assessment visit. These questionnaires are designed to capture additional information on access to the facility, perception of care provided and services received. This is assessed from both the provider and the patient's perspective. These can be self-administered or via interview from caregivers, patients and clients. The following are the interview questionnaires in this section:

- Interview with new mother
- Interview with caregivers or family members of children
- Interview of health professionals

* This section also provides a postal questionnaire that may be sent to the hospital in advance to collect information infrastructure, staffing and supplies

2. Adaptation of the tool

The tool that has been developed is a generic framework that needs to be adapted to the epidemiology and structure at country/local level. The adaptation may include deleting items that do not appear to be crucial, adding new priority items, or changing the assessment visit agenda to adapt to local needs/resources. For example: A section on management of dengue fever will be necessary in some countries in the South-East Asia. The tool is also sectionalized into modules to allow it's adaptation for assessments of maternal, newborn or paediatric care. The tool can also be used at different levels of care, e.g. in small district hospitals or tertiary care centres. It is therefore necessary that the team of national and international assessors, when planning the assessment, identify the sections of the tool that is relevant to the level of hospital being assessed. For example in some hospitals, paediatric surgical services might not be provided and therefore that section maybe removed from the tool, the same is true for the sections regarding obstetric care and particularly obstetric complications. As some specific items within the same section may not be applicable to the facility being assessed, it will be sufficient to classify the item as N.A. (Not Applicable) when this occurs.

2.1 Review of the assessment tool

The WHO integrated hospital assessment tool is based on the WHO standards of care and needs to be adapted to the national standards by reviewing the WHO guidelines and its relevance to the country. Items that are not important, such as: a specific disease conditions that do not exist in the country e.g. malaria, dengue fever, are removed from the assessment tool, and other items relevant to the country may be added. Some areas to be considered in the adaptation process are:

- Type of hospital and level of care.
- National standards of for the hospitals
- Existing protocols (clinical guidelines), oxygen or blood transfusion procedures.

- Essential drug list
- Essential supplies and equipment
- Sections on diseases particular to local epidemiology (e.g. malaria)

In some countries there will be need to translate the national adaptation of the assessment tool into the local language.

2.2 National standards of care

The assessment should be based on national standards for hospital care. Ensuring that there are clear evidence-based standards of care against which the tool will assess is critical for improving quality of care and is a major part of the process. Countries may already have various guidelines for managing maternal, neonatal and paediatric conditions in form of national treatment guidelines or hospital case management protocols. These guidelines should be reviewed and compared against WHO standards and guidelines by all stakeholders especially senior clinicians, nurses, representatives from medical and nursing training institutions, professional associations, committees in charge of national treatment guidelines and practicing doctors and nurses from public as well as private hospitals. The assessment tool needs to be adapted to these national standards.

It is important that the standards used are evidence based and are line with the WHO standards of care. All the assessors will therefore use the same standards. Where there are no national standards or care or guidelines, then the generic tool should be used as it is and the development of guidelines or standards of care is should become one of the outcomes of this process.

3. Guide to using the assessment tool

The assessment tool is useful for introducing the concept and the contents of internationally recommended guidelines and standards. Indeed, quality assessment appears to be an effective way of introducing WHO guidelines and international standards in the clinical practice at country level. After these have been adapted to the national standards, then the tool can be used for the national level assessment. Through a combination of different sources, the tool allows to build an overall diagnosis of quality of care and to single out those areas that represent a gap in the quality of care.

The tool can be used country-wide as a component of a quality improvement strategy in perinatal and paediatric health. Alternatively, a representative sampling of health care facilities can be assessed to provide results that can be reliably generalizable to interested health authorities at national, provincial, district, or hospital level. The tool can also be used in a single facility for a pilot program of quality improvement. The tool, by providing a semi-quantitative assessment of the quality of care in a variety of key areas, can be used to assess and monitor the baseline situation and subsequent

improvements, thus providing key information before and after interventions to improve quality of care, as well as for incentive and accreditation programs.
The assessment tool can be used both for external assessment and self assessment.

3.1 Using the tool

To evaluate the different aspects of the hospital, information is collected in various formats including:

- Brief questionnaires on hospital layout and structure with yes or no answers, and space for written information to be completed during hospital visit observation or through interviews with staff.
- Checklists for equipment, drugs and supplies for completion
- Documenting the management of different conditions based on accepted standards of care and criteria to meet these standards. The documentation follows a scoring system for the practices ranging from are good (according to standards) to weak needing improvement.

Each section is evaluated with the information gathered by different sources and is scored on the criteria that need to be met to reach the standards. The national hospital standards are the minimum requirements for good quality of care for mothers, newborn and children. For the case management sections, the instructions in the assessment tool provide guidance to the standards but do not cover all aspects of a given standard, and therefore it is important to refer to the relevant sections of the WHO *Pocket book of Hospital Care for Children* and the *WHO Integrated Management of Pregnancy and Childbirth (IMPAC)* which may have been adapted to the local context and guidelines in the country.

The tool ensures that the general information, which has been collected prior to the visit through a postal questionnaire, is validated during the hospital visit. The core of the assessment is a hospital visit that lasts about 2 days. Assessors complete the assessment tool recording form. One recording form is used for each hospital. Since the tool is modular it is possible for each area i.e. maternal, newborn or paediatric care to be assessed separately. At the end of the assessment each of section is summarised and a mean score assigned for each standard and comments made on general weaknesses and strengths. At the end of the hospital visit, assessors and hospital administration meet for a debriefing and agree on a plan of action for immediate and later improvements that would be reviewed in the next cycle of hospital assessment.

3.2 Questionnaires and checklists

Prior to visiting the facility questionnaires are sent out well in advance of the actual hospital visit (see Annex 4: Postal questionnaire), together with a letter explaining the purpose of the exercise, to hospital directors with a request to provide the information prior to the visit. These questionnaires focus on information expected to be of

importance for planning quality improvement interventions. Examples of information in this section include: admission rates, case fatality rates, availability of essential drugs, etc. The advantage of sending out the questionnaires/checklists is the possibility to obtain, within a short time and at low cost, comprehensive information on a number of factors that influence the ability of a hospital to provide good quality care. Information from the postal questionnaires will have to be reviewed together with information from onsite observations of quality of care during the visit for hospital assessment.

3.3 Hospital visits

The sections of the assessment tool for completion during the hospital visits include information from observations of case management and physical environment with information from interviews with hospital staff and caregivers of sick children. It is suggested to spend as much time as possible on the wards to gain first-hand information by direct observation, especially on the management and care in the hospital. Try to establish by direct observation if the drugs and equipment are available in the emergency room, on the ward or in pharmacy. If possible have a look in theatre/ operating room to check if essential equipment is available. Try to verify information provided by the hospital, staff or patients while observing during the visit. Information from postal questionnaires would be cross-checked during the hospital visit.

3.4 Sources of information

i. **Case observations**: For quality of clinical case management, this is the preferred source of information, and should be used as much as possible. The care for new arrivals and admitted patients to the hospital should be observed first hand without causing any interference. This is complemented by discussion of the case with staff, review of the case records and monitoring charts, and interviewing the caregivers.

ii. **Records**: If there are not sufficient patients for direct case observations, assessors should ask staff if it is possible to review records. Assessors obtain information on the quality of care for admitted and recently discharged patients by checking records. This source of information is particularly important for relatively rare, but severe conditions such as meningitis, where there might be no case admitted during the time of the visit.

iii. **Interviews**: Assessors conduct interviews with hospital staff and caregivers to gain some idea of their perception of care for patients in the hospitals. The assessment tool provides an outline for interviews with mothers, caregivers and health workers that can be found in Annexes 2 and 3 respectively. Also, if there are not enough cases for direct review of case management, simulated cases may be presented to staff to assess their competence in clinical case management.

iv. During hospital visit and rounds there is observation of other items such as cleanliness, whether clinical protocols are being followed, and whether the drugs and equipment listed are available as indicated by the facility. Try to verify information provided; areas of doubt can be clarified by interview.

3.5 Scoring system

For overall scoring, numbers from 5 to 1 are awarded, 5 being good practice complying with standards of care; 4 showing little need for improvement to reach standard of care; 3 meaning some need for improvement to reach standards of care; 2 indicating considerable need for improvement to reach standards of care; and 1 being services not provided, totally inadequate care or potentially life-threatening practices. The assessing group can also chose to adapt the scoring system to that of 0-3 with 0 -equating to service not being provided/totally inadequate care/potentially life threatening practices and 3- good practice complying with standard of care. But this modification should only be done when there is clear agreement and a consensus reached on what each value means. These scores are simply added up at the end of each section and an average for the section used. For each score mark that had been given, sufficient space is left to make a few comments indicating why that score has been given, where possible additional information should be noted, especially on how the information has been obtained (chart review, staff interview, observation of care provided). This information contained in the commentary is useful during the debriefing sessions with hospital staff.

Each of the different sections ends with a summary table, in which the findings can be condensed, and space is provided to include comments on the main strengths and weaknesses, to facilitate a quick overview of each chapter. This will help with keeping in mind important points which should be covered during the final debriefing of the hospital director and staff.

Table 1: Scoring system, summary score

Summary score	Good	To be improved			
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement)

The summary score should be the average score for the whole section.

After completion of the assessment, there is a summary evaluation score table, where every topic is marked in the evaluation sheet. This table also includes a comments section where the key strengths at the end of the hospital assessment are summarized and the key weaknesses that have been identified are also summarized in a narrative manner, this will be helpful during the debriefing of the hospital staff. This can assist in monitoring hospital improvements over time and to make inter-hospital comparison. Note that if sections of the tool are removed or edited, the total potential summary score

should be revised. A table is also included for the debriefing and action plan, this can be adapted as needed by the hospital staff and assessors.

4. Overview of the assessment process

The core of the assessment is a hospital visit, which depending on the size of the hospital, may vary from 1-3 full days. It is important that the facility is assessed both in the evenings and also at night. The assessment teams should be composed of people who are well experienced and with complementary and mixed backgrounds, to put the findings into perspective, such as paediatricians, midwives, obstetricians, general physicians, nurses or clinical officers. Depending on the purpose of the assessment, the teams can be composed of internal assessors only; a combination of internal and external assessors that have representation of both national and international members; or only of external assessors. It is always advisable to include staff from other hospitals as part of the assessment team as this will help foster collaboration between hospitals in improving quality of care.

4.1 Training of assessors

Before conducting the assessment, all the assessors need to be made thoroughly familiar with the national accepted standards of care, and/or guidelines and the assessment tool. Such a training takes about 3 days, which will be composed of training sessions to familiarize with the National standards, review of the assessment tool, and practical sessions on hospital wards to become familiar with the assessment tool and to agree between the assessors on scoring.

4.2 Planning to conduct the assessment

After general agreement, written information should be sent to all participant hospitals on the purpose of the assessment and the proposed agenda prior to the visit. The hospital director must be informed in advance and should have agreed to perform the assessment. It is emphasized that the assessment is part of an initiative to support the hospital in improving the quality of care provided to patients and that its purpose is to identify areas of care with greatest potential for positive change. It is explained that in addition to a structured layout of services provided, management of cases will be observed and staff and patients will be interviewed about hospital routines and practices and that the assessor(s) would like to directly observe clinical practice in selected areas.

The visit should attempts include all relevant services: admission, labour and delivery ward, postnatal ward, nursery, neonatal intensive care unit, paediatric ward, outpatient and emergency area, pharmacy, laboratory, blood bank, etc. The visit is considered over when the information collected is deemed sufficient to allow a reasonable assessment of the quality of care in each main area.

4.3 Steps in conducting the hospital assessment

The following are the key steps that the assessment units should take when assessing the quality of care being provided in a hospital.

Step 1: Introductory meeting:

Schedule a meeting with the medical director, administrators, pharmacists, senior matron, doctors and nursing staff from maternity, newborn and paediatrics. The objectives, purpose and assessment processes and what will be required during the process e.g. patient records and charts (on ward, discharges and deaths), and hospital statistics, are all explained and discussed with the hospital staff. A quick tour of the hospital is requested to see which areas the team will be assessing, you will also agree on when you will be meeting the staff again for the follow-up debriefing session at the end of the visit.

Step 2: Full team walk-through hospital

This should be a quick walk-through to get an idea of the layout, sense of patient load and various areas that may need to be visited. The team should try to do this without much interruption of hospital activities. During the walk through take note and understand the organization and other areas that you may need to visit in detail later.

Step 3: Conduct the assessment

Decision would be made with the group on how the assessment team will be divided for the different sections that will be assessed. Generally grouping should be into three groups (Maternal, Newborn, Paediatric), but allow for flexibility on how to manage the different areas and sections. Each group should go through patient flow and together and then the various tasks could then be divided as appropriate. The relevant patient/caregiver and health worker interviews should be conducted in each respective team. The team leaders should manage the overall planning and organization of how the team will manage to collect all the information. At the end of the assessment, the different groups summarize their scores to prepare for the assessors' team meeting

Step 4: Assessors meeting

At this meeting, regroup and share your key findings and agree on important issues and highlights to debrief the staff from each section. Summarize the key high impact priorities on the summary action plan sheet. Agree on who will be the lead person in providing feedback to the hospital staff.

Debriefing hospital staff

Each hospital will receive an immediate feedback at the end of the visit, the purpose is to review the assessment findings and commence planning for implementation of the improvement process. Reconvene all the staff you met at the beginning and start by thanking them, and inform them that the debriefing session will be useful to the staff in making plans to improve quality of care within the hospital. Highlight and commend them on the good things you found, and then present the key weaknesses especially those that have major impact on patient outcomes. There could be some additional

limited comments may be made by 1 or 2 other members of the assessing team. Encourage the hospital staff to respond to this feedback to reflect on the issues you have raised (should be dialogue with all staff with suggestions) and how they would try to address them.

Hospital action plan

Work with them to develop a draft action plan summary sheet concentrating on issues they can address locally and in immediate future, identifying resources required.

Wider briefing

After assessing the planned sample of facilities the assessors prepare a report summarizing findings and recommendations and present the report to MOH (or local) authorities and other relevant partners. It will be good to invite the staff from selected hospitals to come with a final action plan to the main (national) debrief.

Module A - General Hospital Information

Contents

General Hospital Information

Source: This information should ideally be collected before the visit through postal questionnaire available in annexes and be available for reference during the visit. If it has not been collected before, collect the information early during the visit. Information in the postal questionnaire should be crosschecked during the visit for accuracy. Tick as applicable. Information will be collected through hospital walk-through, observation, and interviews with staff leadership

Instructions: Collect information on numbers and time. Several questions have space for you to describe your answer in more detail.

Date
Town, province, country
Facility name (hospital, specific service(s))
Name of director/manager of hospital
Name of head of maternity ward
Name of head of paediatric ward
Name of head of neonatal unit
Survey number
Name of evaluator

1. Layout

Does the health facility have a separate outpatient department? Y N

Does the health facility have a separate emergency department? Y N

Is it open 24 hours? Y N

If not, what hours is it open? From……hrs to……hrs

Comments and descriptions of the above:

What is the estimated HIV prevalence in the area? ……

MATERNAL

Is the obstetrical outpatient area separate from the general outpatient department? Y N

At what time does the obstetrical outpatient department open? …….. hrs

At what time does the obstetrical outpatient department close? …….. hrs

Does the health facility have a ward for admitting obstetrics patients? Y N

If yes, how many beds? ……beds

Does the health facility have a theatre to perform CS? Y N

If yes, is the operating theatre available 24 hours? Y N

If not, what hours is it open? From…… hrs to…… hrs

Are the most seriously ill women cared for in a section (near the nursing station) where they receive closest attention? Y N

Comments and descriptions of the above:

NEONATAL

Does the health facility have a separate ward for admitting newborns? Y N

If yes, how many beds? ……beds

Up to which age are babies admitted to the NICU? …… (age in months)

Is the duration of babies' care in the NICU restricted/regulated? Y N

If yes, where are they transferred to? ……

Does the health facility have a separate room or ward for admitting newborn “Infectious” cases (i.e. isolation ward)? Y N

If so, how many beds? ……beds

Comments and descriptions of the above:

PAEDIATRIC

Is the paediatric outpatient area separate from the general outpatient department? Y N

At what time does the paediatric outpatient department open? ……..hrs

At what time does the paediatric outpatient department close? …….. hrs

Does the health facility have a ward for admitting paediatric patients? Y N

If yes, how many beds? ……..beds

Does the health facility have a separate room or ward for admitting paediatric "Infectious" cases (i.e. isolation ward)? Y N

If so, how many beds? …… beds

Where are children with surgical conditions admitted?

……

……

……

Where are children with severe conditions requiring special or high level care admitted?

……

……

……

Are the most seriously ill children cared for in a section (near the nursing station) where they receive closest attention? Y N

Comments and descriptions of the above:

2. Infrastructure

	YES	NO	Comments
Is electricity continuously available?			
Is there a back-up power supply in the case of a power cut (i.e. diesel generator)?			
Is there running water?			
If no: Is there water for hand-washing available in the area?			
Is there soap and/or disinfectant available?			
Is there a sharps disposal box available?			
Is there a functioning fridge available for drugs or vaccines?			
Is there a complaints box on the hospital premises or a formal way patients can communicate with the hospital?			

3. Staffing

Type of staff	during working hours *(number)*	after working hours *Present/ not present If present, number*	Remarks
Administrative clerk			
Auxiliary Nurse			
Nurse			
Midwife			
Generic medical officer			
Obstetrician-gynecologist			
Pediatrician			

Comments

4. Hospital statistics

Source: This information should ideally be collected before the visit, and be available for reference during the visit. If it has not been collected before, collect the information early during the visit from the records department, chief nursing officer, or hospital administration. Make use of routine statistics; adjust the categories accordingly (e.g. age groups) where necessary.

4.1 Maternal and neonatal statistics

Please use the figures for the last available year. If data are available for a different period, please specify.

Year……..Any other period……..

MATERNAL / NEONATAL

Number of deliveries	
Number of live births[1]	
Number of low birth weight newborn babies (<2500 g)	
Number of very low birth weight newborn babies (<1500 g)	
Number of extremely low birth weight babies (<1000g)	
Number of deliveries: <37 completed weeks	
Number of deliveries: < 32 weeks	
Number of deliveries: < 28 weeks	
Number of babies diagnosed with birth asphyxia[2]	
Number of babies with Apgar score <3 at 5 minutes	
Number of neonatal deaths	
Number of still births	
Number of perinatal deaths (number of stillbirths plus neonatal deaths in hospital)	
Number of maternal deaths in hospital	
Maternal mortality ratio (number of maternal deaths per 100,000 live births)[3]	

Caesarean section deliveries as % of all births	
Episiotomies as % of all births	
Instrumental deliveries as % of all births	
Inductions as % of all births	
Augmentations (stimulations) as % of all births	
Prevalence of anaemia (defined as Hb concentration of less than 110g/l or 11g/dL) per 1000 pregnant women[4]	
Average length of stay for vaginal delivery (number of days)	
Average length of stay for operative vaginal delivery (number of days)	
Average length of stay for caesarean section (number of days)	
Number of women transferred to higher level of care	

[1] Reference WHO definition for live births: Live birth refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born. Please specify if other definition is used.

[2] Criteria: live birth with an Apgar score at 5 minutes of <3, depression at birth requiring resuscitation with a mask for >3 minutes and/or intubation. World Federation of Neurology Group 1993.

[3] The maternal mortality ratio can be assessed with a denominator of 10,000 births, if it is anticipated to be very high.

[4] From MPS/PEPC assessment and follow up after training-Manual and Interview form Feb 2006-form 7 page

4.2 Paediatric statistics

Please use the figures for the last available year. If data are available for a different period, please specify.

Year……..Any other period……..

PAEDIATRIC

Number of children under-5 hospitalized in the facility	
Number of under-5 child deaths in the facility	
Under-5 mortality rate in facility	
Number of child deaths reviewed in the health facility	
Number of hospitalized children with pneumonia	
Number of child deaths caused by pneumonia in facility	
Number of children hospitalised with diarrhoea	
Number of child deaths caused by diarrhoeal disease in facility	
Number of children admitted in facility with severe malnutrition	
Number of child deaths caused by severe malnutrition in facility	

Paediatric surgery details

Most common paediatric surgical procedures performed:

	Procedure	Annual number of procedures	Performed by
1.			
2.			
3.			
4.			
5.			

How often are the following paediatric surgical procedures performed?

	Regularly	Infrequent	Never	Performed by	Referred to another facility
Phimosis/ circumcision					
Hernia repair					
Fractures					
Skin grafting					
Laparotomy including appendectomy					
Incision and drainage for abscesses/ pyomyositis					

4.3 Patient load, deaths and fatality rates

Indicate the total number of outpatient visits in pregnancy / puerperium / neonatal / paediatric period, emergency visits and admissions per year (indicate year; if any other period of time, e.g. semester, is used, indicate the exact period) for women and children. Include all medical diagnosis but exclude patients dead on arrival.

Year: ……

MATERNAL	**Outpatient visits**	**Emergency visits**	**Inpatients / admissions**	**Number of total deaths including women under 19)**	**Number of adolescent death**
Pregnant women					
Number of deliveries					
PAEDIATRIC	**Outpatient visits**	**Emergency visits**	**Inpatients/ admissions**	**Number of deaths**	**Age-specific fatality rate**
0-7 days					
7-28 days					
1-12 months					
1-5 years					
>5 years					

4.4 Reasons for hospital visits and admissions, deaths and case fatality rates

From the hospital records, list the five most important medical reasons (diagnoses) for outpatient visits (excluding routine ANC visits), emergency visits, and hospital admissions in pregnancy/puerperium (excluding labour). Similarly, list the five most important medical reasons for neonates and for children.

MATERNAL **Most frequent diagnosis**	**Outpatient visits**	**Emergency visits**	**Hospital admissions**	**Deaths**	**Case fatality rate**
First					
Second					
Third					
Fourth					
Fifth					
NEONATAL **Most frequent diagnosis**	**Outpatient visits**	**Emergency visits**	**NICU admissions**	**Deaths**	**Case fatality rate**
First					
Second					
Third					
Fourth					
Fifth					

PAEDIATRIC **Most frequent diagnosis**	**Outpatient visits**	**Emergency visits**	**Hospital admissions**	**Deaths**	**Case fatality rate**
First					
Second					
Third					
Fourth					
Fifth					

Comments

5. Health information system and medical records

Source: This information should ideally be collected before the visit, and be available for reference during the visit. If it has not been collected before, collect the information early during the visit from the records department, chief nursing officer, or hospital administration.

5.1 Health information system

Standards and criteria	**Score 1-5**	**Comments**
Existence and quality of a computer-based information system on patient flow (admissions, outpatients, etc.)		
Existence and quality of a computer-based information system on important medical indicators		
Existence and quality of paper-based information system on patient flow (admissions, outpatients, etc.), if computer-based unavailable		
Existence and quality of paper-based information system on important medical indicators, if computer-based unavailable		
Periodical review and evaluation of statistics and indicators by the relevant professional teams		

5.2 Medical records

Standards and criteria	Score 1-5	Comments
Are all records clear and legible?		
Are records dated?		
Are all admissions and discharge diagnoses clearly written in the notes?		
Are all drugs and treatments clearly identifiable?		
Is information from previous admissions available to staff providing care to mothers, neonates and children?		
Is information from antenatal records available to staff providing care during labour?		
Are all antenatal and intrapartum records available to staff providing care during postpartum period?		
Do mothers have access to their medical records?		
Do parents have access to their child's medical records?		

5.3 Summary – Health information system and medical records

Score

Summary score - Health information system and medical records					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates efficient and quality health record management, 4 to 1 indicating levels of necessary improvement (4=just a few shortcomings in health record management, 1=non-existent health records)

Main strengths

……

……

……

……

Main weaknesses

……

……

……

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6. Essential drugs and blood products

Source: This information should ideally be collected before the visit, and be available for reference during the visit. If it has not been collected before, collect the information early during the visit from the pharmacy.

Availability of drugs varies considerably in different regions. Please indicate the drugs available. For some drugs, local adaptations of use might exist (specify in note). If drugs are only available for sale and not freely available for patients, make a note. Check for the presence of drugs and enquire with staff whether drugs are regularly available. Check expiry dates. Note whether drugs with the earliest expiry date are used first (in the front-row).

Drugs	Pharmacy	Comments
General anaesthetics and oxygen		
Halothane inhalation		
Ketamine injection		
Oxygen inhalation		
Nitrous oxide inhalation		
Thiopental iv		
Local anaesthetics		
Lidocaine injection		
Lidocaine + epinephrine injection		
Ephedrine injection		
Preoperative medications and sedations for short term procedures		
Atropine iv		
Promethazine iv		

Drugs	Pharmacy	Comments
Analgesics, antipyretics, non-steroidal anti-inflammatory drugs		
Acetylsalicylic acid po/pr		
Ibuprofen lysine (for PDA)		
Indomethacin (for PDA)		
Paracetamol/acetaminophen po/pr		
Morphine po/im/iv		
Anti-histamines/anti-anaphylactics		
Chlorphenamine po/iv		
Epinephrine injection		
Corticosteroids		
Betamethasone im		
Dexamethasone im		
Hydrocortisone po/iv		
Prednisolone po		
Antidotes and other substances used in poisoning		
Calcium gluconate injection		
Naloxone injection		
Anticonvulsants and antiepileptics		
Diazepam po/iv/pr		
Magnesium sulphate injection		
Phenobarbital		
Anti-infective medicines		
Mebendazole		
Antibacterials		
Amoxicillin		
Ampicillin iv		
Benzathine benzylpenicillin injection		
Cefixime		
Ceftriaxone im		
Ciprofloxacin po/iv		

Drugs	Pharmacy	Comments
Ceftazidime		
Cefotaxime		
Co-trimoxazole		
Doxycycline		
Erythromycin po/iv		
Gentamicin iv		
Nitrofurantoin		
Metronidazole po/iv		
Spectinomycin po		
All anti-TB drugs needed according to the national TB control program		
Antifungal medicines		
Amphotericin injection		
Clotrimazole cream/tablet		
Miconazole		
Fluconazole po/injection		
Nystatin topical/po		
Antiviral medicines		
Aciclovir po		
All Anti-HIV drugs according to HIV program		
All anti-malaria drugs needed according to national malaria control program		
Anti-pneumocystis and antitoxoplasmosis medicines		
Pentamidine po		
Medicines affecting the blood		
Ferrous salt + Folic acid po		
Iron syrup po		
Low molecular weight heparin (LWMH) injection		
Respiratory Drugs		

Drugs	Pharmacy	Comments
Aminophylline		
Caffeine citrate		
Surfactants		
Plasma substitutes		
Dextran 79 injection		
Cardiovascular medicines		
Glyceryl trinitrate spray/po		
Digoxin injection/po		
Hydralazine injection/po		
Methyldopa po		
Furosemide iv/po		
Dermatological medicines (topical)		
Disinfectants and antiseptics (topical)		
Chlorexidine		
Polyvidone iodine		
Insulins and other antidiabetic agents		
Insulin injection (soluble)		
Intermediate acting insulin		
Immunologicals		
Anti-D Immunoglobulin (human) injection		
Anti-tetanus immunoglobulin (human) injection		
Vaccines		
BCG vaccine		
Diphtheria + tetanus vaccine		
Measles vaccine		
Rubella vaccine		
Hepatitis B vaccine		
Poliomyelitis vaccine		

Drugs	Pharmacy	Comments
Pertussis vaccine		
Muscle relaxants and cholinesterase inhibitors		
Suxamethonium injection		
Ophtalmological preparations (topical)		
Tetracycline		
Oxytocics and antioxytocics		
Ergometrine injection		
Oxytocin injection		
Misoprostol tablets		
Nifedipine tablets		
Solutions correcting water, electrolyte and acid-base disturbances		
Glucose 5-10-50%		
Glucose with sodium chloride		
Sodium chloride 0.9% isotonic		
Ringer's lactate		
Water for injection		
ORS		
Vitamins and minerals		
Vitamin A oral		
Vitamin K IM		

Are there any expired drugs in the pharmacy or in the pharmacy?	Y	N
Is cold chain respected for vaccines?	Y	N
Is there a blood bank in the facility?	Y	N
Are blood units available for transfusion?	Y	N

6.1 Summary - Essential drugs and blood products

Score

Summary score - Essential drugs and blood products					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates all essential drugs are available and not expired/expiring, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent or chronic shortages of drugs/chronic lapses in the quality leading to potentially life threatening situation to both patient and staff)

Main strengths

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7. Laboratory

Source: This information should ideally be collected before the visit, and be available for reference during the visit. If it has not been collected before, collect the information early during the visit from the laboratory and chief laboratory technician.

Try to see as many essential laboratory investigations being carried out as possible. Are the following laboratory investigations and their results readily available? (e.g. blood glucose, Hemoglobin, Hematocrit (PCV) within ½ hour, other investigations 1-2 hours). If available, indicate average time to get results.

Lab test	Not available	Available	Time to get results	Comments
Blood glucose				
Haemoglobin				
Haematocrit (PCV)				
Immature to total neutrophil ratio				
Leukocyte count				
Blood gas analysis				
Blood grouping and crossmatch				
Bilirubin				
Rhesus antibodies				
Urine dipstick				
Urine microscopy				
Bacteriology (culture)				
Bacterioscopy (smear)				
Full blood count				
Coagulation tests				

Lab test	Not available	Available	Time to get results	Comments
Liver function tests				
Bilirubin				
Renal function tests				
Electrolytes				
HIV test				
CD4 count or HIV plasma viral loads according to national guidelines				
Coombs' test: direct and indirect				
Serum protein and albumin				
Urinalysis				
Rapid test for syphilis				
Microscopy or rapid diagnostic test (RDT) for malaria parasites				
CSF microscopy				

Are essential lab tests available continuously and results available in a rapid manner? Y N

7.1 Summary – Laboratory

Score

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates all

Summary score - Laboratory					
(to be circled)	**5**	**4**	**3**	**2**	**1**

laboratory tests and possible and results available in a rapid manner constantly, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1= most laboratory tests not possible in facility and adversely affects the managements of patients).

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8. Guidelines and auditing

8.1 Guidelines

Standards and criteria	Score 1-5	Comments
A recent neonatal textbook is readily available		
A recent obstetric textbook is readily available		
Guidelines/protocols on care during normal child birth are available		
Guidelines/protocols on management of emergency conditions for mothers are available as pocket instructions, wall charts, or job aids		
Guidelines/protocols on management of emergency conditions for newborn babies are available as pocket instructions, wall charts, or job aids		
Guidelines/protocols on management of emergency conditions for children are available as pocket instructions, wall charts, or job aids		
Hospital essential drugs list is available		
Periodical staff meetings are held to discuss and revise protocols		

8.2 Auditing

Standards and criteria	Score 1 -5	Comments
Audits are conducted to review cases of deaths and complications		
Clinical audits involve all team members including midwives and nurses		
The audits take into account monitoring, hospital flow and quality of care as well as more clinical aspects		
Recommendations from audits are discussed and implemented		
Nurses and midwives run their own periodical meetings		
Nurses and midwives are involved in organizational staff meetings		
Periodical staff meetings are held to discuss organizational aspects		
Periodical staff meetings are held to discuss and revise protocols		

8.3 Summary – Guidelines and auditing

Score

Summary score - Guidelines and auditing					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates excellent guidelines, protocols and information are available for staff; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

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Module B - Maternal Care

Contents

Maternal Care

Source: This information should be collected by visiting the labour, delivery ward and operating theatre and observing the treatment and other clinical practices of women, review of records and logbooks and interviews with staff and women.

1. Emergency obstetric care

1.1 Patient flow

Source: Visit to the emergency department/labour ward and interviews with staff dealing with emergencies. Instructions: Interview staff where emergencies would present, observe who would see them, how senior staff are contacted to respond to the condition, and where and how severe conditions are handled.

Where are patients with an emergency obstetric condition received?

Describe the patient flow of a typical obstetric emergency (woman presenting as an emergency to hospital):

A.

B.

C.

D.

E.

F.

G.

H.

I

J.

Is there an emergency management area equipped to take care of pregnant women?	Y	N
Is there a separate consultation area for moderately ill women?	Y	N
Is this separate from the normal outpatient facility dealing with patients?	Y	N

Comments and descriptions:

Do patients come with referral notes when they have been referred from first level units?
Never □ Sometimes □ Always □

Are there any job aids (wall charts, chart booklets) displayed for the management of obstetric cases Y N

If so, describe about what, and comment on adequacy:

Distance from reception area to emergency management area:

In the same building, distance……

In another building, distance……

Distance from consultation area to emergency management area:

In the same building, distance……

In another building, distance……

1.2 Staff providing emergency obstetric care

Type of staff	**during working hours** *Present/ not present If present, number*	**after working hours** *Present/ not present If present, Number*	Trained in **assessment/ detection of** emergency conditions *Yes/No*	Trained in **management of** emergency conditions *Yes/No*	**Comments**
Administrative clerk					
Auxiliary Nurse					
Nurse					
Midwife					
Generic medical officer					
Obstetrician-gynaecologist					

1.3 Layout and structure of emergency care

Standards and Criteria	Score 1-5	Comments
A system is in place to prioritize severely ill patients (triage)		
Triage is done in a timely manner and not hindered by registration procedures, payment etc. before lifesaving action takes place		
Staff in charge of triage are adequately trained and able to apply triage criteria[1]		
A health professional is always available to manage patients with emergency conditions		
Essential drugs for emergency conditions are always available[2]		
Essential lab tests (glucose, PCV) and equipment (including AMBU bags and face masks for adults and newborns) for emergency conditions are always available[2]		
Case Management (see below)		

1 Information is mainly obtained by direct case observation and through interviews with staff about the routine practice. If no cases with emergency conditions are observable, staff is interviewed about how they would manage such conditions.

2 Please refer to the tables in the section "Essential maternal drugs, equipment and supplies". Please note when judging the adequacy of supplies that some drugs (e.g. oxygen, anticonvulsants) need to be immediately available; whereas for others (e.g. antibiotics) it is sufficient that availability is assured.

1.4 Case managements of emergency conditions

Source: Information is obtained by case observation of cases presenting, as far as possible, and through interviews with staff about the routine practice.

If you cannot observe one to two cases, describe scenarios to staff of two to three cases presenting with eclampsia or post-partum haemorrhage.

Cases to observe include women presenting with danger signs (i.e. significant vaginal bleeding, eclamptic fits etc.). Case management is observed during working hours and after hours. Enquire about the management of a pregnant woman with significant vaginal bleeding, convulsions, or shortness of breath.

1.5 Summary - Emergency obstetric care

Summary	Score 1-5	Comments
Patient Flow		
Layout and structure		
Essential Drugs		
Equipment		
Staffing		
Case management		

Score

Summary score - Emergency obstetric care					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care i.e. well-staffed emergency department with experienced and trained staff available on hand at all hours to help manage emergency cases, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

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2. Maternity wards

Source: Observation during the visit to the ward, and interviews with staff and persons accompanying the patients

Are healthy newborns roomed-in with their mothers? Y N

2.1 Maternity ward staffing

	# on day shift	# on night shift	# on weekend shifts
Obstetricians			
Doctors-GPs			
Nurses			
Midwives			
Resident doctors			
Auxiliary staff			
Others (please specify)			

2.2 Hygiene and accident prevention

Standards and criteria	Score 1- 5	Comments
Patient toilets are accessible to patients and separate from public, or staff, toilets		
Toilets are clean		
There is running water and patients can wash their hands after using the toilet		
Patients have access to clean running water, soap and an appropriate space by the ward, to wash themselves.		
Beds are safe, clean, well maintained and have mattresses		
Patients have access to clean bed linen		
Enough space is provided for mothers to wash their hands in rooming-in wards		
Staff have regular access to hand washing facilities (refer to Section 4.1)		
Mosquito nets are available for use by patients (if relevant)		
Ward is kept clean		
Dangerous items are inaccessible to patients		
Sharps are disposed of in a special container to prevent accidents		

2.3 Attention to the most seriously ill patients

Is there an emergency management area in or near to each ward?	Y	N
Are the most seriously ill patients cared for in a section close to the nursing station where they receive closer attention?	Y	N
Is there a heat source on the ward, and room temperatures kept above 25C, if applicable ?	Y	N

Comments:

2.4 Summary - Maternity wards

Score

Summary score - Maternity wards					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates adequately staffed, clean and well-equipped maternal wards; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=indicates significant deficiencies in one or more of the wards)

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3. Infection control and supportive care

3.1 Infection control in the maternity ward

Appropriate hand hygiene

Standards and criteria	Score 1- 5	Comments
Hand washing stations are well organized and equipped: - soap[1] - single-use towels - containers for used towel collection		
Alcohol-based hand rub is available at the point of care		
Written protocols on hygiene for hands are available and information on hand washing technique *How to handwash and How to handrub* are put above or near the sinks and the alcohol based formulation dispensers respectively (WHO Guidelines on Hand Hygiene in Health Care page 154/155)		
Protocols on hand washing and disinfection for various procedures are available and all staff has been briefed		
HCWs have a dedicated time available for infection control training, including sessions on hand hygiene		
HCWs' adherence to recommended hand hygiene practices are monitored and performance feedback is provided to them		
Hands are washed with soap and water when visibly dirty or visibly soiled with blood or other body fluid or after using the toilet - - hands are wet with water and amount of product necessary to cover all surfaces is applied - hands are rinsed with water and dried thoroughly with a single-use towel. - a towel is used to turn off tap/faucet - hands are dried thoroughly using a method that does not recontaminate hands. - towels are not used multiple times or by multiple people		
Alcohol-based handrub is used as the preferred means for routine hand antisepsis in all other clinical situations, if hands are not visibly soiled		

[1] Liquid, bar, leaf or powdered forms of soap are acceptable. WHO Guidelines on Hand Hygiene in Health Care

Standards and criteria	Score 1- 5	Comments
Soap and alcohol-based handrub are not used concomitantly		
Hand hygiene is performed: a. before and after touching the patient b. before handling an invasive device for patient care, regardless of whether or not gloves are used c. after contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings d. if moving from a contaminated body site to another body site during care of the same patient e. after contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient f. after removing sterile or non-sterile gloves		
Surgical scrub or surgical hand and forearm disinfection are performed for: - severely immuno-compromised patients (<500 WBC/ml), multiple trauma, severe burns, organ transplant - surgery or high-risk invasive procedures (e.g. central venous catheter, manual removal of placenta, endotracheal intubation)		
Surgical hand preparation is carried out appropriately: - rings, wrist-watch, and bracelets are removed before beginning - artificial nails are prohibited - if hands are visibly soiled, hands are washed with plain soap before surgical hand preparation - debris are removed from underneath fingernails using a nail cleaner, preferably under running water - no brushes are used for surgical hand preparation - a suitable antimicrobial soap or suitable alcohol-based handrub is used - when an antimicrobial soap is used hands and forearms are scrubbed for 2–5 minutes - surgical hand scrub and surgical handrub with alcohol-based products are not applied sequentially - after application of the alcohol-based handrub hands and forearms are allowed to dry thoroughly before donning sterile gloves		
If hands touch a contaminated surface during procedure or care of patient, surgical scrub is repeated		

Use of gloves

Standards and criteria	Score 1-5	Comments
Sterile gloves are used for surgical operations, minor surgical operations on skin, any procedure that may penetrate into tissues and mucous membranes, inserting sterile catheters, gavages etc., or any contact with sterile tissue or body fluids (blood, amniotic fluid)		
The use of gloves does not replace hand hygiene by either handrubbing or handwashing		
Gloves are used when it can be anticipated that contact with blood or other potentially infectious materials, mucous membranes, or non-intact skin will occur		
Gloves are removed after caring for a patient. The same pair of gloves are not used for the care of more than one patient.		
Gloves are changed or removed during patient care if moving from a contaminated body site to either another body site (including non-intact skin, mucous membrane or medical device) within the same patient or the environment		
The reuse of gloves is not recommended: In the case of glove reuse, the safest reprocessing method is implemented		
Gloves are used when handling soiled instruments and when disposing of contaminated waste items		

Practices for infection control

Standards and criteria	Score 1-5	Comments
Routine disinfection of premises performed, facilities are closed regularly for disinfection		
Ultra-violet lamp is routinely used for disinfection		
Routine policy of changing dress and footwear by staff observed		
Bandages on aseptic wound/IV catheter are changed daily		
Hair is not routinely removed preoperatively		
Wound dressing is changed at least every 48 hrs		
There is an infection control policy for visitors in the hospital, that may require restriction of access to some patients		
Caps and masks are routinely used by staff		

Summary- Infection control

Summary	Score 1-5	Comments
Appropriate hand hygiene:		
Use of Gloves		
Practices for infection control		

Score

Summary score - Infection control					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates excellent infections control practices are being used at all times in all wards; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

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3.2 Supportive care

Nutritional needs of admitted patients

Standards and criteria	Score 1-5	Comments
Nutritional needs of hospitalized pregnant women/mothers are met		
IV-glucose should not be used as calorie source for more than maximum 24 hours		

Use of Intravenous fluids

Standards and criteria	Score 1-5	Comments
Intravenous fluids are given only when indicated according to international guidelines		
Appropriate fluids are chosen		
The flow rate is monitored closely		

Drug treatment

Standards and criteria	Score 1-5	Comments
Routine use of drugs/ supplements of unproven effectiveness are NOT used		
Drugs are only given for an established or highly suspected diagnosis, or under clear indication for usage		
Routine use of sedative drugs or anti-histamines are NOT used		

Blood transfusion

Standards and criteria	Score 1-5	Comments
Blood is only given when indicated		
Only screened blood is used		
The flow rate is monitored		

Summary- Supportive care

Summary	Score 1-5	Comments
Nutritional needs		
Intravenous fluids use		
Drug treatment		
Blood transfusion		

Score

Summary score - Supportive care					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

Main strengths

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4. Maternal essential drugs, equipment and supplies

4.1 Drugs

Source: This information should ideally be collected before the visit, and be available for reference during the visit. If it has not been collected before, collect the information early during the visit from the emergency and ward areas.

Availability of drugs varies considerably in different regions. Please indicate the drugs available. For some drugs, local adaptations of use might exist (specify in note). If drugs are only available for sale and not freely available for patients, make a note. Check for the presence of drugs and enquire with staff whether drugs are regularly available. Check expiry dates.

	Lying-in	Labour ward	Comments
Water for Injection			
Normal saline IV			
Ringer's lactate IV			
Adrenaline			
Hydralazine			
Oxytocin			
Misoprostol			
Ergometrine			
Calcium gluconate			
Injection Magnesium Sulphate			
Diazepam			
Ampicillin / Amoxicillin			
Benzylpenicillin			
Gentamycin			
Metronidazole			
Lidocaine			
Tetracycline 1% eye ointment			
Eye antimicrobial (1% silver nitrate or 2.5% povidone iodine)			
Vitamin A			

Are there any expired drugs in the ward? Y N

4.2 Equipment and supplies in the maternity ward

Is the following equipment available in delivery room for normal labour, caesarean section (if delivery room for normal labour and caesarean section are in common, please specify in the note)? If a postal questionnaire was sent, cross check the information obtained in advance. Check the information during the visit. Ask the person in charge of the delivery room/ward for the items to be shown to you, and check that they are safe, hygienic and in good working order.

	Delivery room (normal labour)	**Delivery room (caesarean section)**	**Comments**
Adequate lighting			
Wall clock			
Partographs			
Heating lamp for neonates			
Towels for drying newborn babies			
Oxygen source: oxygen cylinder			
Oxygen source: oxygen			

	Delivery room (normal labour)	**Delivery room (caesarean section)**	**Comments**
concentrator			
Oxygen source: central supply			
Flow-meters for oxygen			
Equipment for the administration of oxygen			
via nasal prongs			
via catheters			
via masks			
Self-inflating bags for respiratory support			
Bags and Masks (adult and neonatal size)			
Anaesthetic equipment			
Normal thermometer (body temperature)			
Sterile gloves (re-sterilized or disposable?)			
Sterile gauze			
Foetal stethoscope			
Stethoscope			
Sphygmomanometer			
Infusion sets			
Infusion pumps/dosimeters			
IV catheters			
Syringes			
Needles			
Suturing set (scissors, needles holder)			
Suturing material			
Balance for baby			
Cord cutting/cord clamping set			
Vacuum extractor –			
Forceps			
Vacuum aspirator			
Beds - delivery beds			
Beds - regular beds			
Beds - operating theatre beds			
Neonatal equipment:			
- tracheal tubes			
- face masks			
- laryngoscope blades			
- oropharyngeal airways			
- breathing valves			
- resuscitation bags			

Is all the equipment safe?	Y	N
Is all the equipment cleaned regularly and sanitary?	Y	N
Is all the equipment kept in good working order?	Y	N

4.3 Summary - Essential drugs, equipment and supplies

Score

Summary score - Essential drugs, equipment and supplies					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates an adequate amount and quality of all essential drugs, equipment and supplies and also that drugs are not expired/expiring, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=indicates chronic shortages of essential drugs, equipment and supplies or recurrent lapses in the quality leading to potential dangerous and life threatening situations to both patients and staff)

Main strengths

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5. Maternal case management

Source: Visit to the labour and delivery ward, observation of practices, review of records and logbooks and interviews with staff and women.

Instructions: Give priority to direct observation, use interviews to staff and mothers to provide additional information.

5.1 Antepartum care

Hypertension in pregnancy, mild/severe pre-eclampsia and eclampsia

Diagnosis of hypertension, mild/ severe pre-eclampsia and eclampsia

Standards and Criteria	Score 1-5	Comments
The HCW is able to define hypertension, mild/ severe pre-eclampsia and eclampsia correctly		
Chronic hypertension: Diastolic blood pressure 90 mm Hg or more before first 20 weeks of gestation		
Chronic hypertension with superimposed mild pre-eclampsia: Diastolic blood pressure 90–110 mm Hg before 20 weeks of gestation Proteinuria up to 2+		
Pregnancy-induced hypertension: Two readings of diastolic blood pressure 90–110 mm Hg 4 hours apart after 20 weeks gestation No proteinuria		
Mild pre-eclampsia: Two readings of diastolic blood pressure 90–110 mm Hg 4 hours apart after 20 weeks gestation Proteinuria up to 2+		
Severe pre-eclampsia: Diastolic blood pressure 110 mmHg or more after 20 weeks gestation and/or Proteinuria 3+ or more		
Eclampsia: Convulsions Diastolic blood pressure 90 mm Hg or more after 20 weeks gestation Proteinuria 2+ or more		
Blood pressure and screening for proteinuria are done in all pregnant women seen in the antenatal clinic		

Dipstick urine is immediately performed in women coming to hospital with hypertension		
Mild and severe pre-eclampsia and eclampsia are correctly diagnosed (see criteria above) Check records and/or observe		

Prevention of pre-eclampsia

Standards and Criteria	Score 1-5	Comments
Calcium supplementation (1.5 – 2.0 g elemental calcium/day) is recommended for the prevention of pre-eclampsia to pregnant women at risk for pre-eclampsia from areas where dietary calcium intake is low.		
Low-dose acetylsalicylic acid (aspirin, 75 mg) is recommended for the prevention of pre- eclampsia in women at high risk of developing the condition.		
Women are not advised to rest at home for the primary prevention of pre-eclampsia and hypertensive disorders		
Strict bed rest is not recommended for improving pregnancy outcomes in women with hypertension (with or without proteinuria)		
The following are NOT done to prevent/treat pre-eclampsia: - Restriction in dietary salt intake - Vitamin D supplementation - Individual or combined vitamin C and vitamin supplementation - Treatment with - diuretics, particularly thiazides		

Management of mild-pre-eclampsia

Standards and Criteria	Score 1-5	Comments
GESTATION LESS THAN 37 WEEKS Women with stable or normalizing signs are followed up twice a week as an outpatient		
If women is admitted (at gestation less than 37 weeks): Normal diet is provided (salt restriction is discouraged); - blood pressure (twice daily) and urine for proteinuria (daily) are monitored; - No anticonvulsants, antihypertensives, sedatives or tranquillizers are given (unless blood		

pressure or urinary protein level increases) - No diuretics are given (only indicated for use in pre-eclampsia with pulmonary oedema or congestive heart failure)		
GESTATION MORE THAN 37 WEEKS In women with mild pre-eclampsia or mild gestational hypertension at term, induction of labour is recommended.		

Management of severe pre-eclampsia and eclampsia

Standards and Criteria	Score 1-5	Comments
Guidelines and a well-defined written protocol for management of severe pre-eclampsia and eclampsia are available, known and routinely used by staff		
A kit is ready for management of severe pre-eclampsia and eclampsia		
Staff skilled to manage severe pre-eclampsia and eclampsia are 24 hours available		
IV infusion is started using a large-bore (16-gauge or largest available) cannula or needle and IV fluids (normal saline or Ringer's lactate) are infused		
Magnesium sulfate is infused for the prevention of eclampsia in women with severe pre- eclampsia and for treatment of women with eclampsia Loading dose • 4 g of 20% magnesium sulfate solution IV over five minutes. • Followed promptly with 10 g of 50% magnesium sulfate solution: 5 g in each buttock as a deep IM injection with 1 mL of 2% lignocaine in the same syringe. Maintenance dose 5 g of 50% magnesium sulfate solution with 1 mL of 2% lignocaine in the same syringe by deep IM injection into alternate buttocks every four hours		
Vital signs (pulse, blood pressure, respiration), reflexes and fetal heart rate are monitored regularly (at least hourly) and woman is never left alone		
Fluid balance chart is maintained to prevent fluid overload the bladder is catheterized to monitor urine output and proteinuria. • the amount of fluids administered is monitored		
If diastolic blood pressure remains above 110 mm Hg, antihypertensive drugs, namely hydralazine 5 mg IV is given slowly every five minutes until the diastolic blood pressure is lowered to less than 100 mm Hg but not below 90 mm Hg (and repeated hourly or hydralazine 12.5 mg IM is given every two hours if needed)		

Standards and Criteria	Score 1-5	Comments
1 g Calcium gluconate (10 ml of 10% solution) is kept ready in case of signs of toxicity of magnesium sulphate		
In women with severe pre-eclampsia at term, early delivery is pursued		
Labour is induced in women with severe pre-eclampsia at a gestational age when the fetus is not viable or unlikely to achieve viability within one or two weeks.		
In women with severe pre-eclampsia, a viable fetus and before 34 weeks of gestation, a policy of expectant management is adopted provided that uncontrolled maternal hypertension, increasing maternal organ dysfunction or fetal distress are absent and are monitored.		
In women with severe pre-eclampsia, a viable fetus and between 34 and 36 (plus 6 days) weeks of gestation, a policy of expectant management is adopted, provided that uncontrolled maternal hypertension, increasing maternal organ dysfunction or fetal distress are absent and are monitored.		
Corticosteroids are not used for the specific purpose of treating women with HELLP syndrome,		
Women are carefully monitored after delivery.		
Clinicians aware of risk of developing eclampsia post-partum		
Women with severe pre- eclampsia/eclampsia are kept in the hospital for at least 4 days postpartum		
Follow-up is planned at 6 weeks for women with pre-eclampsia and further investigation implemented if persistent hypertension or proteinuria		

Antihypertensive treatment

Standard and Criteria	Score 1-5	Comments
Antihypertensive treatment is started when diastolic BP>110 OR if high proteinuria is present		
Antihypertensive treatment NOT routinely started if BP<160/100		
The choice and route of administration of an antihypertensive drug for severe hypertension during pregnancy, in preference to others, is based primarily on the prescribing clinician's experience with that particular drug, its cost and local availability.		

In women treated with antihypertensive drugs antenatally, antihypertensive treatment is continued postpartum		
Treatment with antihypertensive drugs is provided for severe postpartum hypertension.		

Summary - Hypertension in pregnancy, mild/severe pre-eclampsia and eclampsia

Summary	Score 1-5	Comments
(a) Diagnosis of hypertension, mild/ severe pre-eclampsia and eclampsia		
(b) Prevention of pre-eclampsia		
(c) Management of mild pre-eclampsia		
(d) Management of severe pre-eclampsia and eclampsia		
(e) Antihypertensive treatment		

Score

Summary score - Hypertension in pregnancy, mild/severe pre-eclampsia and eclampsia					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices

Main strengths

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Main weaknesses

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Prevention and management of infections in pregnancy

Antibiotic prophylaxis in pregnancy

Standards and criteria	Score 1-5	Comments
Adequate antibiotics are given in case of preterm prelabour rupture of membranes (PROM) (erythromycin 250 mg by mouth three times per day for seven days; PLUS amoxicillin 500 mg by mouth three times per day for seven days;)		
Adequate antibiotic prophylaxis is given to prevent infection in case of prolonged (more than 18 hours) rupture of membranes at or near term (prophylactic penicillin or ampicillin to help reduce Group B streptococcus infection in the neonate)		
Adequate antibiotics are given to women with established preterm labour (penicillin G 2 million units IV every six hours until delivery; OR ampicillin 2 g IV every six hours)		
Adequate antibiotics according to aetiology are given in labour to women with fever >38ºC		
Adequate antibiotics are given for prophylaxis in C-section (after delivery and cord clamping)		

Screening and management of urinary tract infections in pregnant women

Standards and Criteria	Score 1-5	Comments
Screening at 12-16 weeks with urine culture is performed in all antenatal patients.		
Cystitis is diagnosed correctly and treated with - amoxicillin 500 mg by mouth three times per day for three days; - OR trimethoprim/sulfamethoxazole one tablet (160/800 mg) by mouth two times per day for three days.		
Pyelonephritis is correctly treated according to standard treatment guidelines: Urine culture and sensitivity is checked, if possible, and infection treated with an antibiotic appropriate for the organism. • If urine culture is unavailable, treat with - ampicillin 2 g IV every six hours; - PLUS gentamicin 5 mg/kg body weight IV every 24 hours • Once the woman is fever-free for 48 hours, give amoxicillin 1 g by mouth three times per day to complete 14 days of treatment.		

Screening and management of syphilis in pregnant women

Standards and Criteria	Score 1-5	Comments
Appropriate syphilis testing is performed in all women at first antenatal visit and if possible in the third trimester.		
Penicillin) is given at the appropriate dose. BENZATHINE PENICILLIN IM (2.4 million units in 5ml as two injections at two different sites) Or (if woman is allergic) erythromycin 500 mg		
Women with syphilis are also screened and treated for other STDs; and partner screened and tested if found infected.		
Women with syphilis are not hospitalized and isolated during pregnancy/delivery.		

Screening and management of HIV in pregnant women

Standards and Criteria	Score 1-5	Comments
Guidelines and a written protocol for testing, counselling and management of pregnant women with HIV is available, known and routinely used by staff.		
Couples and partners in antenatal care settings should be offered voluntary HIV testing and counselling with support for mutual disclosure Provider-initiated testing and counselling is offered for women as a routine component of the package of care in all antenatal, childbirth, postpartum and paediatric care settings. Re-testing is offered in the third trimester, or during labour or shortly after delivery, because of the high risk of acquiring HIV infection during pregnancy.		
All pregnant women infected with HIV are initiated on triple ARVs (ART): once-daily fixed-dose combination of TDF + 3TC (or FTC) + EFV		
Pregnant women with HIV receive additional interventions such as screening for sexually transmitted infections, nutritional support and infant feeding and family planning counselling		
Facility- based delivery by trained skilled birth attendants is promoted. (Although caesarean section has been shown to protect against HIV transmission, especially in the absence of ARV drugs or in the case of high viral load, WHO does not recommend it in resource-limited settings specifically for HIV infection)		
Unnecessary instrumentation and premature rupture of membranes are avoided by using a partograph to monitor stages of labour;		
PMTCT – see section on PMTCT		

Screening and management of malaria in pregnant women

Standards and Criteria	Score 1-5	Comments
Guidelines and a written protocol for diagnosing and management of Malaria in pregnancy is available, known and routinely used by staff		
Parasite-based diagnosis is carried out to confirm clinical diagnosis before treatment is given to pregnant women (WHO Malaria treatment guidelines, 2010)		
Appropriate treatment is given to women with Malaria during pregnancy (First trimester: quinine +clindamycin for 7 days; artesunate + clindamycin for 7 days if first line treatment failed) (second or third trimester: ACT (with the exception of DHA+PPQ for which there is insufficient information in second and third trimesters of pregnancy to use as firstline therapy) if known to be effective in the country/region or artesunate plus clindamycin to be given for 7 days or quinine plus clindamycin to be given for 7 days.) (WHO Malaria treatment guidelines, 2010)		
Intermittent Presumptive Treatment (IPTp) with Sulfadoxine/Pirymethamine (SP) is used for all pregnant women at each scheduled antenatal care visit (in areas of moderate –to-high malaria transmission), with the first dose administered as early as possible during the 2nd trimester of gestation. (WHO recommendation, Nov 2012)		

Screening and management of gonorrhoea in pregnant women

Standards and Criteria	Score 1-5	Comments
If there is a high prevalence of gonorrhoea in the population, screening is performed by cervical culture		
Appropriate treatment is given to the woman and the partner is tested and treated.		
Women who are infected are not admitted to the hospital/not isolated and the eradication of the infection is checked with a follow-up swab and culture after treatment.		

Screening and management of other infections in pregnant women

Standard and Criteria	Score 1-5	Comments
Screening for Tuberculosis in pregnancy is performed in high risk population (e.g. people living with HIV).		
Screening for Hepatitis B is performed in all pregnant women and babies receive appropriate immunoglobulin treatment and vaccination at birth if the mother is found positive.		
Pregnant Women with genital herpes are not isolated and hospitalized		
Caesarean section is performed if genital herpes present or prodromal symptoms develop at the time of delivery.		
Termination of pregnancy is offered to women diagnosed with rubella in the first 16 weeks of pregnancy		
Women with cytomegalovirus, toxoplasmosis, trichomoniasis, and candidiasis are not hospitalized or isolated from other women.		
Women with rubella are not hospitalized (for rubella) If hospitalized are isolated from other women.		
Vaccination for rubella is offered to all seronegative women after childbirth, or miscarriage, when probability for another pregnancy in the next 30 days is low.		
Rooming in is promoted appropriately Depending on mother's infection status: IF mother has VDRL, gonorrhea, Chlamydia, GBS, toxoplasmosis, malaria, trichomonas or candidiasis, AND mother and baby are adequately treated, baby can room-in and breast feed with mother IF mother has TB, AND has normal chest Xray and/or no clinical evidence of TB/sputum negative, baby can room-in and breast feed with mother. IF mother has TB, BUT has active disease, baby MUST be isolated from mother until both are treated appropriately and maternal sputum is clear of bacilli. IF mother has hepatitis B, baby can room-in and breast feed with mother, IF baby has been vaccinated and treated appropriately with immunoglobulin treatment IF mother has herpes, CMV or rubella, baby MUST be isolated from other babies, though can room-in with mother. IF baby is pre-term, then mothers with CMV CANNOT breastfeed baby.		

Standard and Criteria	Score 1-5	Comments
General recommendation are given to pregnant women for prevention of listeriosis and toxoplasmosis		

Summary – Prevention and management of infections in pregnant women

Standards and Criteria	Score 1-5	Comments
1. Antibiotic prophylaxis in pregnancy		
2. Screening and management of urinary tract infection in pregnancy		
3. Screening and management of syphilis in pregnancy		
4. Screening and management of HIV in pregnancy		
5. Screening and management of Malaria in pregnancy		
6. Screening and treatment of gonorrhoea in pregnancy.		
7. Screening and management of other infections in pregnancy		

Score

Summary score – Prevention and management of infections in pregnant women					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices

Main strengths

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Main weaknesses

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5.2 Intrapartum & postpartum care

Normal labour and vaginal delivery

Source: Visit to the labour and delivery ward, observation of practices, review of records and logbooks and interviews with staff and women.

Instructions: Give priority to direct observation, use interviews to staff and mothers to provide additional information.
Please note: the page-references refer to the English version of the WHO IMPAC guidelines, "Managing complications in pregnancy and childbirth", 2007.

Delivery conditions

Standards and Criteria	Score 1-5	Comments
Labour ward teams use childbirth checklist		
Guidelines and a written protocol for delivery are available, known and used by staff		
Appropriate admission history is taken		
Cleanliness of the woman and her environment is ensured		
Staff wash their hands before delivery, and use high level disinfected/ sterile gloves while assisting with delivery.		
Staff use sterile instruments for delivery.		
Privacy and confidentiality is ensured Single room or curtains/screens available if there is more than one woman per room Bed is positioned far from door or window (not in front of them)		
The woman's consent is obtained for attendance of people other than staff (i.e. students)		
Staff use gloves while disposing waste		
The room is kept at an adequate temperature		

Supportive care throughout labour

Standards and Criteria	Score 1-5	Comments
There is at least one skilled service provider present throughout labour and birth.		
Chosen birth companion is allowed to remain with woman throughout labour and birth		
A supportive, encouraging atmosphere for birth that is respectful of the woman's wishes is provided and her complaints listened to and taken seriously		

Standards and Criteria	Score 1-5	Comments
- all procedures are explained, permissions are sought, and findings discussed with the woman. - she is kept informed about the progress of labour. - she is praised, encouraged and reassured that things are going well		
Breathing techniques for labour and delivery are explained and taught to the woman		
Mobility - the woman is encouraged to walk around freely during the first stage of labour. - the woman's choice of position is supported (left lateral, squating, kneeling, standing supported by the companion) for each stage of labour and delivery.		
Women are encouraged to eat and drink as they wish - if wasting is visible or woman tires during labour, it is ensured that she eats and drinks		
Women are encouraged to empty their bladder frequently (and reminded every 2 hours)		
For pain and discomfort relief change of position is suggested - mobility is encouraged - companion is encouraged to: - massage the woman's back if she finds this helpful. - hold the woman's hand and sponge her face between contractions. Woman is encouraged to use the breathing technique and warm bath or shower		
The following are NOT done: enemas, pubic shaving, or swabbing vagina with antiseptics		

Partogram/Partograph

Standards and Criteria	Score 1-5	Comments
Partogram is used properly and consistently at the bedside		
Partogram's information is collected, recorded and interpreted by skilled birth attendant and is used to support labour management interventions		

Foetal monitoring during labour

Standards and Criteria	Score 1-5	Comments
Intermittent auscultation for low risk pregnancy		
Guidelines for intermittent auscultation are in place stating how auscultation should be performed, and are known and used routinely by staff.		
Health service providers performing intermittent auscultation are skilled enough to recognize fetal heart beat pattern, maternal uterine activity and maternal pulse.		
Continuous electronic fetal monitoring (EFM) or cardiotocography (CTG)		
Guidelines for performing and interpreting EFM/CTG are in place in the unit, known and used by the staff		
If abnormal EFM/CTG suggests the need of expedited delivery, an emergency caesarean section / operative vaginal delivery is performed within 30 minutes.		
Continuous EFM/CTG is used only in higher risk pregnancy according to local protocol.		
EFM/CTG machines are in good condition and correctly working with the proper settings for date and time, paper speed and fetal heart rate.		
Name of the woman, mode of delivery, significant intra-partum events, uterine activity, day and time are registered on the paper and stored with the notes		
If medical staff is called to review the EFM/CTG, the evaluation is written in the notes or on the trace.		
Women don't lie on their back when undergoing EFM/CTG.		

Care during first stage of labour

Standard and Criteria	Score 1-5	Comments
Guidelines for safe delivery are available, known and used by skilled birth attendants		
Guidelines for anticipating and managing shoulder dystocia are available, known and used by skilled birth attendants		
Guidelines for managing cord prolapse are available, known and used by skilled birth attendants		

Standard and Criteria	Score 1-5	Comments
Women are monitored at least hourly and during active labour every 30 minutes for: - emergency signs - Frequency, intensity and duration of contractions. - Fetal heart rate - Mood and behaviour (distressed, anxious)		
Every 4 hours monitoring is carried out of: - Cervical dilatation (Unless indicated, vaginal examination is NOT done more frequently than every 4 hours.) - temperature - pulse - Blood pressure		
Findings are recorded regularly in Labour record and Partograph/Partogram - time of rupture of membranes and colour of amniotic fluid are recorded		
supportive care is given (see section on supportive care throughout labour)		
Progress of labour is assessed correctly and appropriate actions taken (After 8 hours if: Contractions stronger and more frequent but No progress in cervical dilatation with or without membranes ruptured→ complications during labour After 8 hours if: no increase in contractions, and membranes are not ruptured, and no progress in cervical dilatation → discharge and advise when to return - Cervical dilatation 4 cm or greater.--> manage active labour)		
Woman is never left alone during active labour		

Care during second stage of labour

Standards and Criteria	Score 1-5	Comments
When cervix is dilated 10 cm or bulging thin perineum and head visible: - women is never left alone and monitored every 5 minutes for emergency signs Frequency, intensity and duration of contractions. Fetal heart rate Perineum thinning and bulging. Visible descent of fetal head or during contraction. Mood and behaviour (distressed, anxious)		
Monitoring findings are recorded		
Controlled delivery oft the head is ensured		
Episiotomy is NOT routinely performed (only if fetal distress/operative delivery)		
Local anaesthesia is given if episiotomy is performed		
Mothers abdomen is accessed - second baby excluded - vaginal bleeding accessed		
10 IU oxytocin IM are given to the mother		
Essential newborn care is provided (refer to Chapter Neonatal Care)		

Care during third stage of labour

Standards and Criteria	Score 1-5	Comments
Active management of third stage is appropriately performed		
Mother is monitored (as above)		
Baby is monitored (refer to Chapter Neonatal Care)		
Placenta is delivered - strong uterine contraction (2-3 minutes) is awaited and placenta by controlled cord traction delivered - Placenta and membranes are checked for completeness		

Care of mother after delivery

Standards and Criteria	**Score 1-5**	**Comments**
Blood loss, fundal height and blood pressure are monitored regularly post-partum		
Minor tears are not stitched if not bleeding **p P83**		
Episiotomy/ tears are repaired with local anaesthesia		
Vagina and perineum are NOT swabbed with antiseptics after delivery		
Bladder catheterisation is NOT routinely performed in post-partum		
Cervix is NOT routinely checked after delivery		

Summary- Normal labour and vaginal delivery

Standard and Criteria	**Score 1-5**	**Comments**
(a) Conditions of delivery		
(b) Supportive care throughout labour		
(c) Partogram/Partograph		
(d) Foetal monitoring during labour		
(e) Care during first stage of labour		
(f) Care during second stage of labour		
(g) Care during third stage of labour		
(h) Care of mother after delivery		

Score

Summary score - Normal labour and vaginal delivery					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices

Main strengths

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Main weaknesses

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Prevention and management of preterm labour

Prevention of preterm labour

Standards and Criteria	Score 1-5	Comments
Bed rest, hospitalization and refraining from sexual activity are not currently recommended for women at risk of PTD.		
Prophylactic oral betamimetics/ magnesium sulphate/calcium supplementation are not given to women at risk of PTD.		

Management of preterm labour

Standards and Criteria	Score 1-5	Comments
Guidelines and written protocol with indications and procedures for tocolysis are available, known and used by skilled birth attendants		
Tocolysis is attempted in case of premature labour if: - gestation is less than 37 weeks; - the cervix is less than 3 cm dilated; - there is no amnionitis, pre-eclampsia or active bleeding; - there is no fetal distress		
Appropriate tocolytic drugs are used at correct doses: Salbutamol: Initial dose: 10 mg in 1 L IV fluids. IV infusion is started at 10 drops per minute. Subsequent dose: If contractions persist, infusion rate is increased by 10 drops per minute every 30 minutes until contractions stop or maternal pulse exceeds 120 per minute. If contractions stop, the same rate is maintained for at least eight hours Indomethacin: 100 mg loading dose by mouth or rectum, subsequent dose: 25 mg every six hours for 48 hours are given - Nifedipine as first choice?? - Betamimetics only if no contraindications??		

Standards and Criteria	Score 1-5	Comments
- Magnesium sulphate NOT used ?		
Tocolytics are not given for more than 48 hours		
Maternal and fetal condition are monitored (pulse, blood pressure, signs of respiratory distress, uterine contractions, loss of amniotic fluid or blood, fetal heart rate, fluid balance, blood glucose, etc.).		
Repeated treatment with tocolytics is NOT given after first successful treatment		
Oral betamimetics/ magnesium for maintenance therapy are not used		
If preterm labour continues despite use of tocolytic drugs, it is arranged for the baby to receive care at the most appropriate service with neonatal facilities		
Labour is allowed to progress if: - gestation is more than 37 weeks; - the cervix is more than 3 cm dilated; - there is active bleeding; - the fetus is distressed, dead or has an anomaly incompatible with survival; - there is amnionitis or pre-eclampsia.		
If labour continues and gestation is less than 37 weeks, prophylactic antibiotics are given in order to help reduce Group B streptococcus infection in the neonate: penicillin G 2 million units IV every six hours until delivery; - OR ampicillin 2 g IV every six hours.		
Delivery by vacuum extraction is avoided, as the risks of intracranial bleeding in the preterm baby are high.		
It is prepared for management of preterm or low birth weight baby and the need for resuscitation is anticipated		

Antenatal administration of corticosteroids

Standards and Criteria	Score 1-5	Comments
If less than 34 weeks gestation, corticosteroids are given to the mother to improve fetal lung maturity and chances of neonatal survival:		

- betamethasone 12 mg IM, two doses 24 hours apart; - OR dexamethasone6 mg IM, four doses 12 hours apart.		
Corticosteroids are not used in the presence of frank infection.		
Repeated courses are NOT routinely given		

Summary – Prevention and management of preterm labour

Standards and Criteria	Score 1-5	Comments
Prevention of preterm labour		
Management of preterm labour		
Antenatal administration of corticosteroids		

Score

Summary score - Management of preterm labour					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices

Main strengths

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Caesarean section (CS)

Source: This information should be collected by observing the treatment and care of women undergoing surgery, interviewing staff and caregivers and reviewing guidelines, where available.

Instructions: Give priority to direct observation, use interviews to staff and mothers to provide additional information

Emergency caesarean section

Standards and Criteria	Score 1-5	Comments
Guidelines and a written protocol for emergency caesarean section is available, known and used routinely by staff		
Anaesthesiologist, surgeon and operating theatre staff are always available for emergency caesarean section		
Emergency caesarean section starts in less than 30 min after decision made to proceed		
An operating theatre is 24 hours/7 days fully ready for emergency caesarean sections (surgery kit, electricity. etc)		
Stored blood (particularly O negative blood) is readily available in case blood transfusion needed		

Timing of caesarean section and informed consent

Standards and Criteria	Score 1-5	Comments
Elective caesarean sections are performed after 39 weeks age of gestation.		
Informed consent is obtained from women undergoing caesarean section		

Indications for caesarean section and policies to reduce inappropriate caesarean section incidence

Standard and Criteria	Score 1-5	Comments
Indication for caesarean section is reviewed before carrying out the procedure		
A surgeon is always involved in the decision to perform a caesarean section		
Caesarean section on maternal request is not allowed unless in very specific circumstances (e.g. previous stillbirth)		

Standard and Criteria	Score 1-5	Comments
When there is a maternal request for caesarean section, risks and benefits of vaginal delivery vs. CS are discussed with woman and discussion is documented in the notes.		
The decision about mode of birth after a previous caesarean section is taken after considering risk of uterus rupture during labour: - the previous surgery was NOT a low transverse caesarean incision; - the fetus is NOT in a normal vertex presentation; - emergency caesarean section canNOT be carried out immediately if required if the woman has a history of two lower uterine segment caesarean sections or ruptured uterus caesarean section is carried out		
Women with breech presentation are offered the option of an external cephalic version, if: - breech presentation is present at or after 37 weeks - vaginal delivery is possible; - facilities for emergency caesarian section are available; - membranes are intact and amniotic fluid is adequate; - there are no complications (e.g. fetal growth restriction, uterine bleeding, previous caesarean delivery, fetal abnormalities, twin pregnancy, hypertension, fetal death).		
Caesarean section is planned if external cephalic version fails		
Elective caesarean section is performed in uncomplicated twin pregnancies only if first twin is not vertex lie.		
Caesarean section is NOT routinely offered in preterm pregnancies or term small for gestational age babies.		
Caesarean section is NOT routinely offered for maternal viral infections other than primary HSV infection in the 3rd trimester (e.g. HCV+, HBV+).		
Caesarean section is NOT routinely carried out for mothers with HIV infection		

Procedures related to caesarean section

Standards and Criteria	Score 1-5	Comments
Guidelines and written protocol (or checklist) for caesarean section procedures are available, known and used by staff		
Pre- operative care principles are followed prior to caesarean section - the operating theatre is prepared according to guidelines - the women is prepared according to guidelines		
Oxygen, suction and resuscitation equipment are readily available and functioning.		
A blood sample for haemoglobin or haematocrit and type is sent and screened, and blood for possible transfusion ordered		
The bladder is catheterized if necessary and urine output monitored		
Spinal anaesthesia, local infiltration with lignocaine, ketamine or general anaesthesia are used Regional anaesthesia is offered as a first choice to all women undergoing caesarean section		
Intra- operatives care principles are followed The women is positioned appropriately this includes that the operating table is tilted 15° as long as baby is not yet delivered to decrease supine hypotension syndrome Surgical hand scrub is carried out The incision side is prepared		
Proper, evidence-based caesarean section technique is used		
A single dose of prophylactic antibiotics (ampicillin 2 g IV; OR cefazolin 1 g IV) is given after the cord is clamped and cut		
The woman´s condition is monitored throughout the procedure: - vital signs (blood pressure, pulse, respiratory rate), level of consciousness and blood loss are monitored - pain is managed		

Immediate post-caesarean care

Standards and Criteria	Score 1-5	Comments
There are specific notes from the surgeon on the procedure performed, required monitoring and necessary treatment. There is handover for the nurses from theatre staff.		
After recovery from anaesthesia, observations (respiratory rate, heart rate, blood pressure, pain and sedation) are continued every 15 min in the first hour, every half hour for the second hour, and hourly thereafter provided that the patient is stable. If patient is not stable, more frequent observations and medical review are done It is ensured that the woman has constant supervision until she is conscious.		
Guidelines on post-operative pain relief are available, known and used by staff		
If there is no contraindication, non-steroidal anti-inflammatory drugs are offered post-CS as an adjunct to other analgesics. Good postoperative pain control regimens include: • non-narcotic mild analgesics such as paracetamol 500 mg by mouth as needed; • narcotics such as pethidine 1 mg/kg body weight (but not more than 100 mg) IM or IV slowly or morphine 0.1 mg/kg body weight IM every four hours as needed; • combinations of lower doses of narcotics with paracetamol.		
Removal of the urinary bladder catheter is carried out once patient is mobile after regional anaesthesia and not sooner than 12 hours after the last 'top up' dose It is ensured that the urine is clear before removing the catheter. If the urine is clear, the catheter is removed eight hours after surgery or after the first postoperative night. • If the urine is not clear, the catheter is left in place until the urine is clear. • 48 hours after surgery before removing the catheter are waited, if there was: - uterine rupture; - prolonged or obstructed labour;		

Standards and Criteria	Score 1-5	Comments
- massive perineal oedema; - puerperal sepsis with pelvic peritonitis.		
Women, who are recovering well and mobilizing after caesarean section and do not have complications, can eat and drink when they feel hungry or thirsty		

Care after the first 24 hours and discharge after caesarean section

Standards and Criteria	Score 1-5	Comments
Women are prescribed regular analgesia for postoperative pain, using, if no contra-indication: • non-narcotic mild analgesics such as paracetamol 500 mg by mouth as needed; • narcotics such as pethidine 1 mg/kg body weight (but not more than 100 mg) IM or IV slowly or morphine 0.1 mg/kg body weight IM every four hours as needed; • combinations of lower doses of narcotics with paracetamol.		
Temperature is monitored to exclude fever		
Dressing is removed 24 hours after the caeseran section		
Wound is assessed for signs of infection, separation or dehiscence		
Wound care is carried out appropriately - the wound is gently cleaned and dried daily		
Women who are recovering well, do not have fever or complications following caesarean section are offered early discharge (after 24 hrs) from hospital and follow-up at home		
Removal of sutures/clips is planned at discharge if needed		
At the time of discharge from the hospital, women are informed to seek care for abnormal symptoms such as fever, abnormal uterine bleeding, urinary symptoms, chest and leg symptoms of deep vein thrombosis.		
Women discuss with healthcare providers the reasons for the caesarean section and implications for the child or future pregnancies and delivery methods for subsequent children.		
Women are informed that they can resume activities, such as formal exercise, once they have fully recovered from the caesarean section		

Summary - Caesarean section

Standard and Criteria	Score 1-5	Comments
(a) Emergency caesarean section		
(b) Timing of caesarean section and informed consent		
(c) Indications for caesarean section and policies to reduce the inappropriate caesarean section incidence		
(d) Procedures related to caesarean section		
(e) Immediate post-caesarean care		
(f) Care after the first 24 hours and discharge after caesarean section		

Score

Summary score - Caesarean section					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices.

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Postpartum haemorrhage (PPH)

Standards and Criteria	Score 1-5	Comments
Guidelines and a written protocol for preventing and managing PPH is available, known and used by skilled birth attendants **p S25-34**		
Adequate equipment, drugs and personnel are readily available in case of PPH.		
Uterine tonus is controlled after delivery (every 15 min in the first hour; at the end of the 2nd, 3rd, 4th hour, then every 4 hours) and uterus massaged if necessary		
In the delivery room and during early puerperium, the facility has reliable means of measuring blood loss		
Blood can be obtained without delay 24 hours a day **p C23**		
A written protocol is readily available, known and used routinely by staff for immediate notification of on-call-staff, initial assessment, treatment and resuscitation **p S25-27**		
A written protocol is readily available, known and used routinely by staff for treatment of uterine atony **p S28-31**		
A written protocol is readily available, known and used routinely by staff for refractory haemorrhages after medical treatment		

Summary - Postpartum haemorrhage

Score

Summary score - Postpartum haemorrhage					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices

Main strengths

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Main weaknesses

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Management of unsatisfactory progress of labour

Diagnosis of unsatisfactory progress of labour

Standard and Criteria	Score 1-5	Comments
Stage and phase of labour are correctly diagnosed		
Onset of labour is correctly diagnosed (presence of regular uterine contractions leading to effacement and dilatation of the cervix)		
False labour is correctly diagnosed (cervix not dilated with infrequent contractions and no cervical changes in 4 hours) and women are discharged after excluding urinary infection/ rupture of membranes		
Partograph is used		
Unsatisfactory progress of labour is correctly diagnosed ▪ Latent phase > 8 hours (cervical dilatation less than 4 cm after 8 hours of regular uterine contractions), OR ▪ Labor lasting more than 12 hours and the baby has not been delivered, OR ▪ Cervical dilatation line in the partograph is between Alert Line and Action Line, OR ▪ No progress of descent of fetal presenting part in stage II.		

Management of unsatisfactory progress of labour

Standard and Criteria	Score 1-5	Comments
Prolonged active phase is correctly diagnosed (cervical dilatation to the right of the action line)		
Uterine contractions are assessed and if efficient, cephalopelvic disproportion, obstruction, malposition or malpresentation are suspected		
If no sign of cephalopelvic disproportion/obstruction and membranes intact, artificial rupture of membranes/ amniotomy (ARM) is performed		
If there is secondary arrest of cervical dilatation and descent of presenting part in presence of good contractions, cephalopelvic disproportion is diagnosed and caesarean section performed		

Standard and Criteria	Score 1-5	Comments
Signs of obstructed labour are known and evaluated and correctly managed		
If there is a prolonged active phase, contractions are inefficient and cephalopelvic disproportion/obstructed labour excluded: - ARM is performed - oxytocin infusion started after 1 hour from ARM if good labour not established; progress reassessed after 2 hours of good uterine contractions - CS performed if no progress - cervix reassessed after 2 hours if there is progress		
Routine early amniotomy is NOT performed		
Amniotomy is safely and correctly performed		
Supine position in labour is not encouraged; woman encouraged to walk around and a birth companion is present in labour		

Oxytocin augmentation

Standard and Criteria	Score 1-5	Comments
Guidelines and protocol for indications,,dosage and usage of oxytocin are available, known and used by staff.		
Oxytocin infusion is stopped if fetal heart rate less than 100/min		
Amniotomy is performed when feasible before starting infusion		
Oxytocin is NOT given less than 12 hours after starting prostaglandins		
Prostaglandins are NOT used iv for induction or augmentation		

Summary - Management of unsatisfactory progress of labour

Standard and Criteria	Score 1-5	Comments
Diagnosis of unsatisfactory progress in labour		
Management of unsatisfactory progress in labour		
Oxytocin augmentation		

Score

Summary score Management of unsatisfactory progress in labour					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices

Main strengths

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6. Monitoring and follow-up

Note: Applies to women with complications.

Standards

- Every woman with a complication of pregnancy has a monitoring chart according to severity of condition where individual progress is monitored.
- Reassessment and monitoring is adequately done and correctly recorded by the nurses and a senior health professional is called when needed.
- Admitted women are reassessed by a doctor regularly according to severity of illness.
- Follow up is arranged prior to discharge with a discharge note explaining the condition and advice for return to the facility if condition reoccurs

6.1 Monitoring of individual progress

Standards and criteria	Score 1-5	Comments
Nutritional status is assessed in all admitted patients		
At the time of admission, a monitoring plan is made according to the severity of the patient's condition		
A standard monitoring chart is used with the following information: patient details, vital signs, clinical signs depending on condition, treatments given, feeding and outcome		

6.2 Reassessment and monitoring by nurses

Standards and criteria	Score 1-5	Comments
Key risk signs are monitored and recorded by a nurse twice a day and at least 4 times a day for critically ill patients		
Dosages and time are recorded for every patient receiving medications and IV fluids given by the nurse		
Additional special monitoring is performed and recorded appropriately when needed to follow the progress of particular conditions: e.g. use of MgSO4 in pre-eclampsia,		
Nurses use the results of patient monitoring to alert the physicians of problems or changing patient status warranting their attention		

6.3 Reassessment by physicians

Standards and criteria	Score 1-5	Comments
Seriously ill patients are assessed by a doctor upon admission and reviewed at least twice daily until improved		
All patients are reassessed daily during working days by a doctor		
Sick patients or new admissions are also reviewed by a physician on weekends and holidays		

6.4 Follow up

Standards and criteria	**Score 1-5**	**Comments**
If needed, follow up is arranged before discharge in the health facility closest to the patient's home that can provide the necessary follow up treatment		
All women receive a discharge note explaining their condition and providing information for the staff at the follow up facility		

6.5 Summary-Monitoring and follow up

Summary	**Score 1-5**	**Comments**
Nutritional status is assessed in all women		
Each woman's progress is individually monitored, and charts are used		
The most ill women receive highest attention		
All admitted women are appropriately reassessed by a doctor		
Follow-up		

Score

Summary score - Monitoring and follow up					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care and excellent monitoring and follow/up procedures of all patients occurs; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

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7. Summary scores – Module B: Maternal care

Summary scores		5	4	3	2	1
B.1.	Emergency obstetric care					
B.2.	Maternity wards					
B.3.	Infection control and supportive care					
	Infection control					
	Supportive care					
B.4.	Essential drugs, equipment and supplies					
B.5.	Maternal case management					
	Hypertension in pregnancy, mild/severe pre-eclampsia and eclampsia					
	Management of infections					
	Normal labour and vaginal delivery					
	Preterm labour					
	Caesarean section					
	Postpartum haemorrhage					
	Management of unsatisfactory progress of labour					
B.6.	Monitoring and follow up					
Module B	**TOTAL SCORE**					

Comments on the summary scores/ total score:

Module C - Neonatal Care

Contents

NEONATAL CARE

Source: Observation during the visit to the ward, and interviews with staff and persons accompanying the patients.

1. Neonatal resuscitation

Source: Observation during the visit, and interviews with staff

Standards and Criteria	Score 1-5	Comments
Guidelines for resuscitation and care of the newborn baby are available, known and used by staff		
There is always (24/7) staff available able to appropriately help a newborn baby breath and to perform resuscitation appropriately		
At every delivery resuscitation can be performed immediately (staff and equipment is available) if needed		
There is a clean resuscitation bed with a heating source and equipment ready to use		
A functioning self-inflating bag with functioning relief valve is available		
Appropriate sized masks (size 0, size 1) are available		
Post resuscitation care is provided appropriately - once adequate ventilation and circulation has been established, ventilation is stopped - newborn is returned to mother for skin-to-skin contact as soon as possible. - newborn is closely monitored for breathing difficulties, signs of asphyxia - need for further care is anticipated		

1.1 Summary - Neonatal resuscitation

Score

Summary score - Neonatal resuscitation					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates adequately staffed, clean and well-equipped nursery facilities; 4 to 1 indicating levels of

necessary improvement (4=small need for improvement, 1=indicates significant deficiencies in one or more of the wards)

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2. Neonatal wards

Source: Observation during the visit to the ward, and interviews with staff and persons accompanying the patients.

2.1 Neonatal ward staffing

	# on day shift	# on night shift	# on weekend shifts
Doctors			
Nurses			
Medical assistants or Residents			
Auxiliary staff			
Others (please specify)			

2.2 Rooming, hygiene and safety

Standards and criteria	Score 1-5	Comments
Sick newborns are kept in a separate unit or room from healthy babies		

Standards and criteria	Score 1-5	Comments
Mothers of sick newborns are rooming in with their babies, with adequate facilities		
Beds are safe, clean, well maintained and have mattresses		
Patients have access to clean bed linen		
Staff have regular access to hand washing facilities		
Mothers have access to clean running water, soap and an appropriate space by the ward to wash.		
Mosquito nets are available for use by mother and babies (if relevant)		
Ward is kept clean		
Toilets and washing facilities are kept clean		
Dangerous items are inaccessible to patients		
Sharps are disposed of in a special container to prevent accidents		

2.3 Attention to the most seriously ill neonates

Is there an emergency management area in or near to each ward? Y N

Are the most seriously ill neonates cared for in a section close to the nursing station where they receive closer attention? Y N

Is there a heat source on the ward, and room temperatures kept above 25C? Y N

Comments:

2.4 Summary – Neonatal wards

Score

Summary score - Neonatal wards					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates adequately staffed, clean and well-equipped nursery facilities; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=indicates significant deficiencies in one or more of the wards)

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3. Infection control and supportive care

3.1 Infection control in the neonatal wards

Hand hygiene

Standards and criteria	Score 1- 5	Comments
Hand washing stations are well organized and equipped: - soap[1] - single-use towels - containers for used towel collection		
Alcohol-based hand rub is available at the point of care		
Written protocols on hygiene for hands are available and information on hand washing technique *How to handwash and How to handrub* are put above or near the sinks and the alcohol based formulation dispensers respectively (WHO Guidelines on Hand Hygiene in Health Care page 154/155)		
Protocols on hand washing and disinfection for various procedures are available and all staff has been briefed		
HCWs have a dedicated time available for infection		

[1] Liquid, bar, leaf or powdered forms of soap are acceptable. WHO Guidelines on Hand Hygiene in Health Care

Standards and criteria	Score 1- 5	Comments
control training, including sessions on hand hygiene		
HCWs' adherence to recommended hand hygiene practices are monitored and performance feedback is provided to them		
Hands are washed with soap and water when visibly dirty or visibly soiled with blood or other body fluid or after using the toilet - - hands are wet with water and amount of product necessary to cover all surfaces is applied - hands are rinsed with water and dried thoroughly with a single-use towel. - a towel is used to turn off tap/faucet - hands are dried thoroughly using a method that does not recontaminate hands. - towels are not used multiple times or by multiple people		
Alcohol-based handrub is used as the preferred means for routine hand antisepsis in all other clinical situations, if hands are not visibly soiled		
Soap and alcohol-based handrub are not used concomitantly		
Hand hygiene is performed: a. before and after touching the patient b. before handling an invasive device for patient care, regardless of whether or not gloves are used c. after contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings d. if moving from a contaminated body site to another body site during care of the same patient e. after contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient f. after removing sterile or non-sterile gloves		
Surgical scrub or surgical hand and forearm disinfection are performed for: - severely immuno-compromised patients (<500 WBC/ml), multiple trauma, severe burns, organ transplant - surgery or high-risk invasive procedures (e.g. central venous catheter, manual removal of placenta, endotracheal intubation)		

Standards and criteria	Score 1- 5	Comments
Surgical hand preparation is carried out appropriately: rings, wrist-watch, and bracelets are removed before beginning artificial nails are prohibited if hands are visibly soiled, hands are washed with plain soap before surgical hand preparation debris are removed from underneath fingernails using a nail cleaner, preferably under running water no brushes are used for surgical hand preparation (a suitable antimicrobial soap or suitable alcohol-based handrub is used - when an antimicrobial soap is used hands and forearms are scrubbed for 2–5 minutes - surgical hand scrub and surgical handrub with alcohol-based products are not applied sequentially - after application of the alcohol-based handrub hands and forearms are allowed to dry thoroughly before donning sterile gloves		
If hands touch a contaminated surface during procedure or care of patient, surgical scrub is repeated		

Use of gloves

Standards and criteria	Score 1-5	Comments
Sterile gloves are used for surgical operations, minor surgical operations on skin, any procedure that may penetrate into tissues and mucous membranes, inserting sterile catheters, gavages etc., or any contact with sterile tissue or body fluids (blood, amniotic fluid)		
The use of gloves does not replace hand hygiene by either handrubbing or handwashing		
Gloves are used when it can be anticipated that contact with blood or other potentially infectious materials, mucous membranes, or non-intact skin will occur		
Gloves are removed after caring for a patient. The same pair of gloves are not used for the care of more than one patient.		
Gloves are changed or removed during patient care if moving from a contaminated body site to either another body site (including non-intact skin, mucous membrane or medical device) within the same patient or the environment		

The reuse of gloves is not recommended: In the case of glove reuse, the safest reprocessing method is implemented		
Gloves are used when handling soiled instruments and when disposing of contaminated waste items		

Practices for infection control

Standards and criteria	Score 1-5	Comments
Routine disinfection of premises performed, facilities are closed regularly for disinfection		
Ultra-violet lamp is routinely used for disinfection		
Routine policy of changing dress and footwear by staff observed		
Bandages on aseptic wound/IV catheter are changed daily		
There is an infection control policy for visitors in the hospital, that may require restriction of access to some patients		
Caps and masks are routinely used by staff		

3.2 Summary - Infection control

Summary	Score 1-5	Comments
Appropriate hand hygiene:		
Use of Gloves		
Practices for infection control		

Score

Summary score - Infection control					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates excellent infections control practices are being used at all times in all wards; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

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3.3 Supportive care

Nutritional needs of sick neonates

see section on case management of the sick neonate

Use of Intravenous fluids

Standards and criteria	Score 1-5	Comments
Intravenous fluids are given only when indicated by international guidelines		
Appropriate fluids are chosen		
The flow rate is monitored closely		

Drug treatment

Standards and criteria	Score 1-5	Comments
Drugs/ supplements of unproven effectiveness are NOT used		
Drugs are only given for an established or highly suspected diagnosis/under clear indication for usage		
Routine use of sedative drugs is NOT the norm		

Blood transfusion

Standards and criteria	Score 1-5	Comments

Blood is only given when indicated		
Only screened blood is used		
The flow rate is monitored		

3.4 Summary- Supportive care for sick neonates

Summary	Score 1-5	Comments
Intravenous fluids use		
Drug treatment		
Blood transfusion		

Score

Summary score - Supportive care					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

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4. Neonatal essential drugs, equipment and supplies

Drugs

Source: This information should ideally be collected before the visit, and be available for reference during the visit. If it has not been collected before, collect the information early during the visit from the emergency and ward areas.

Availability of drugs varies considerably in different regions. Please indicate the drugs available. For some drugs, local adaptations of use might exist (specify in note). If drugs are only available for sale in the emergency area and not freely available for patients, make a note. Check for the presence of drugs and enquire with staff whether drugs are regularly available. Check expiry dates

Drugs	**Comments**
Ampicillin	
Cefotaxime	
Cloxacillin	
Penicillin	
Ceftriaxone	
Chloramphenicol	
Gentamicin	
Kanamycin	
Vancomycin	
Cardiovascular drugs	**Comments**
Ibuprofen lysine (for PDA)	
Indomethacin (for PDA)	
CNS drugs	**Comments**
Naloxone	
Phenobarbital	
Phenytoin	
Fentanyl	
Diuretics	**Comments**
Furosemide	
Respiratory drugs	**Comments**
Aminophylline	
Caffeine citrate	
Surfactants	

Miscellaneous drugs	**Comments**
Isotonic crystalloid (normal saline or Ringer's lactate)	
Sodium bicarbonate	
Vitamins/minerals	**Comments**
Vitamin K	
Vitamin D	
Ferrous sulfate	

Are there any expired drugs in the ward? Y N

4.2 Equipment and supplies

	Y	N	Number	Comments
Incubators				
Radiant warmers				
Heated mattress cots				
Phototherapy lamps				
Ambu Bag				
Oxygen supply/concentrator				
Appropriate sized masks				
CPAP systems				
Multi-function monitors				

	Y	N	Number	Comments
Pulse-oximeters				
Breast pumps				
Nasogastric tubes				
Infusion pumps				
Exchange transfusion kit				
Portable ultrasound				
Dedicated X-ray				
Glucometers				
Bilirubinometer				
Transport incubator without ventilation system				
Transport incubator with ventilation system				

Is all the equipment safe? Y N

Is all the equipment cleaned regularly and sanitary? Y N

Is all the equipment kept in good working order? Y N

4.3 Summary - Essential drugs, equipment and supplies

Score

Summary score - Essential drugs, equipment and supplies					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates all essential drugs are available and not expired/expiring, equipment and supplies are present and are of good quality, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent or chronic shortages of drugs/chronic lapses in the quality of equipment leading to potentially life threatening situation to both patient and staff)

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5. Routine neonatal care

Source: Please collect the information by observing the treatment and care of children with the relevant condition and interviewing staff and carers.

Keep the baby in skin-to-skin contact on the mother's chest or at her side, in a warm, draught-free room.

Start breastfeeding within the first hour as soon as the baby shows signs of readiness to feed.

Let the infant breastfeed on demand if able to suck.

Give IM vitamin K (phytomethadione) to all newborns.

– 1 ampoule (1 mg/0.5 ml or 1 mg/ml) once. (Do not use 10 mg/ml ampoule.)

– For preterm neonates, give 0.4 mg/kg IM (maximum dose, 1 mg).

Keep umbilical cord clean and dry.

Apply antiseptic eye drops or ointment (e.g. tetracycline ointment) to both eyes once, according to national guidelines.

Give oral polio, hepatitis B and bacille Calmette-Guérin (BCG) vaccines, depending on national guidelines.

5.1 Newborn assessment and immediate care

Standards and criteria	Score 1-5	Comments
The newborn baby is assessed and dried immediately after birth		
The newborn baby is kept in a warm room, with no draughts, and if transport is required, baby is kept warm		
Baby's temperature is monitored while in the hospital		
Routine suctioning of the nose or catheterization of oesophagus is NOT done		
Umbilical cord is clamped after pulsation stops		
Stump of umbilical cord is left without dressing		
Mother and baby are covered together; baby given warm hat		
Bathing or washing are postponed to a few hours after birth		

5.2 Screening, prevention and management of vertically transmitted infectious diseases in the newborn

Syphilis

Standards and criteria	**Score 1-5**	**Comments**
Newborn babies are tested (serum blood) for syphilis and assessed for clinical signs of syphilis		
If the mother was not treated, inadequately treated or treatment status is unknown and baby does not have signs of syphilis, baby is treated with procaine benzylpenicillin (or benzathine benzylpenicillin) IM at the appropriate dose and followed up in 4 weeks to check growth and signs of congenital syphilis		
If women were treated more than 30 days before delivery, no treatment is given to the baby.		

Ophthalmia neonatorum

Standards and criteria	**Score 1-5**	**Comments**
Appropriate eye care is provided to all newborns at the time of birth to prevent ophthalmia neonatorum within 1 hour of delivery → antiseptic eye drops or ointment (e.g. tetracycline) are applied to both eyes once		

Tuberculosis

Standards and criteria	**Score 1-5**	**Comments**
Tuberculosis vaccine at birth (BCG) is given to all newborn babies unless the mother has active TB treated for less than 2 months before birth (in this case vaccine is given two weeks after treatment of the newborn baby is completed)		

Hepatitis B

All newborn babies receive Hepatitis B vaccination at birth		

Rooming in of neonates, according to mother's infection status

Babies are roomed-in and breast feed with their mother, if the mother has VDRL, gonorrhoea, Chlamydia, GBS, toxoplasmosis, malaria, trichomonas or candidiasis, AND mother and baby are adequately treated, if the mother has TB, AND has normal chest Xray and/or no clinical evidence of TB/ is sputum negative if mother has hepatitis B, AND, if baby has been vaccinated and treated appropriately with immunoglobulin treatment Babies are isolated from their mother if the mother has active TB disease until both are treated appropriately and maternal sputum is clear of bacilli Babies are isolated from other babies, but roomed-in with their mother if the mother has herpes, CMV or rubella, If the baby is pre-term,, mothers with CMV are not breastfeeding theire baby		

5.2 Early and exclusive breastfeeding

Standards and criteria	Score 1-5	Comments
The baby is put onto the mothers chest in skin-to-skin contact immediately after delivery (if there is no need for resuscitation or maternal problem)		
Initiation of breastfeeding is encouraged within the first hour, and it is ensured that mothers and babies are undisturbed,		
Staff are trained and help mother and babies to initiate breastfeeding within an hour after delivery		
There is no promotion of infant formula on the ward and samples are not distributed to mothers or staff		

Standards and criteria	Score 1-5	Comments
There are no restrictions on the frequency or length of breastfeeding		
At discharge, exclusive breastfeeding is recommended until the age of 6 months and complementary breastfeeding until 24 months		
Expressed breast-milk is given by cup or NG-tube when the child is unable to feed or if the mother cannot stay with the child all the time		
Infant formula, glucose supplementation, water supplementation are not used unless upon written medical instruction		
Exceptions to exclusive breastfeeding are based on current evidence		

5.4 Routine prophylaxis

Standards and criteria	Score 1-5	Comments
Eye prophylaxis (at the end of first hour) is provided		
Vitamin K is given i.m.		
Immunizations are administered according to the local policy		
Baby's Rh status is checked after delivery if mother is Rh negative		

5.5 Monitoring of newborns before discharge

Standards and criteria	Score 1-5	Comments
Breathing rate is assessed and documented in the first day of life		
Documentation on breastfeeding and frequency is kept		
Documentation on absence or presence of jaundice kept		

5.6 Information and counselling for mothers

Standard and Criteria	Source 1-5	Comments
Guidelines available to teach mothers on how to care for the baby at home		
Mothers shown how to bathe the baby, how to take care of the umbilical stump and of their breasts		
Every baby is recorded in the delivery room register		
Gestational age, weight, length and head circumference at birth and weight at discharge are recorded in the information provided to mothers		

5.7 Summary - Routine neonatal care

Summary Routine Neonatal Care	Score 1-5	Comments
Newborn assessment and immediate care		
Screening, prevention & adequate management of vertically transmitted infectious diseases in the newborn		
Early and exclusive breastfeeding		
Routine prophylaxis		
Monitoring of the newborn before discharge		
Information and counselling for mothers		

Score

Summary score - Routine neonatal care					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

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6. Case management of the sick newborn

Note: Sick newborns might be admitted in different areas, the maternity ward or the infant ward. Information should be primarily by case observation

6.1 Monitoring and treatment for sick newborns

Standards and criteria	Score 1-5	Comments
Sick babies are kept in a separate unit or room from healthy babies		
Mothers are NOT routinely separated from babies, and can room-in together		
Heart rate and breathing rate are documented every 3-6 hrs. according to the clinical situation		
Temperature is recorded every 6-12 hrs. or 3-6 hrs. if under radiant source		
Weight is recorded at least daily (twice daily in LBW babies)		
Special feeding needs are included in the plan/record		
Routine medications are NOT given if no specific indications		

6.2 Neonatal sepsis

Standards and criteria	Score 1-5	Comments
Sepsis is suspected in neonates with signs such as difficulty feeding, hypotonia, lethargy and babies are appropriately investigated (urine microscopy, search for foci of infection, etc.)		
Lumbar puncture is done to rule out or confirm meningitis		
Newborn babies get oxygen if cyanosed or in severe respiratory distress		
Antibiotics are given according to age and weight of the baby		
Clinical status and the response to treatment is monitored and recorded		

6.3 Specific feeding needs

Standards and criteria	Score 1-5	Comments
Mothers' milk is given to Low Birth Weight (LBW) babies as much as possible		
Frequent feedings (at least 8 per day) are provided to LBW babies and intake is monitored		
Babies unable to feed are given expressed breast milk by cup, spoon or fed by naso-gastric tube in adequate amounts according to age. Intake is monitored		
If IV fluids are given, they are recorded and precautions are taken to prevent fluid overload		
In LBW babies (< 1.75 Kg) that are being nursed, heat loss is minimized by kangaroo-care and a cap on the head		

6.4 Recognition and treatment of hypoglycaemia, hypocalcaemia and jaundice

Standards and criteria	Score 1-5	Comments
Guidelines for recognition and treatment of hypoglycaemia are available, known and used by staff		

Standards and criteria	Score 1-5	Comments
Guidelines for prevention of hypoglycaemia in SGA, LGA and babies of diabetic mothers are available, known and used by staff		
In case of "convulsions" or "lethargy", glucose, calcium and magnesium levels are checked and corrected		
Facilities for exchange transfusion are available, or there are guidelines when to transfer a seriously jaundiced baby		
Phototherapy and guidelines when to use it are available and adequate hydration is ensured		
Procedures are in place to check the bilirubin level		
Phototherapy lamps are checked regularly for correct functioning		

6.5 Appropriate and safe use of oxygen for preterm babies

Standards and criteria	Score 1-5	Comments
Guidelines for the use and monitoring of oxygen therapy in preterm infants are available, known and used by the staff		
Oxygen need is routinely assessed using a pulse-oxymeter		
Preterm babies with oxygen therapy have SatO2 monitored		

6.6 Summary - Case management of the sick newborn

Summary	Score 1-5	Comments
Monitoring and treatment for sick newborns		
Neonatal sepsis		
Specific feeding needs		
Recognition and treatment of hypoglycaemia, hypocalcaemia and jaundice		
Appropriate and safe use of oxygen for preterm babies		

Score

Summary score - Case management and sick newborn care					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

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7. Monitoring and follow-up

7.1 Monitoring of individual progress

Standards and criteria	Score 1-5	Comments
Nutritional status is assessed in all sick neonates		
At the time of admission, a monitoring plan is made according to the severity of the neonates condition		
A standard monitoring chart is used with the following information: patient details, vital signs, clinical signs depending on condition, treatments given, feeding and outcome		

7.2 Monitoring by nurses

Standards and criteria	Score 1-5	Comments
Key risk signs are monitored and recorded by a nurse twice a day and at least 4 times a day for critically ill patients		
Dosages and time are recorded for every patient receiving medications and IV fluids given by the nurse		
Additional special monitoring is performed and recorded appropriately when needed to follow the progress of particular conditions: e.g. coma scale for unconscious neonates		
Nurses use the results of patient monitoring to alert the physicians of problems or changing patient status warranting their attention		

7.3 Reassessment by physicians

Standards and criteria	Score 1-5	Comments
Seriously ill neonates are assessed by a doctor upon admission and reviewed at least twice daily until improved		
All patients are reassessed daily during working days by a doctor		
Sick neonates or new admissions are also reviewed by a physician on weekends and holidays		

7.4 Follow up

Standards and criteria	Score 1-5	Comments
If needed, follow up is arranged before discharge in the health facility closest to the patient's home that can provide the necessary follow up treatment		
All mothers/caretakers of admitted neonates receive a discharge note explaining their condition and providing information for the staff at the follow up facility		

7.5 Summary - Monitoring of the sick neonate

Summary	Score 1-5	Comments
1. Monitoring of individual progress		
2. Monitoring by nurses		
3. Reassessment by physicians		
4. Follow up		

Score

Summary score - Monitoring and follow up					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care and excellent monitoring and follow/up procedures of all patients occurs; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

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Main weaknesses

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8. Summary scores – Module C: Neonatal Care

Summary scores		**5**	**4**	**3**	**2**	**1**
C.1.	Neonatal resuscitation					
C.2.	Nursery facilities					
C.3.	Infection control and supportive care					
	Infection control					
	Supportive care					
C.4.	Essential drugs, equipment and supplies					
C.5	Routine neonatal care					
C.6.	Case management of the sick newborn					
C.7.	Monitoring and follow up					
Module C	**TOTAL SCORE**					

Comments on the summary scores/ total score:

Module D - Paediatric Care

Contents

PAEDIATRIC CARE

Source: This information should be collected by checking for drugs, equipment and supplies; and through observing the treatment and care of children presenting in emergencies and also those with the relevant condition and interviewing staff and caregivers.

1 Paediatric emergency care

Source: Visit to the emergency paediatric ward and interviews with staff dealing with emergencies.

Instructions: Interview staff where emergencies would present, who would see them; how senior staff are called, and where and how severe conditions are handled.

1.1 Patient flow

Where are children with medical or surgical emergency conditions received?

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Describe the patient flow of a typical obstetric emergency (woman presenting as an emergency to hospital):

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Is there an emergency management area equipped to take care of children? Y N

Is there a separate consultation area for moderately ill children? Y N

Is this separate from the normal outpatient facility dealing with patients? Y N

Comments and descriptions:

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Do patients come with referral notes when they have been referred from first level units?

never □ sometimes □ always □

Are there any job aids (wall charts, chart booklets) displayed for the management of paediatric emergencies? Y N

If so, describe about what, and comment on adequacy:

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Distance from reception area to emergency management area:

In the same building, distance _____

In another building, distance _____

Distance from consultation area to emergency management area:

In the same building, distance _____

In another building, distance _____

1.2 Staffing

Type of staff	**during working hours** *Present/ not present* *If present, number*	**after working hours** *Present/ not present* *If present, number*	Trained in **assessment/ detection of** emergency conditions *Yes/No*	Trained in **management of** emergency conditions *Yes/No*	**Remarks**
Administrative clerk					
Auxiliary Nurse					
Triage Nurse					
Medical officer					
Paediatrician					

1.3 Layout and structure of emergency care

Standards and criteria	**Score 1-5**	**Comments**
A system is in place to prioritize severely ill patients (triage)		
Assessment is done in a timely manner and not hindered by registration procedures, payment etc. before lifesaving action takes place		
A wall chart or job aid for identifying children by severity of condition is located in the emergency admissions area.		
A Staff is designated to do triage and is trained in the ETAT guidelines and can implement them appropriately when the emergency room gets busy during peak hours		
A health professional is always available to manage patients with emergency conditions and is skilled in the management of common emergency conditions and starts treatment without delay: Management of convulsions, lethargy, severe respiratory distress, shock and severe dehydration		
Essential drugs for emergency conditions (anticonvulsants, glucose, iv fluids) are always available and free of charge to the family		
Essential lab tests (glucose, Hb or PCV) are available and results are obtained timely		

Standards and criteria	Score 1-5	Comments
Essential equipment (needles and syringes, nasogastric tubes, oxygen equipment, self-inflating resuscitation bags with masks of different sizes, nebulisers or spacers) is available		
Case Management (see below)		

1 Information is mainly obtained by direct case observation and through interviews with staff about the routine practice. If no cases with emergency conditions are observable, staff is interviewed about how they would manage such conditions.

2 Please refer to the tables in the section "Essential paediatric drugs, equipment and supplies". Please note when judging the adequacy of supplies that some drugs (e.g. oxygen, anticonvulsants) need to be immediately available, whereas for others (e.g. antibiotics) it is sufficient that availability is assured.

1.4 Case management

Source: Information is obtained by case observation of cases presenting, as far as possible, and through interviews with staff about the routine practice. If you cannot observe one to two cases, describe scenarios to staff of two to three cases with convulsions, severe respiratory distress, and shock.

Cases include neonates and children presenting with danger signs (i.e. severe respiratory distress, severe dehydration). Case management is observed during working hours and after hours. If no cases with emergency conditions present, staff are interviewed about how they would manage such conditions. Enquire about the management of a child presenting with convulsions, with lethargy, with severe respiratory distress, or with severe dehydration.

1.5 Summary - Emergency paediatric care

Summary	Score 1-5	Comments
Patient flow		
Staffing		
Layout and structure		
Case management of emergency conditions		

Score

Summary score - Emergency paediatric care					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care i.e. well-staffed emergency department with experienced and trained staff available on hand at all hours to help manage emergency cases, 4 to 1 indicating

levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

Main strengths

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Main weaknesses

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2. Paediatric wards

2.1 Staffing

Source: Observation during the visit to the ward, and interviews with staff and persons accompanying the patients.

	# on day shift	# on night shift	# on weekend shifts
Paediatricians			
Medical Officers			
Nurses			
Medical assistants			
Auxiliary staff			
Others (please specify)			

2.2 Hygiene and accident prevention

Standards and criteria	1	2	3	4	5	Comments
Patient toilets are accessible to patients and separate from public, or staff, toilets						
Toilets are clean						
Beds are safe, clean, well maintained and have mattresses						
Patients have access to clean bed linen						
Staff have regular access to hand washing facilities (refer to Section 16.1.)						
Patients have access to clean running water, soap and an appropriate space by the ward, to be washed						
Mosquito nets are available for use by patients (if relevant)						
Ward is kept clean						
Dangerous items are inaccessible to patients						
Sharps are disposed of in a special container to prevent accidents						

2.3 Attention to the most seriously ill patients

Is there an emergency management area in or near to each ward? Y N

Are the most seriously ill patients cared for in a section close to the nursing station where they receive closer attention? Y N

Is there a heat source on the ward, and room temperatures kept above 25C? Y N

Comments:

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2.4 Summary - Paediatric wards

Score

Summary score - The paediatric wards					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates adequately staffed, clean and well-equipped paediatric ward; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=indicates significant deficiencies in one or more of the wards)

Main strengths

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Main weaknesses

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3. Infection control and supportive care in the paediatric ward

3.1 Infection control

Hand hygiene

Standards and criteria	Score 1- 5	Comments
Hand washing stations are well organized and equipped: - soap[1] - single-use towels - containers for used towel collection		
Alcohol-based hand rub is available at the point of care		
Written protocols on hygiene for hands are available and information on hand washing technique *How to handwash and How to handrub* are put above or near the sinks and the alcohol based formulation dispensers respectively (WHO Guidelines on Hand Hygiene in Health Care page 154/155)		
Protocols on hand washing and disinfection for various procedures are available and all staff has been briefed		
HCWs have a dedicated time available for infection control training, including sessions on hand hygiene		
HCWs' adherence to recommended hand hygiene practices are monitored and performance feedback is provided to them		
Hands are washed with soap and water when visibly dirty or visibly soiled with blood or other body fluid or after using the toilet - - hands are wet with water and amount of product necessary to cover all surfaces is applied - hands are rinsed with water and dried thoroughly with a single-use towel. - a towel is used to turn off tap/faucet		

[1] Liquid, bar, leaf or powdered forms of soap are acceptable. WHO Guidelines on Hand Hygiene in Health Care

Standards and criteria	Score 1- 5	Comments
- hands are dried thoroughly using a method that does not recontaminate hands. - towels are not used multiple times or by multiple people		
Alcohol-based handrub is used as the preferred means for routine hand antisepsis in all other clinical situations, if hands are not visibly soiled		
Soap and alcohol-based handrub are not used concomitantly		
Hand hygiene is performed: a. before and after touching the patient b. before handling an invasive device for patient care, regardless of whether or not gloves are used c. after contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings d. if moving from a contaminated body site to another body site during care of the same patient e. after contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient f. after removing sterile or non-sterile gloves		
Surgical scrub or surgical hand and forearm disinfection are performed for: - severely immuno-compromised patients (<500 WBC/ml), multiple trauma, severe burns, organ transplant - surgery or high-risk invasive procedures (e.g. central venous catheter, manual removal of placenta, endotracheal intubation)		
Surgical hand preparation is carried out appropriately: rings, wrist-watch, and bracelets are removed before beginning artificial nails are prohibited if hands are visibly soiled, hands are washed with plain soap before surgical hand preparation debris are removed from underneath fingernails using a nail cleaner, preferably under running water		

Standards and criteria	Score 1- 5	Comments
no brushes are used for surgical hand preparation (a suitable antimicrobial soap or suitable alcohol-based handrub is used - when an antimicrobial soap is used hands and forearms are scrubbed for 2–5 minutes - surgical hand scrub and surgical handrub with alcohol-based products are not applied sequentially - after application of the alcohol-based handrub hands and forearms are allowed to dry thoroughly before donning sterile gloves		
If hands touch a contaminated surface during procedure or care of patient, surgical scrub is repeated		

Use of gloves

Standards and criteria	Score 1-5	Comments
Sterile gloves are used for surgical operations, minor surgical operations on skin, any procedure that may penetrate into tissues and mucous membranes, inserting sterile catheters, gavages etc., or any contact with sterile tissue or body fluids (blood, amniotic fluid)		
The use of gloves does not replace hand hygiene by either handrubbing or handwashing		
Gloves are used when it can be anticipated that contact with blood or other potentially infectious materials, mucous membranes, or non-intact skin will occur		
Gloves are removed after caring for a patient. The same pair of gloves are not used for the care of more than one patient.		
Gloves are changed or removed during patient care if moving from a contaminated body site to either another body site (including non-intact skin, mucous membrane or medical device) within the same patient or the environment		
The reuse of gloves is not recommended: In the case of glove reuse, the safest reprocessing method is implemented		

Standards and criteria	Score 1-5	Comments
Gloves are used when handling soiled instruments and when disposing of contaminated waste items		

Practices for infection control

Standards and criteria	Score 1-5	Comments
Routine disinfection of premises performed, facilities are closed regularly for disinfection		
Ultra-violet lamp is routinely used for disinfection		
Routine policy of changing dress and footwear by staff observed		
Bandages on aseptic wound/IV catheter are changed daily		
There is an infection control policy for visitors in the hospital, that may require restriction of access to some patients		
Caps and masks are routinely used by staff		

Summary – Infection control

Summary	Score 1-5	Comments
Appropriate hand hygiene:		
Use of Gloves		
Practices for infection control		

Score

Summary score - Infection control					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates excellent infections control practices are being used at all times in all wards; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

Main strengths

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Main weaknesses

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3.2 Supportive care

Nutritional needs of admitted patients

Standards and criteria	Score 1-5	Comments
Nutritional needs of all patients are met, according to age and ability to feed		
IV-glucose should not be used as calorie source for more than maximum 24 hours		
Breastfed infants continue to receive breast milk from mother **p 262** - see also Section 13.1.3		
Appropriate complementary feedings is offered at least 3 times a day to breastfed infants of 6-12 months of age **p 262**		
Feedings are offered at least 5 times a day to non-breast-fed infants of 6 to 24 months of age **p 271**		
All children admitted receive their full caloric requirement unless there is good medical reasons for not giving it **p 270**		
A sufficient caloric intake (100 calories/kg for children under 10 kg) is provided; for children too sick to feed, feed by nasogastric tube		

Use of Intravenous fluids

Standards and criteria	Score 1-5	Comments
Intravenous fluids are given only when indicated by international guidelines		
Appropriate fluids are chosen		
The flow rate is monitored closely		

Drug treatment

Standards and criteria	Score 1-5	Comments
Routine use of drugs/ supplements of unproven effectiveness are NOT used		
Drugs are only given for an established or highly suspected diagnosis, or under clear indication for usage		
Routine use of sedative drugs or anti-histamines are NOT used		

Blood transfusion

Standards and criteria	Score 1-5	Comments
Blood is only given when indicated		
Only screened blood is used		
The flow rate is monitored		

Summary- Supportive care for sick children

Summary	Score 1-5	Comments
Nutritional needs		
Intravenous fluids use		
Drug treatment		
Blood transfusion		

Score

Summary score - Supportive care					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

Main strengths

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4. Paediatric essential drugs, equipment and supplies

4.1 Drugs

Source: This information should ideally be collected before the visit, and be available for reference during the visit. If it has not been collected before, collect the information early during the visit from the emergency and ward areas.

Availability of drugs varies considerably in different regions. Please indicate the drugs available. For some drugs, local adaptations of use might exist (specify in note). If drugs are only available for sale in the emergency area and not freely available for patients, make a note. Check for the presence of drugs and enquire with staff whether drugs are regularly available. Check expiry dates.

	Emergency area	Paediatric Ward	Comments
Glucose 30-50% IV			
Glucose 10 % IV			
Glucose 5 % IV			
Normal saline IV			
Ringer's lactate IV			
Epinephrine (Adrenaline) subcutaneously			
Corticosteroids IV or oral			
Furosemide IV			
First line anticonvulsant: Diazepam/Paraldehyde IM, IV			
Phenobarbital IM, IV.			
Ampicillin / Amoxicillin			
Benzylpenicillin			
Antistaphylococcal penicillin (e.g. Flucloxacillin)			
Ceftriazone			

Chloramphenicol			
Ciprofloxacin			
Gentamicin			
Co-trimoxazole			
All anti-malaria drugs needed according to national malaria control programme			
Vitamin K IM injection			
ORS			

Are there any expired drugs in the ward? Y N

4.2 Equipment and Supplies

Is the following equipment available in the emergency area, or on the ward? If a postal questionnaire was sent, cross check the information obtained in advance. Check the information during the visit to the ward, and the emergency area. Ask the person in charge of the area/ward for the items to be shown to you, and check that they are safe, hygienic, and in good working order. Check that the size is adequate for use in infants and children

		Emergency area	Ward	Comments
Resuscitation table/area				
Torch				
Otoscope				
Scales for children				
Measuring board to measure length and height (lying/standing according to age)		(length) (height)	(length) (height)	
Stethoscopes				
Thermometers				
Heat source				
Oxygen source	oxygen cylinder			
	oxygen			

	concentrator central supply			
Flow-meters for oxygen				
Equipment for the administration of oxygen				
Indicate which equipment you use	nasal prongs catheters masks			
Self-inflating bags for resuscitation				
Masks	___ infant size ___ child size ___ adult size			
IV-giving sets with chambers for paediatric use				
Butterflies and/or cannulas of paediatric size				
NG-tubes, paediatric size				
Equipment for intra-osseous fluid administration				
Suction equipment				
Chest tubes				
Nebulisers for administration of salbutamol				
Indicate type of nebulizer:	___ electricity driven ____ oxygen driven ___ foot pump driven			

Spacers with masks for administration of metered doses (spray) of salbutamol			

Is all the equipment safe? Y N

Is all the equipment cleaned regularly and sanitary? Y N

Is all the equipment kept in good working order? Y N

4.3 Summary- Essential drugs, equipment and supplies

Score

Summary score - Essential drugs, equipment and supplies					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates an adequate amount and quality of all essential drugs, equipment and supplies and also that drugs are not expired/expiring, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=indicates chronic shortages of essential drugs, equipment and supplies or recurrent lapses in the quality leading to potential dangerous and life threatening situations to both patients and staff)

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5 Case management of common paediatric diseases

Source: This information should be collected by observing the treatment and care of children with the relevant condition and interviewing staff and carers.

Please note: the page references refer to the English version of the WHO Pocket Book of Hospital care for Children

5.1 Cough/difficult breathing

Assessment and treatment of pneumonia

Standards and Criteria	Score 1-5	Comments
Health workers correctly diagnose pneumonia and classify/ recognize severity by observing the patient's clinical signs **p 69-74, 78**		
Signs such as chest-indrawing, respiratory rate, presence of cyanosis and general condition are used **p 70-73**		

Administration of antibiotics

Standards and Criteria	Score 1-5	Comments
Antibiotics are given ONLY to children with a diagnosis consistent with significant bacterial infection **p 74,75,79, 80**		
Appropriate antibiotics are administered for the proper diagnosis at the correct dosage for weight **p 74,75,79,80**		
If child has not improved after two days or condition worsens, a health professional looks for complications or considers other diagnoses **p 76,79**		

Administration of oxygen therapy

Standards and Criteria	Score 1-5	Comments
Oxygen is administered ONLY to children who demonstrate signs of hypoxemia. **p 75, 79, 281-284**		

Oxygen is administered correctly (prongs or catheter, correct flow, no interruptions) and monitored appropriately Oxygen mask and headbox are avoided due to waste of oxygen and risks **p 281-284**		

Use of chest X-ray

Standards and Criteria	Score 1-5	Comments
Chest x-rays are performed when clinically indicated ONLY: Young infants cases with suspected complications (e.g. empyema, pneumothorax, abscess) patients not responding to appropriate antibiotic treatment after > 48 hours		
Chest x-ray is NOT performed in patients with uncomplicated pneumonia or cough and cold unless there is a clear indication **pp 76-77**		

Management of wheezing

Standards and Criteria	Score 1-5	Comments
Children in need of bronchodilators are correctly identified/ diagnosed **p 87,88**		
Inhaled bronchodilators are correctly administered (method, dosage and frequency) by spacer or nebulizer **p 88-89** Inhaled bronchodilators are affordable (free of charge or available through an exemption scheme)		
Children who are discharged have follow-up treatment prescribed and explained to parents **p 91**		

TB treatment

Standards and Criteria	Score 1-5	Comments
Correct anti-TB treatment is given to children with suspected TB, according to national guidelines **p 101-104**		
TB is considered part of the differential diagnosis of un-resolving pneumonia and		

malnutrition **p 76**		
Every child with malnutrition receives anti-TB treatment ONLY if indicated **p 192**		

Summary - Cough/difficult breathing

	Score 1-5	**Comments**
1. Assessment and treatment of pneumonia		
2. Administration of antibiotics		
3. Administration of oxygen therapy		
4. Use of Chest X-ray		
5. Management of wheezing		
6. TB treatment		

Score

Summary score -Cough and difficult breathing					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

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5.2 Diarrhoea

Assessment of dehydration

Standards and Criteria	Score 1-5	Comments
The degree of dehydration is assessed in all patients with diarrhoea **p 111**		
Dehydration is correctly classified based on recommended signs, according to guidelines **pp 18,111-113**		
Children with dysentery and severe malnutrition and infants with dysentery are properly assessed and admitted **p 127**		

Management of rehydration and diarrhoea

Standards and Criteria	Score 1-5	Comments
The correct rehydration plan is chosen based on the severity of dehydration (Plan A, Plan B, Plan C) **p 114,117,120**		
Rate of rehydration is correctly calculated for weight (Plan B and C) and administered appropriately **p 114,117**		
Signs of dehydration are monitored during rehydration, and fluid intake and rate of infusion are monitored and adjusted, if necessary **p115**		
Zinc supplementation is given **p118**		

Antibiotics use

Standards and Criteria	Score 1-5	Comments
Antibiotics are given ONLY to children with bloody diarrhea or suspected cholera **p 110, 128, 129**		
Antibiotics are NOT given to children with only watery diarrhea and without any other condition requiring antibiotic treatment **p122**		
Correct choice of antibiotics according to WHO guidelines and national standards given **p 128-129**		
Antidiarrheal drugs are NOT given **p110**		

Continued feeding

Standards and Criteria	Score 1-5	Comments
Feeding (breast milk and/or other food) is continued and encouraged **p 118-119**		
Frequent small feedings are offered **p 118-119**		

Summary – Diarrhoea

Summary	Score 1-5	Comments
Assessment of dehydration		
Management of rehydration and diarrhoea		
Antibiotic use		
Continued feeding		

Score

Summary score - Diarrhoea					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good practice complying to standard of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement)

Main strengths

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5.3 Fever

Differential diagnosis and investigations

Standards and Criteria	Score 1-5	Comments
Appropriate assessment and investigations are undertaken for all children presenting with fever, with appropriate consideration of potential differential diagnoses. **p 133-137**		
Children admitted with fever have a differential diagnosis for possible and likely conditions considered **p135**		
Appropriate investigations are undertaken to establish a diagnosis (LP, blood film for malaria, urine examination, chest x-ray) **p137**		

Diagnosis and management of meningitis

Standards and Criteria	Score 1-5	Comments
Lumbar puncture is performed without delay when meningitis is suspected **p 149**		
Adequate antibiotic treatment is started without delay when bacterial meningitis is suspected. **p 150**		
Complications of meningitis are diagnosed and treated appropriately: - Convulsions - Hypoglycaemia **p 153**		
Appropriate patient monitoring is performed and charted: **p 153** - State of consciousness - Respiratory rate - Pupil size		

Diagnosis and management of severe/complicated malaria

Standards and Criteria	Score 1-5	Comments
Malaria diagnosis is confirmed by microscopy or a rapid diagnostic test **p 137**		
For possible cerebral malaria and malaria-associated respiratory distress, alternative diagnoses are ruled out **p 139-140**		
Correct anti-malarial treatment is given **p 140-141**		

Standards and Criteria	Score 1-5	Comments
Complications are anticipated, monitored for and treated appropriately, and prevented if possible **p 142-144** Coma Severe anaemia Hypoglycaemia Acidosis Aspiration pneumonia		

Diagnosis and management of measles

Standards and Criteria	Score 1-5	Comments
Children admitted with measles are isolated on the ward, and all staff and patients are checked for their immunization status and immunized if necessary **p157**		
Vitamin A is given to all patients with measles **p 155**		
Appropriate nutritional support is given **p 155**		
Complications are anticipated, monitored for and treated appropriately, and prevented if possible **p 154**		

Diagnosis and management of dengue haemorrhagic fever

Standards and Criteria	Score 1-5	Comments
Children are correctly assessed for Dengue, where the risk exists.		
The severity of dengue is correctly classified, according to guidelines **p 166-168**		
Correct management and monitoring of severe dengue occurs **p 168-169**		
Complications are anticipated, monitored for and treated appropriately **p 171**		

Other severe febrile conditions

Standards and Criteria	Score 1-5	Comments
Appropriate assessment and differential diagnosis performed. Appropriate treatment and monitoring given. **p 133-138**		
Correct Treatment is given		

Summary - Fever

Summary Fever	Score 1-5	Comments
1. Differential diagnosis and investigations		
2. Diagnosis and management of meningitis		
3. Diagnosis and management of severe / complicated malaria		
4. Diagnosis and management of measles		
5. Diagnosis and management of dengue haemorrhagic fever		
6. Other severe febrile conditions		

Score

Summary score -Fever					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

Main strengths

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Main weaknesses

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5.4 Malnutrition

Assessment of nutritional status

Standards and Criteria	Score 1-5	Comments
Scale available and calibrated regularly, weight for height correctly calculated **p 174**		
An appropriate history is taken and laboratory exams done **p174-175**		
Clinical examination for signs and complications of severe malnutrition done **p174-175**		
Differential diagnoses for malnutrition considered and ruled out, if needed **p 174-175**		

Management of infection and micronutrient supplementation

Standards and Criteria	Score 1-5	Comments
Broad spectrum antibiotics are administered to all severely malnourished patients **p 182-183**		
If needed, measles vaccination		
Treatment of worms with mebendazole		
Vitamin/mineral supplementation given, with particular emphasis on Vitamin A **p 183,184**		
Iron ONLY given in the recovery phase **p 183**		

Management of dehydration

Standards and Criteria	Score 1-5	Comments
ReSoMal given orally or NG- tube for rehydration. IV fluid NOT given except for shock and inability to take orally **p 179-181**		
Potassium and magnesium supplement given **p 181-182**		
Use of low sodium rehydration fluid and food preparation without salt **p182**		

Prevention and management of hypoglycaemia and hypothermia

Standards and Criteria	Score 1-5	Comments
Routine procedures in place to prevent hypoglycaemia and hypothermia **p 177-178**		
Frequent feeding of malnourished children from		

admission and even at night. **p177**		
If a child is deteriorating, blood glucose is checked **p177**		

Feeding of severely malnourished children

Standards and Criteria	Score 1-5	Comments
Appropriate (caloric intake and frequency) feeding regimen is started in all severely malnourished children **p 184**		
Frequent feeding-day and night **p184,187**		
Daily monitoring of intake and weight gain **p 188**		
Follow up is organized for children discharged before recovery **p 193-194**		

Management of associated conditions and supportive care

Standards and Criteria	Score 1-5	Comments
Correct treatment of associated conditions: eye problems, severe anaemia, dermatitis, diarrhoea, TB, etc. **p 190-192**		
Sensory stimulation, emotional support and social support is provided **p 189-190**		

Summary - Malnutrition

Summary	Score 1-5	Comments
1. Assessment of nutritional status		
2. Management of infection and micronutrient supplementations		
3. Management of dehydration		
4. Prevention and management of hypoglycaemia and hypothermia		
5. Feeding of severely malnourished children		
6. Management of associated conditions and supportive care		

Score

Summary score - Malnutrition					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good practice complying to standard of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement)

Main strengths

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5.5 HIV/AIDS

Counselling and diagnosis of paediatric HIV/AIDS

Standards and criteria	Score 1-5	Comments
Counselling is done by a formally-trained, well-supervised HIV counsellor in a separate room and confidentiality is ensured. Proper documentation is done **p 201-203**		
In choosing which method to feed baby, mothers are counselled on the importance of exclusive breastfeeding until 6 months of age, as well as the risks of HIV transmission. If bottle feeding is considered, the financial and hygienic requirements are considered and explained **p 219, 220**		
Counsellors receive formal training in HIV counselling, are regularly updated and do get		

Standards and criteria	Score 1-5	Comments
adequate supervision and support **p202**		
Detailed counselling-documentation is done		
Pregnant women found to be HIV positive counselled on pediatric transmission. Follow-up is arranged for both mother and child post-partum.		
HIV tests are offered routinely for children presenting with clinical signs of possible HIV infection **p 200, 201**		
HIV testing without the informed consent of the parent/guardian is NOT done		
All family members of children with a positive HIV test are offered HIV testing and counselling **p 201**		
A high proportion of current in-patients with severe malnutrition or TB show a documented offer of HIV screening		
DNA/RNA tests are used for children <18 months and HIV antibody tests for those >18months **p 203, 204**		
The staging is done according to the WHO pediatric clinical staging system **p 204-206**		

Antiretroviral treatment (ARV) and monitoring

Standards and criteria	Score 1-5	Comments
Antiretroviral regimens are initiated and changed according to national guidelines **p 207-209**		
If possible, pediatric formulations and fixed-dose combinations are given **p 207**		
On all follow-up visits weight and height are taken. In children < 24 months the head circumference is also recorded to detect growth failure. The dosing of ARV is done correctly and adjusted for weight-gain regularly		
CD4 count and/or clinical monitoring is done according to national guidelines **p 210**		

Opportunistic infections and supportive care

Standards and criteria	Score 1-5	Comments
Immunization status is checked and updated except for Yellow Fever and BCG in symptomatic disease Measles vaccine is added at age 6 months **p214**		
All mothers receive nutritional advice before discharge **p 216**		
Correct treatment of opportunistic infections **p 216-219**		
Initiation of ARV is deferred until patient has been stabilized and opportunistic infections are treated (incl. TB) **p 209**		

Supportive care and follow-up of HIV infected children

Standards and criteria	Score 1-5	Comments
Carers are referred to home based care-/palliative care-/support before discharge **p 221-224**		
Terminal care focuses on symptom control **p 221**		
Follow-up is ensured for all HIV infected children discharged from the ward **p 220**		
Prophylactic Co-trimoxazole is offered to all children at risk of or suspected of HIV **p 214, 215**		

Summary - HIV/AIDS

Summary	Score 1-5	Comments
Counselling and diagnosis of paediatric HIV/AIDS		
Antiretroviral (ARV) treatment and monitoring		
Opportunistic infections and supportive care		
Supportive care and follow up of HIV infected children		

Score

Summary score - HIV/AIDS					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

Main strengths

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Main weaknesses

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6. Monitoring and follow-up

6.1 Monitoring of individual progress

Standards and criteria	Score 1-5	Comments
Nutritional status is assessed in all admitted children		
At the time of admission, a monitoring plan is made according to the severity of the patient's condition		
A standard monitoring chart is used with the following information: patient details, vital signs, clinical signs depending on condition, treatments given, feeding and outcome		

6.2 Monitoring by nurses

Standards and criteria	Score 1-5	Comments
Key risk signs are monitored and recorded by a nurse twice a day and at least 4 times a day for critically ill patients		
Dosages and time are recorded for every patient receiving medications and IV fluids given by the nurse		
Additional special monitoring is performed and recorded appropriately when needed to follow the progress of particular conditions: e.g. coma scale for unconscious children, etc.		
Nurses use the results of patient monitoring to alert the physicians of problems or changing patient status warranting their attention		

6.3 Reassessment by physicians

Standards and criteria	Score 1-5	Comments
Seriously ill patients are assessed by a doctor upon admission and reviewed at least twice daily until improved		
All patients are reassessed daily during working days by a doctor		
Sick patients or new admissions are also reviewed by a physician on weekends and holidays		

6.4 Follow up

Standards and criteria	Score 1-5	Comments
If needed, follow up is arranged before discharge in the health facility closest to the patient's home that can provide the necessary follow up treatment		
All mothers/caretakers receive a discharge note explaining their condition and providing information for the staff at the follow up facility		

6.5 Summary - Monitoring and follow up

Summary	Score 1-5	Comments
1. Monitoring of individual progress		
2. Monitoring by nurses		
3. Reassessment by physicians		
4. Follow-up		

Score

Summary score - Monitoring and follow up					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care and excellent monitoring and follow/up procedures of all patients occurs; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

Main strengths

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Main weaknesses

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7. Paediatric surgery and rehabilitation

Source: This information should be collected by observing the treatment and care of children undergoing surgical treatment, interviewing staff and carers and reviewing guidelines, if available.

7.1 Paediatric size anaesthesia-equipment

Paediatric size.....are	available, in good working condition	not always available	not available
Tracheal tubes			
Face masks			
Laryngoscope blades			
Oropharyngeal airways			
Breathing valves			
Resuscitation bags			
Blood pressure-cuffs			

7.2 Pre-operative care

Standard and Criteria	Score 1-5	Comments
Standard procedures are in place to prepare a child for surgery: weight, haemoglobin level, blood group of the child and consent of the carer is recorded **p 228-229**		
Starving is kept to a minimum (8hrs no solids/6hrs no formula/4 hrs no milk or clear liquids) and children are put first on the operating list to avoid unnecessary starving **p 228**		

7.3 Intraoperative Care

Standard and Criteria	Score 1-5	Comments
The child is kept warm during surgery and IV-fluids containing glucose are given for long procedures (e.g. 0.45% NaCl + 5% glucose) **p 231**		
Guidelines are in place for the safe use of local anaesthetic (weight adjusted) **p 229**		
Blood loss is monitored **p 231**		

7.4 Post-operative care and monitoring

Standard and Criteria	Score 1-5	Comments
There are specific notes from the surgeon on the procedure performed, necessary monitoring and treatment. There is a handover for the nurses from theatre staff		
Fluid status is closely monitored post-operatively with urine output being recorded **p 232-233**		
Post-operatively, children are closely observed in a safe place and frequent recording of vital signs (blood pressure, pulse, respiration rate every 15-30 min initially) is ensured **p 232**		
Oxygen and equipment for resuscitation/ suction are readily available and working		
Nursing staff have adequate guidelines on post-operative pain relief **p 233**		
Children are allowed to eat as soon as they have fully recovered from anaesthesia **p 233**		

7.5 Rehabilitation

Standard and Criteria	Score 1-5	Comments
Basic rehabilitation equipment is locally manufactured or provided for to children (crutches…)		
Some form of organized physiotherapy is available to children		
The surgical ward is child friendly, provides food for children and opportunities to play		

7.6 Summary - Paediatric surgery and rehabilitation

Summary	Score 1-5	Comments
1. Paediatric size anaesthesia-equipment		
2. Pre- operative care		
3. Intraoperative care		
4. Post-operative care and monitoring		
5. Rehabilitation		

Score

Summary score -Paediatric surgery and rehabilitation					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good support, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement)

Main strengths

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Main weaknesses

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8. Summary scores – Module D: Paediatric care

Summary scores		5	4	3	2	1
D.1.	Paediatric emergency care					
D.2.	Paediatric wards					
D.3.	Infection control and supportive care					
	Infection control					
	Supportive care					
D.4.	Essential drugs, equipment and supplies					
D5	Maternal case management					
	Cough/ difficult breathing					
	Diarrhoea					
	Fever					
	Malnutrition					
	HIV/AIDS					
D.6.	Monitoring and follow up					
D.7.	Paediatric surgery and rehabilitation					
Module D	**TOTAL SCORE**					

Comments on the summary scores/ total score:

Summary Evaluation of the Hospital

Summary evaluation of the Hospital

This summary helps identifying the most critical areas as a basis for identifying priorities and work plan to guide the discussion with senior hospital staff at debriefing.

Summary scores		**5**	**4**	**3**	**2**	**1**
A.2.	Infrastructure					
A.3.	Staffing and training					
A.5.	Health information system and medical records					
A.6.	Essential drugs and blood products					
A.7.	Laboratory					
A.8.	Policies					
A.9.	Referral					
A.10.	Guidelines and auditing					
Module A	**TOTAL SCORE**					
Summary scores – Maternal Care		**5**	**4**	**3**	**2**	**1**
B.1.	Emergency obstetric care					
B.2.	Maternity wards					
B.3.	Infection control and supportive care					
	Infection control					
	Supportive care					
B.4.	Essential drugs					
	Equipment and supplies					
B5	Maternal case management					
	Management of pre-eclampsia and eclampsia					
	Management of infections					
	Normal labour and vaginal delivery					
	Preterm labour					
	Caesarean section					
	Postpartum haemorrhage					
	Management of unsatisfactory progress of labour					
B.6.	Monitoring and follow up					
Module B	**TOTAL SCORE**					
Summary scores - Neonatal Care		**5**	**4**	**3**	**2**	**1**
C.1.	Neonatal resuscitation					
C.2.	Nursery facilities					
C.3.	Infection control and supportive care					
	Infection control					
	Supportive care					

C.4.	Essential drugs					
	Equipment and supplies					
C.5	Routine neonatal care					
C.6.	Case management of the sick newborn					
C.7.	Monitoring and follow up					
Module C	**TOTAL SCORE**					
Summary scores - Paediatric Care		**5**	**4**	**3**	**2**	**1**
D.1.	Paediatric emergency care					
D.2.	Paediatric wards					
D.3.	Infection control and supportive care					
	Infection control					
	Supportive care					
D.4.	Essential drugs					
	Equipment and supplies					
D5	Maternal case management					
	Cough/ difficult breathing					
	Diarrhoea					
	Fever					
	Malnutrition					
	HIV/AIDS					
D.6.	Monitoring and follow up					
D.7.	Paediatric surgery and rehabilitation					
Module D	**TOTAL SCORE**					

Module A	**TOTAL SCORE**					
Module B	**TOTAL SCORE**					
Module C	**TOTAL SCORE**					
Module D	**TOTAL SCORE**					

Debriefing and action plan

Discuss above summary of hospital findings with the senior hospital management, giving details as appropriate.

Discuss their perception of the findings, and how action could be taken to improve the quality of services for each area. Discuss importance in terms of morbidity and mortality, and the feasibility to take action. Develop a plan of action, using the following list.

ITEMS	Summary score			Impact on mortality and morbidity		Feasibility		Action needed	Priority		Timetable and responsible person
	To be strongly improved	To be improved	Not to be improved	High	Low	High	Low		High	Low	

Comments on the Summary Score

Annexes

Contents

Annexes

1. Guidelines for conducting the interviews

We would like to record interviewees' honest opinions. It is important that health care workers, caregivers and mothers understand the aim of the survey and trusts that the information will be used confidentially. Please let them know that they will not be identified in any way in reports to the hospital.

Please do not leave forms lying in places that people who are not members of the team can read them.

Ask the questions in a face-to-face interview in a suitable private place. Try to record comments *as they are spoken* rather than trying to summarize the view expressed. Recording the real words used often helps to properly represent what the person is trying to say. When doing this please put the comments in quotation marks.

For example:

"we have a real problem with the water supply, sometimes days go by without piped water, how can we wash our hands to prevent spreading infection"

Before thanking the interviewee, please ensure that all questions are correctly answered. If an interviewee does not want to answer a particular question please note and proceed to the next question.

At the end of the interview you should offer the interviewee to read what you have written. If they wish, they should be allowed to make changes and clarifications.

Please thank them for providing the interview.

2. Interview with patients

The purpose of the interview is to evaluate the quality of the contact between the patients or caregiver and the hospital staff; and to see if appropriate counselling has been provided and find out about their feelings and opinion on what can be done to improve the wellbeing of new mothers, newborn babies and older children that seek care at the facility. It also serves to complement information from the hospital assessment on whether case management that is being provided has met the minimum standard recommendation.

For the purposes of the hospital assessment, a total of at least 6 interviews should be carried out with new mothers and caregivers of sick children:

- At least one mother who had vaginal birth and a healthy baby

- At least one mother who had a caesarean section
- At least one mother with a preterm baby
- At least three different caregivers of three different sick children

Where possible, one additional mother should be interviewed 3 months after vaginal birth and a normal baby. Just after birth the experience might be related in a different way, women could be affected by hormones and in shock if they had a bad experience. In these conditions some women say everything went fine, and later they realize they do not feel satisfied with the services provided.

2.1 How to carry out the interview and complete the form

Make sure your attitude is positive in both words and action.

Do not conduct the interview during a clinical session to avoid influencing case management practices of other health providers.

Do not conduct the interview in the presence of other mothers/caregivers whom you are going to interview and as far as possible conduct the interview without other clinical staff around, in order to avoid influencing the answers received.

Hold the form upright, out of the view of the person being interviewed as the different options provided in it might influence the answer given.

Take as much time as necessary to talk to the new mother or caregiver of the sick child and make sure questions asked are understood.

Ask the question as they are written down in the interview form and repeat it in your own words only if the original question has not being understood.

Do not read the different answers that appear after each question. They are there only to facilitate your work. Instead, listen to the answers, asking the interviewee to be as precise as possible, and tick [X] when the answer provided matches one of the listed points. Sometimes it will be necessary to tick an answer that is close, but not exactly, the one listed. If the answer provided does not match any of the listed points, write a brief summary, as appropriate, in the space provided under “Other (Specify)”.

As you complete the form, make brief notes of your observations to be discussed with health workers during the feedback session. Also, underline or circle points in any of the issues you feel need commenting on. This will remind you to bring up problems or positive issues during the feedback session.

Make notes of the discussion during the interview and write summaries of important points under “Comments, discussions, problems”. Use these notes at the feedback session. Please write clearly in print characters so that the form is easy to read.

2.2 Questionnaire – new mother

(print at least 4 times)

A.	**Personal data**		
1.	Age of mother:	2. Number of children:	3. Level of education attained by mother:
4.	Partner or relative present at delivery?	5. Type of birth (vaginal, C-section):	
6.	How far away do you live from the hospital?	7. Kilometres:	8. Hours:
9.	What type of transport did you use to get to the hospital?		
B.	**Antenatal care**		
10.	How many antenatal visits did you make during your pregnancy?		
11.	How many ultrasounds did you receive during your pregnancy?		
C.	**Admission**		
12.	How long before your delivery were you admitted to the health facility?		
13.	Did you have a family member/friend with you at all times during admission?		Y/N
14.	Were you examined vaginally at admission?		Y/N
15.	Was the baby's heart rate listened to at admission?		Y/N
D.	**Labour and delivery**		
16.	a) How long were you in labour? (hours, days) b) How long did you push for the baby? (hours)		
17.	Did you have a vein punctured during labour?		Y/N

18.	Were you examined vaginally during labour? Do you remember how many times? Were you asked for your consent prior to being examined?	Y/N
19.	How did they listen to the baby?	
20.	Did each member of the delivery team introduce and identify him or herself when they came into the room?	Y/N
21.	What methods of pain relief were you offered? Were they effective?	 Y/N
22.	Was your baby healthy at delivery? If YES, go to question 26. If NO, what was the problem:	Y/N
23.	Birth asphyxia	Y/N
24.	Preterm birth	Y/N
25.	Other: please describe	
26.	What was baby's weight?	
27.	Was your baby in skin to skin contact immediately after delivery	Y/N
28.	Was your baby kept with you in your room for almost the whole time you were in the hospital?	Y/N
29.	Was your baby separated from you at birth?	Y/N
30.	If YES in 29, do you know the reasons why? Can you explain what happened?	

E.	**Newborn care**			
31.	What are you feeding your baby? (breast milk, formula, expressed milk, other)			
32.	If you are breastfeeding, who from the hospital team has given you the most support and education about breastfeeding (doctor, midwife, nurse, etc.)?			
33.	When were you asked to initiate breastfeeding after delivery?			
34.	How often were you advised to breastfeed our baby?			
35.	How did you find the quality of the facilities (labour room, ward room, place to wash, toilet, etc.)?			
36.	How often, and for how long, did you interact with staff? How much support did you feel? Did you feel that you could ask questions, and that your questions would be answered?			
F.	**Attitude of staff**			
We are interested in what you thought about the staff looking after your child				
37.	What was the attitude of the staff towards you and your child most of the time?	Polite, helpful	Good or bad at different times	Rude, unhelpful
	a) Doctors			
	b) Nurses			

	c) Cleaning/kitchen/other non-medical staff			
	d) Other hospital staff (e.g. nutritionists, physiotherapists, pharmacists)			
38.	Can you think of any examples when you were spoken to or dealt with well/badly? Explain the incident			
G.	**Discharge and follow up**			
39.	Were you given instructions on how to care for baby when you returned home? What kinds of instructions?			
40.	Were you given instructions as to under what circumstances you should bring baby back to hospital?			
41.	Were you given instructions on how to care for yourself when you returned home? What kinds of instructions?			
42.	What drugs, if any, were you given on discharge from the hospital?			
43.	Were you given information about birth control options after birth? Were you given information as to where you could access different forms of birth control? Do you feel that birth control is an option for you?			

44.	What areas, if any, do you think need the most improvement to make the admission and stay easier to bear for yourself and for your child?
45.	Overall, how satisfied are you with your care at the hospital?
H.	**Access to hospital care**
	a. Traditional medicine
46.	Did you consult a traditional practitioner prior to going to hospital?
47.	Why did you prefer the traditional practitioner to hospital care (fees, transport, culture, etc)?
48.	What treatment did you received?
49.	How much did you pay for the traditional services (including goods)?
50.	What contributed to your decision to come to the hospital? How much of a time did pass between the onset of your symptoms and your presentation at the hospital?
	b. Referral by first level or primary health care worker
51.	Did a first level or primary health care provider refer you to the hospital refer you?
52.	Did you receive any treatment before being referred? Which?
53.	Did you receive a referral note from the health care provider?

54.	How much of a time did pass between the referral and your presentation at the hospital?
	c. Transport to the hospital
55.	Was it difficult for you to organize your transport to the hospital? If, yes why?
56.	How much did you pay for transport to the hospital?
57.	How long did it take you to get to the hospital?

Summary

Standards and criteria	Score 1-5	Comments
Antenatal care		
Admission		
Labour and delivery		
Newborn care		
Attitude of staff		
Discharge and follow up		
Access to hospital care		

Score

Summary score - Interview with new mother					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates Mother fully satisfied with the support she has received; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=mother totally unsatisfied with support she has received and there is an urgent need to improve)

2.3 Questionnaire - Caregiver or family members

(Print at least 3 times)

A.	**Personal data of the care taker and the child**					
1.	Age of caregiver:	Age of child:	3. Level of education attained by caregiver:			
4.	Relationship to child:		5. Date child was admitted:			
6.	Length of stay:		7. Where admitted?			
8.	% time on ward with child (please circle) :		<25%	25-50%	50-75%	>75%
9.	How far away do you live from the hospital?		10. Kilometres:		11. Hours:	
12.	What type of transport do you use to get to the hospital?					
B.	**General OPD/ER care**					
13.	After arrival at the hospital, how were you treated in the OPD/ER?					
14.	Were there any good things/bad things about the time your child spent in OPD/ER?					
15.	How do you feel about the care obtained in the OPD/ER (check all that apply)?		Worse than expected	As expected	Better than expected	
	a) The actual time you had to wait was ___ hours. This was:					
	b) The extend of politeness and respect with which you were treated was					
	In your opinion, how thorough was the assessment done by the physician during your child's review and clinical examination					
16.	Was the reason for admission explained to you?					Y/N

17.	What was the reason for admission?			
C. Care received in the paediatric ward				
We are interested in learning what you think about the ward and care for your child				
18.	Once your child was on the ward, what do you think about (check all that apply)	Worse than expected	As expected	Better than expected
	a) The amount of space for you and your child to stay			
	b) The place/bed you and your child slept? Comments on quality:			
	c) The space to wash and the toilet? Comments on quality:			
	d) The cleanliness of the ward			
	e) The number of nurses that are available to look after sick children. Number of nurses noted:			
	f) The thoroughness of the child's assessment by the admitting physician during review and clinical examination			
	g) The frequency of daily monitoring checks by nurses/doctors			
	h) Attention to detail paid by the nurses/doctors during each check			
	i) Was any information given about the child's condition during the checks?			
19.	Do you have any other concerns about the ward or the hospital?			

D. Case management					
We are interested in learning what you think about the medical care that has been provided to your child.					
20.	What is your child's diagnosis?				
21.	a) From whom did you receive most information about your child's admission? b) Who was the person you could most easily ask about your child's admission?				
22.	What did you think about the medical treatment your child received: (check all that apply)	Too much	OK	Too few	N/A
	a) Blood was taken ___ times. This was:				
	b) Injections were given ___ times. This was:				
	Intravenous fluids were given ___ times : This was				
23.	What other tests have been done? How did you feel about each of these (was any explanation given on why they had to be done? Do you think it was necessary/useful)?				
24.	Did you learn anything new on how to keep your child healthy while the child was admitted to hospital? IF yes, what did you learn and how did you learn it?			Y/N	

E. Attitude of staff				
We are interested in learning what you think about the staff looking after your child				
25.	What was the attitude of the staff towards you and your child most of the time (check all that apply)?	Polite, helpful	Good or bad at different times	Rude, unhelpful
	a) Doctors			
	b) Nurses			

	c) Cleaning/kitchen/other non-medical staff			
	d) Other hospital staff (e.g. nutritionists, physiotherapists, pharmacists)			
26.	Can you think of any examples when you were spoken to or dealt with well/badly? Explain what happened			
F. Discharge and follow up				
We are interested in what you thought about your discharge from hospital				
27.	How do you think your child is doing now (at the time of discharge) (circle that which applies)?	Very good	OK	Still poor
28.	The amount of time spent in hospital was (circle that which applies)	Too long	Just right	Too short
29.	Is your child being sent home on medication?			Y/N
30.	Did the staff explain to you how much medicine to give?			Y/N
31.	Did the staff explain to you how often to give the medicine?			Y/N
32.	Did the staff tell you how many days to give the medicine in total?			Y/N
33.	Did you receive a follow up appointment to see how your child is doing? If yes, why do you have to go? If no, go to question 37.			Y/N
34.	Did the doctor/ward staff tell you where to go for the follow-up?			Y/N
35.	Do you know when to go to the follow up appointment?			Y/N

36.	Did you receive a discharge/follow up note explaining the illness of your child and providing information for the staff at the follow up clinic?	Y/N
37.	What do you think about the cost of treatment at the hospital? (How did the family finance the hospital admission? Were costs clearly communicated?)	
38.	What areas, if any, do you think need most improvement to make the admission and stay easier to bear for yourself and for the child?	
39.	Overall, how satisfied are you with the care of your child at the hospital?	
I.	**Access to hospital care**	
	Traditional medicine	
40.	Did you consult a traditional practitioner prior to going to hospital?	
41.	Why did you prefer the traditional practitioner to hospital care (fees, transport, culture, etc)?	
42.	What treatment did your child receiv?	

43.	How much did you pay for the traditional services (including goods)?
44.	What contributed to your decision to come to the hospital? How much of a time did pass between the onset of the symptoms and your presentation of your child at the hospital?
	b. Referral by first level or primary health care worker
45.	Did a first level or primary health care provider refer your child to the hospital refer you?
46.	Did your child receive any treatment before being referred? Which?
47.	Did you receive a referral note from the health care provider?
48.	How much of a time did pass between the referral and your presentation at the hospital?
	Transport to the hospital
49.	Was it difficult for you to organize your transport to the hospital? If, yes why?
50.	How much did you pay for transport to the hospital?
51.	How long did it take you to get to the hospital?

Summary

Standards and criteria	Score 1-5	Comments
General OPD/ER care		
Care received in the paediatric ward		
Case management		
Attitude of staff		
Discharge and follow up		
Access to hospital care		

Score

Summary score - Interviews with caregivers or family members of children					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates Mother/caregiver fully satisfied with the support that has been received; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=mother/caregiver totally unsatisfied with support that has been received and there is an urgent need to improve)

3. Interview with health workers

All groups of health professionals (nursing assistants, nurses / midwives, medical officers and doctors) working in the maternal, newborn and paediatric wards should be considered for this interview. Try to interview 2 staff each from the above mentioned categories of health professionals so that a minimum of 6-8 forms should be filled during the assessment visit.

3.1 How to carry out the interview and complete the form

We would like to record the health workers honest opinions. It is therefore important that the health workers understand the aim of the survey and know and trust that the information will be stored and used while maintaining confidentiality. Please let them know that their names or initials will not be mentioned in any report or to supervisors in the hospital and inform them that interviews would be lasting between 40-60 minutes.

The aim is to complement information that will be gotten from the assessment and possibly shed more information on aspects of quality of care for patients that may not have emerged or cannot be captured solely by the assessment tool. The interviewer should also explain that this interview will be inquiring about their opinion on care provided to patients and on the organisation and management of resources (human or otherwise) that directly or indirectly affect the quality of care provided to patients in hospitals.

To start, please fill in the date, the hospital name and the health worker initials on all five sheets. After this, please fill the little information on the interviewee, so that the answers in the questionnaire can be put in better perspective.

The interview should begin with an open question. Some health workers may have several things to say without prompting them with specific questions. For these people it is important to allow them to speak and record what they say.

For some question you are asked to mark the quality of the facilities of the maternal, newborn and paediatric wards. Please see the criteria below for the three possible grades:

For the scale "Satisfactory/Good" to "Usually inadequate/Not available" consider the following as an explanation:

Table 1

Usually inadequate/absent	On four or more out of ten times when something is used or wanted or on four or more out of ten visits to an area things are unavailable or not of an acceptable standard.
Occasionally inadequate	On up-to four occasions when something is used or wanted/or on up-to four out of ten visits to an area things are unavailable or are not of an acceptable standard.
Satisfactory/good	Only rarely are things unavailable or are not of an acceptable standard.

Please ensure that all questions have been correctly answered. If a health worker does not want to answer a particular question, please note and proceed to the next question. Offer the health worker to read what you have written and if he wishes he should be allowed to make changes. And at the end of the interview, thank the health-worker for the time taken in giving the information.

3.2 Questionnaire – Health worker

(Print at least 8 times)

A.	**Personal data – Health worker**	
1.	Initials	2. Position:
3.	Current service and responsibilities:	4. Length of service at hospital:
B.	**Wards**	
We are interested in your views on the ward/nursery/hospital		
5.	Which area aspects of the hospital buildings/wards that are good, which could be improved?	

6.	For mothers, babies and children admitted to hospital (check what applies):	Satisfactory	Occasionally inadequate	Usually inadequate/ Not available
	a) The accommodation for patients is:			
	b) The toilets and washing facilities for patients are:			
	c) The cleanliness of the ward is:			
	d) The food given to patients is:			
	We are interested in the aetiologies of patient deaths in the hospital in the past 6 months			
C.	**Mortality data and causes**			
7.	In your opinion, what are the most common illnesses resulting in patient death in your ward (i.e. maternal death, neonatal death, paediatric death)? Number 1: Number 2:			
8.	Why do you think these patients died (for cause number 1)?			
	a) Nature of the disease			
	b) Late presentation of patient to hospital			Y/N
	c) Unavailable or poor quality laboratory facilities for this disease			Y/N
	d) Unavailability of drugs			Y/N
	e) Inadequate equipment			Y/N
	f) A lack of staff for care and monitoring (adequate number/qualified)			Y/N
	g) Wrong treatment given or patients not being adequately monitored by staff in charge			Y/N
	h) Other reasons Please explain			Y/N
9.	Why do you think these patients died (for cause number 2)?			
	a) Nature of the disease			Y/N
	b) Late presentation of patient to hospital			Y/N
	c) Unavailable or poor quality laboratory facilities for this disease			Y/N
	d) Unavailability of drugs			Y/N
	e) Inadequate equipment			Y/N
	f) A lack of staff for care and monitoring (adequate number/qualified)			Y/N
	g) Wrong treatment given or patients not being adequately monitored by staff in charge			Y/N

	h) Other reasons Please explain	Y/N

D. Quality of care				
We are interested in the care provided to patients in the hospital				
10.	What do you think about the quality of care provided to patients?			
	Check what applies	Satisfactory	Occasionally inadequate	Inadequate
	a) The quality of information and education about their condition given to patients and their families is:			
	b) The time available to explain patient's conditions to them and their families is:			
	c) The perception that families have of the quality of the care that the staff provides to patients is:			
11.	In what ways could your ward aid in improving patient's understandings of their conditions?			
12.	Can you recall a patient that you recently cared for in your ward and you were pleased with the clinical outcome? IF yes, were you satisfied with the quality of care you had provided? What aspects of your own care satisfied you?			
13.	Can you recall a patient that you recently cared for in your ward and you were not satisfied with the clinical outcome? IF yes, what aspects of the care do you feel went poorly and why do you feel that occurred?			
Drugs and supplies				
We are interested in availability of drugs and supplies in this ward/hospital				
14.	The availability of the following are (check what applies):	Satisfactory/ Good	Occasionally inadequate	Usually inadequate/ Not available
	a) Medications			
	b) Oxygen			

	c) Blood for transfusion			
	d) IV fluids			
	e) Food/special milk for malnutrition			
	f) Laboratory tests			
15.	What do you think about the availability or functionality of equipment? Do you feel that you are adequately supplied?			

F. Staffing				
We are interested in learning how staffing is organized				
16.	Staff availability (check what applies):	Satisfactory / Good	Occasionally inadequate	Usually inadequate/ Not available
	a) The number of staff available at any time to care for patients is:			
	b) The time available to provide the best care for a patient (the way you were trained)?			
	c) The number of nursing staff available during night hours are:			
	d) The number of nursing staff available on weekends and holidays are:			
17.	Is there a fixed rotation of nursing staff within the hospital at regular intervals? a) If yes, how often do you rotate? b) What do you think about this?	Yes / No		
18.	What do you think about the number and qualification of staff available for optimal care in your ward? Are there any key staff missing?			

G. Guidelines, auditing and in-service training				
We are interested on how you feel about working in this facility, available in-service training opportunities for staff and the level of support provided to staff				
19.	Are you clear on what your job description is? Were you provided with terms of reference?			Y/N
20.	Do you perform any functions outside of what your role and responsibilities should be?			Y/N
21.	Knowledge and skills Check what applies	Good/ Satisfactory	Occasionally inadequate	Usually inadequate
	a) How confident do you feel with your knowledge of maternal/neonatal/paediatric illnesses (as applicable to your discipline):			
	b) IF you feel that your knowledge is occasionally/usually inadequate, what areas do you think would benefit most from training?			
22.	What kinds of continuing professional education and trainings are there available in your hospital?			
	Are opportunities for training based on need or related to job performance? Explain your response and what you think about this			
23.	If you have problems getting help when you think you need it is it because:			
	a) There are not enough skilled people to call?			Y/N
	b) You are unable to contact the right people?			Y/N
	c) The response to your request is too slow?			Y/N
	d) Any other reason? Please explain			Y/N
24.	What kinds of guidelines are provided to you to do your work?			
25.	Are you satisfied with the available supportive supervision and mentorship provided from senior clinical staff to help manage sick patients in this hospital?			Y/N
26.	Do you participate in regular staff meetings? IF yes, which ones (i.e. nurses/doctors/midwives)?			Y/N

	How often? What for?				
27.	Are there forums/avenues where you can make suggestions or inform supervisors/management on issues that affect/improve the quality of care provided to patients in your hospital?				Y/N
28.	Have you made suggestions to matrons/doctors/management? If yes, what was the result?				Y/N
29.	Is feedback on decisions of senior management /supervisors provided to staff?				Y/N
30.	Are audits to examine quality of care and/or patient mortality carried out in your ward/department? If yes, what kind?				Y/N
	When was the last audit done (for each type of audit identified in Question 30b)?				
31.	Overall, do you feel that the quality of care this hospital is providing to patients is good:				
	Always	Often	Sometimes	Rarely	Never
32.	Do you have any other suggestions that could improve the care provided to patients in this hospital? IF yes, please explain:				Y/N
33.	Do you think that the majority of your colleagues are generally satisfied with their work in the hospital? IF no, why are people dissatisfied with their work? What could be done to improve job satisfaction?				Y/N
H.	**Referral by first level or primary health care provider**				
34.	Referred patients receive appropriate pre-referral treatment when indicated				
	Always	Often	Sometimes	Rarely	Never
35.	Referred patients are provided with referral notes stating the condition, reason for referral and any treatment given				
	Always	Often	Sometimes	Rarely	Never

36.	Patient gets to hospital without major delay when advised by first level health staff that they are in need of referral care				
	Always	Often	Sometimes	Rarely	Never
37.	Children referred from first level facilities are correctly assessed and classified with the most common conditions requiring referral (IMCI standards for districts where IMCI has been implemented				
	Always	Often	Sometimes	Rarely	Never
I. Care seeking by patients					
38.	Patients and caregivers adequately recognize signs and symptoms that require contact with health services				
	Always	Often	Sometimes	Rarely	Never
39.	Patients and caregivers are given adequate information and advice by primary care services about where and how to refer to hospital				
	Always	Often	Sometimes	Rarely	Never
40.	Sick children and women are brought to health services without significant delay				
	Always	Often	Sometimes	Rarely	Never

Summary

Standards and criteria	Score 1-5	Comments
Wards		
Mortality data and causes		
Quality of care		
Drugs and supplies		
Staffing		
Guidelines, auditing and in-service training		
Referral by first level or primary health care provider		
Care seeking by patients		

Score

Summary score - Interviews health workers					
(to be circled)	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates Mother/caregiver fully satisfied with the support that has been received; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=mother/caregiver totally unsatisfied with support that has been received and there is an urgent need to improve)

4. Postal Questionnaire

Please fill in the information required prior to assessment visit. If some information is not available, please indicate "unknown", and add an explanation why the information is not available, if possible. If an indicator is not applicable for your context, please indicate "N/A".

Please mail the filled in questionnaire back to assessment team as soon as possible and in advance of the hospital visit. Thank you.

4.1. General Hospital Information

Date of planned assessment
Town, province, country
Facility name (hospital, specific service(s))
Name of director/manager of hospital
Name of head of maternity ward
Name of head of paediatric ward
Name of head of neonatal unit
Survey number
Name of evaluator

4.2. Staffing

Type of staff	**during core working hours (8.00-17.00)** *(number available)*	**after working hours and on the weekend** *Present/ not present If present, number*	**Remarks**

Type of staff	during core working hours (8.00-17.00) *(number available)*	after working hours and on the weekend *Present/ not present If present, number*	Remarks
Advanced level associate clinician			
Obstetrician-gynaecologist			
Paediatrician			
Associate clinician			
Non- specialist doctor			
Nurse			
Auxiliary Nurse			
Auxiliary nurse midwife			
Midwife			
Lay health worker			

4.3. Hospital statistics

Maternal and neonatal statistics

Please use the figures for the last available year. If data are available for a different period, please specify.

Year……..Any other period ……..

MATERNAL/ NEONATAL	
Number of deliveries	
Number of live births[1]	
Number of low birth weight newborn babies (<2500 g)	

[1] 1Reference WHO definition for live births: Live birth refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born. Please specify if other definition is used

Number of very low birth weight newborn babies (<1500 g)	
Number of extremely low birth weight babies (<1000g)	
Number of deliveries: <37 completed weeks	
Number of deliveries: < 32 weeks	
Number of deliveries: < 28 weeks	
Number of babies diagnosed with birth asphyxia[2]	
Number of babies with Apgar score <3 at 5 minutes	
Number of neonatal deaths	
Number of still births	
Number of perinatal deaths (number of stillbirths plus neonatal deaths in hospital)	
Number of maternal deaths in hospital	
Maternal mortality ratio (number of maternal deaths per 100,000 live births)[3]	
Caesarean section deliveries as % of all births	
Episiotomies as % of all births	
Instrumental deliveries as % of all births	
Inductions as % of all births	
Augmentations (stimulations) as % of all births	
Prevalence of anaemia (defined as Hb concentration of less than 110g/l or 11g/dL) per 1000 pregnant women[4]	
Average length of stay for vaginal delivery (number of days)	
Average length of stay for operative vaginal delivery (number of days)	
Average length of stay for caesarean section (number of days)	
Number of women transferred to higher level of care	

[2] Criteria: live birth with an Apgar score at 5 minutes of <3, depression at birth requiring resuscitation with a mask for >3 minutes and/or intubation. World Federation of Neurology Group 1993

[3] The maternal mortality ratio can be assessed with a denominator of 10,000 births, if it is anticipated to be very high.

[4] From MPS/PEPC assessment and follow up after training-Manual and Interview form Feb 2006-form 7 page

Paediatric statistics

Please use the figures for the last available year. If data are available for a different period, please specify.

Year……Any other period……..

PAEDIATRIC	
Number of children under-5 hospitalized in the facility	
Number of under-5 child deaths in the facility	
Under-5 mortality rate in facility	
Number of child deaths reviewed in the health facility	
Number of hospitalized children with pneumonia	
Number of children who are correctly prescribed an antibiotic for pneumonia	
Number of child deaths caused by pneumonia in facility	
Number of children hospitalised with diarrhoea	
Number of child deaths caused by diarrhoeal disease in facility	
Number of children admitted in facility with severe malnutrition	
Number of child deaths caused by severe malnutrition in facility	
Number of children needing referral who receive correct pre-referral treatment and referral	

Patient load, deaths and fatality rates

Indicate the total number of outpatient visits in pregnancy / puerperium / neonatal / paediatric period, emergency visits and admissions per year (indicate year; if any other period of time, e.g. semester, is used, indicate the exact period) for women and children. Include all medical diagnosis but exclude patients dead on arrival.

Year: ……..

MATERNAL	**Outpatient visits**	**Emergency visits**	**Inpatients / admissions**	**Number of total deaths**
Pregnant women (including women under 19)				
Pregnant adolescents (women under 19)				
Number of deliveries				
Number of deliveries (adolescents)				

PAEDIATRIC	**Outpatient visits**	**Emergency visits**	**Inpatients / admissions**	**Number of deaths**	**Age-specific fatality rate**
0-7 days					
7-28 days					
1-12 months					
1-5 years					
>5 years					

Reasons for hospital visits and admissions, deaths and case fatality rates

From the hospital records, list the five most important medical reasons (diagnoses) for outpatient visits (excluding routine ANC visits), emergency visits, and hospital admissions in pregnancy/puerperium (excluding labour). Similarly, list the five most important medical reasons for neonates and for children.

Year: ……..

MATERNAL Most frequent diagnosis	**Outpatient visits**	**Emergency visits**	**Hospital admissions**	**Deaths**	**Case fatality rate**
First					
Second					
Third					
Fourth					
Fifth					
NEONATAL Most frequent diagnosis	**Outpatient visits**	**Emergency visits**	**NICU admissions**	**Deaths**	**Case fatality rate**
First					
Second					
Third					
Fourth					
Fifth					

4.4. Essential drugs and blood products

Drugs	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
General anaesthetics and oxygen					
Halothane inhalation					
Ketamine injection					
Oxygen inhalation					
Nitrous oxide inhalation					
Thiopental iv					
Local anaesthetics	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Lidocaine injection					
Lidocaine + epinephrine injection					
Ephedrine injection					
Preoperative medications and sedations for short term procedures	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Atropine iv					
Promethazine iv					
Analgesics, antipyretics, non-steroidal anti-inflammatory drugs	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Acetylsalicylic acid po/pr					
Ibuprofen lysine (for PDA)					
Indomethacin (for PDA)					
Paracetamol/acetaminophen po/pr					
Morphine po/im/iv					
Anti-histamines/anti-anaphylactics	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Chlorphenamine po/iv					

Drugs	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Epinephrine injection					
Corticosteroids					
Betamethasone im					
Dexamethasone im					
Hydrocortisone po/iv					
Prednisolone po					
Antidotes and other substances used in poisoning	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Calcium gluconate injection					
Naloxone injection					
Anticonvulsants and antiepileptics	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Diazepam po/iv/pr					
Magnesium sulphate injection					
Phenobarbital					
Anti-infective medicines	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Mebendazole					
Antibacterials	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Amoxicillin					
Ampicillin iv					
Benzathine benzylpenicillin injection					
Cefixime					
Ceftriaxone im					
Ciprofloxacin po/iv					
Ceftazidime					
Cefotaxime					

Drugs	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Co-trimoxazole					
Doxycycline					
Erythromycin po/iv					
Gentamicin iv					
Nitrofurantoin					
Metronidazole po/iv					
Spectinomycin po					
All anti-TB drugs needed according to the national TB control program	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Antifungal medicines	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Amphotericin injection					
Clotrimazole cream/tablet					
Miconazole					
Fluconazole po/injection					
Nystatin topical/po					
Antiviral medicines	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Aciclovir po					
All Anti-HIV drugs according to HIV program					
All anti-malaria drugs needed according to national malaria control program					
Anti-pneumocystis and antitoxoplasmosis medicines					
Pentamidine po					

Drugs	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Medicines affecting the blood	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Ferrous salt + Folic acid po					
Iron syrup po					
Low molecular weight heparin (LWMH) injection					
Respiratory Drugs	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Aminophylline					
Caffeine citrate					
Surfactants					
Plasma substitutes	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Dextran 79 injection					
Cardiovascular medicines	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Glyceryl trinitrate spray/po					
Digoxin injection/po					
Hydralazine injection/po					
Methyldopa po					
Furosemide iv/po					
Dermatological medicines (topical)	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Disinfectants and antiseptics (topical)	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Chlorexidine					
Polyvidone iodine					
Insulins and other antidiabetic agents	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Insulin injection (soluble)					
Intermediate acting insulin					

Drugs	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Immunologicals	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Anti-D Immunoglobulin (human) injection					
Anti-tetanus immunoglobulin (human) injection					
Vaccines	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
BCG vaccine					
Diphtheria + tetanus vaccine					
Measles vaccine					
Rubella vaccine					
Hepatitis B vaccine	Emergency area	Labour ward	Peds ward		Pharmacy
Poliomyelitis vaccine					
Pertussis vaccine					
Muscle relaxants and cholinesterase inhibitors	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Suxamethonium injection					
Ophtalmological preparations (topical)	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Tetracycline					
Oxytocics and antioxytocics	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Ergometrine injection					
Oxytocin injection					
Misoprostol tablets					
Nifedipine tablets					
Solutions correcting water, electrolyte and acid-base disturbances	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy

Drugs	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Glucose 5-10-50%					
Glucose with sodium chloride					
Sodium chloride 0.9% isotonic					
Ringer's lactate					
Water for injection					
Commodities for managing diarrhoea in children					
ORS					
Zinc Sulphate					
Vitamins and minerals	Emergency area	Labour ward	Peds ward	Neonatal	Pharmacy
Vitamin A oral					
Vitamin K IM					

4.5. Laboratory

Are the following laboratory investigations and their results readily available? If available, indicate average time to get results.

Laboratory tests

Lab test	Not available	Available	Time to get results	Comments
Blood glucose				
Haemoglobin				
Haematocrit (PCV)				
Immature to total neutrophil ratio				
Leukocyte count				
Blood gas analysis				
Blood grouping and crossmatch				

Lab test	Not available	Available	Time to get results	Comments
Bilirubin				
Rhesus antibodies				
Urine dipstick				
Urine microscopy				
Bacteriology (culture)				
Bacterioscopy (smear)				
Full blood count				
Coagulation tests				
Liver function tests				
Bilirubin				
Renal function tests				
Electrolytes				
HIV test				
CD4 count or HIV plasma viral loads according to national guidelines				
Coombs' test: direct and indirect				
Serum protein and albumin				
Urinalysis				
Rapid test for syphilis				
Microscopy or rapid diagnostic test (RDT) for malaria parasites				
CSF microscopy				

4.6. Maternity staffing and supplies

Emergency maternal ward

Type of staff	during core working hours (8.00-17.00) *(number available)*	after working hours and on the weekend *Present/ not present If present, number*	Remarks
Advanced level associate clinician			
Obstetrician-gynaecologist			
Associate clinician			
Non- specialist doctor			
Nurse			
Auxiliary Nurse			
Auxiliary nurse midwife			
Midwife			
Lay health worker			

How many beds does the ward have? _____

Are healthy newborns roomed-in with their mothers? Y N

Maternity ward staffing

Type of staff	during core working hours (8.00-17.00) *(number available)*	after working hours and on the weekend *Present/ not present If present, number*	Remarks
Advanced level associate clinician			
Obstetrician-gynaecologist			
Paediatrician			
Associate clinician			
Non- specialist doctor			
Nurse			
Auxiliary Nurse			

Type of staff	during core working hours (8.00-17.00) *(number available)*	after working hours and on the weekend *Present/ not present If present, number*	Remarks
Auxiliary nurse midwife			
Midwife			
Lay health worker			

Equipment and supplies

	Delivery room (normal labour)	Delivery room (caesarean section)	Comments
Adequate lighting			
Examination light (flashlight ok)			
Wall clock			
Delivery pack			
Blank partographs			
Heating lamp for neonates			
Towels for drying newborn babies			
Oxygen source: oxygen cylinder			
Oxygen source: oxygen concentrator			
Oxygen source: central supply			
Flow-meters for oxygen			
Equipment for the administration of oxygen			
via nasal prongs			
via catheters			
via masks			
Self-inflating bags for respiratory support			
Bags and Masks (adult and			

	Delivery room (normal labour)	**Delivery room (caesarean section)**	**Comments**
neonatal size)			
Anaesthetic equipment			
Normal thermometer (body temperature)			
Sterile gloves (re-sterilized or disposable?)			
Sterile gauze			
Foetal stethoscope			
Stethoscope			
Sphygmomanometer			
Infusion sets			
Infusion pumps/dosimeters			
IV catheters			
Urinary catheter			
Syringes			
Needles			
Suturing set (scissors, needles holder)			
Suturing material			
Balance for baby			
Cord cutting/cord clamping set			
Episiotomy scissors			
Vacuum extractor			
Forceps			
Vacuum aspirator			
Beds – delivery beds			
Beds – regular beds			
Beds – operating theatre beds			

	Delivery room (normal labour)	**Delivery room (caesarean section)**	**Comments**
Neonatal equipment:			
resuscitation table (with heat source) (for newborn resuscitation)			
incubator			
tracheal tubes			
newborn bag and mask size 1 for term babies (for newborn resuscitation)			
newborn bag and mask size 0 for pre-term babies (for newborn resuscitation)			
laryngoscope blades			
oropharyngeal airways			
breathing valves			
electric suction pump (for suction apparatus)			
suction catheter (for suction apparatus)			
suction bulb, single use (for suction apparatus)			
suction bulb, sterilizable multi-use (for suction apparatus)			
baby scales			

4.7. Neonatal ward staffing and supplies

Type of staff	**during core working hours (8.00-17.00)** *(number available)*	**after working hours and on the weekend** *Present/ not present* *If present, number*	**Comments**
Advanced level associate clinician			
Paediatrician Neonatologist			
Associate clinician			
Non- specialist doctor			
Nurse			
Auxiliary Nurse			
Auxiliary nurse midwife			
Midwife			
Lay health worker			

Equipment and supplies

	Y	**N**	**Number**	**Comments**
Incubators				
Radiant warmers				
Heated mattress cots				
Phototherapy lamps				
Ambu Bag				
Oxygen supply/concentrator				
Appropriate sized face masks (sizes 0 an 1)				
CPAP systems				

	Y	**N**	**Number**	**Comments**
Multi-function monitors				
Pulse-oximeters				
Breast pumps				
Nasogastric tubes				
Micrdroppers				
Exchange transfusion kit				
Stethoscope				
Glucometers				
Suction apparatus				
Thermometers				
Weighing scale				

4.8. Paediatric staffing and supplies

Emergency paediatric unit staffing

Type of staff	during core working hours (8.00-17.00) *(number available)*	after working hours and on the weekend *Present/ not present* *If present, number*	Remarks
Advanced level associate clinician			
Paediatrician			
Associate clinician			
Non- specialist doctor			
Nurse			
Auxiliary Nurse			
Auxiliary nurse midwife			
Midwife			
Lay health worker			

Paediatric ward

How many beds does the ward have? _____

Paediatric ward staffing

Type of staff	during core working hours (8.00-17.00) *(number available)*	after working hours and on the weekend *Present/ not present* *If present, number*	Remarks
Advanced level associate clinician			
Obstetrician-gynaecologist			
Paediatrician			
Associate clinician			
Non- specialist doctor			
Nurse			

Type of staff	during core working hours (8.00-17.00) *(number available)*	after working hours and on the weekend *Present/ not present* *If present, number*	Remarks
Auxiliary Nurse			
Auxiliary nurse midwife			
Midwife			
Lay health worker			

Equipment and supplies

		Emergency area	Ward	Comments
Resuscitation table/area				
Torch				
Otoscope				
Scales for children				
Measuring board to measure length and height (lying/standing according to age)		(length) (height)	(length) (height)	
Stethoscopes				
Thermometers				
Heat source				
Oxygen source	oxygen cylinder			
	oxygen concentrator			
	central supply			

		Emergency area	Ward	Comments
Flow-meters for oxygen				
Equipment for the administration of oxygen				
Indicate which equipment you use	nasal prongs catheters masks			
Self-inflating bags for resuscitation				
Masks	___ infant size ___ child size ___ adult size			
IV-giving sets with chambers for paediatric use				
Butterflies and/or cannulas of paediatric size				
NG-tubes, paediatric size				
Equipment for intra-osseous fluid administration				
Suction equipment				
Chest tubes				

		Emergency area	Ward	Comments
Nebulisers for administration of salbutamol				
Indicate type of nebulizer:	___ electricity driven ____ oxygen driven ___ foot pump driven			
Spacers with masks for administration of metered doses (spray) of salbutamol				

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