1. SCAP STG Mar 30_2017 EMRG QU.pdf
2. PUD STG STG_Jan_30_2017 EMRG QU.pdf
3. DM STG Mar 2017 EMRG QU.pdf
4. ICU STG_March 2017 QU.pdf
5. STG SPE Mar Qrtr 2017.pdf
6. PNA STG-Mar 2017 NICU QU.pdf
7. PTB STG-Mar 2017 NICU QU.pdf
8. N.Sepsis STG-Mar 2017 NICU QU.pdf
9. DM STG Mar 2017 OPD QU.pdf
10. PUD STG Mar 2017 OPD QU.pdf
11. Typhoid fever STG Mar 2017 OPD QU.pdf
12. UTI STG Mar 2017 OPD QU.pdf
13. STG HERNIA _Mar 2017 SW QU.pdf
14. STG Laparotomy_Mar 2017 SW QU.pdf
15. STG APPENDICITIS _Mar 2017 SW QU.pdf

DEDER GENERAL HOSPITAL

EMERGENCY DEPARTMENT

Pneumonia management
STG utilization monitoring report

By: *Quality Unit*

Report Period: 3rd Quarter of 2017E.C

Deder, Oromia

March 2017E.

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Pneumonia, including community-acquired pneumonia (CAP) and hospital-acquired pneumonia (HAP), remain significant contributors to morbidity and mortality. Standard Treatment Guidelines (STG) are critical tools for ensuring evidence-based, consistent, and high-quality management of these infections. Regular monitoring of STG adherence identifies gaps and informs interventions to improve care quality. This monitoring report evaluates the utilization of STG for community-acquired pneumonia (CAP) and hospital-acquired pneumonia (HAP) at **Deder General hospital**, identifies gaps in compliance, and proposes actionable recommendations to improve outcomes

AIM

- To assess and improve the adherence to STG standards in the management of Pneumonia at the facility.

Objective

- To evaluate compliance with key STG standards in the management of Pneumonia.
- To identify areas of non-compliance and root causes.
- To develop and implement actionable interventions to enhance STG adherence.

Methodology

Data Collection: A retrospective audit was conducted on 30 patient records diagnosed with Pneumonia between December 21-**March 20, 2017E.**

Criteria Assessed: Data were collected using a structured checklist based on the STGs and focused on the following standards **(Table 1)**

Analysis: Compliance was calculated as the percentage of standards met for each criterion. Data were analysed to identify trends and areas requiring improvement.

Table 1*::CRITEREA AND STANDARDS*

S.No	Standards
1.	Comprehensive symptom and physical assessment
2.	Diagnosis based on chest X-ray or imaging
3.	Initial assessment of CAP vs HAP risk factors
4.	Correct choice of empiric antibiotics
5.	Antibiotic adjustment based on culture
6.	Timely administration of the first dose of antibiotics
7.	Monitoring of respiratory status
8.	Documentation of risk assessment
9.	Patient education on hygiene and vaccination
10.	Referral to higher care level if deterioration
11.	Use of steroids per severity criteria
12.	Follow-up plan documentation

RESULT

The March 2017E.C monitoring of pneumonia management at Deder General Hospital demonstrates excellent adherence to clinical standards, achieving an **overall compliance rate of 95%**. Perfect scores (100%) were attained in **7 of 11 standards**, including comprehensive assessments, correct antibiotic selection, timely first-dose administration, respiratory monitoring, documentation, patient education, and follow-up planning. These results reflect robust systems for diagnostic and therapeutic interventions, as well as strong documentation practices. The **90% compliance** in imaging-based diagnosis, referral protocols, and steroid use indicates minor but manageable gaps, likely due to occasional resource constraints or clinical judgment variations.

While performance is commendable, two areas require attention: **CAP vs HAP risk factor assessment (70%)** showed the lowest compliance, suggesting potential gaps in initial evaluation protocols or staff training. Additionally, the **18 total non-compliant instances** (distributed across imaging, referrals, and steroid use) reveal opportunities to standardize decision-making, particularly for complex cases. Targeted interventions—such as **structured risk-assessment tools, radiologist collaboration for imaging interpretation, and case-review meetings**—could help bridge these gaps. The high overall performance underscores the hospital's effective pneumonia management system, but focused improvements in risk stratification and specialty coordination could further enhance care quality and patient outcomes.

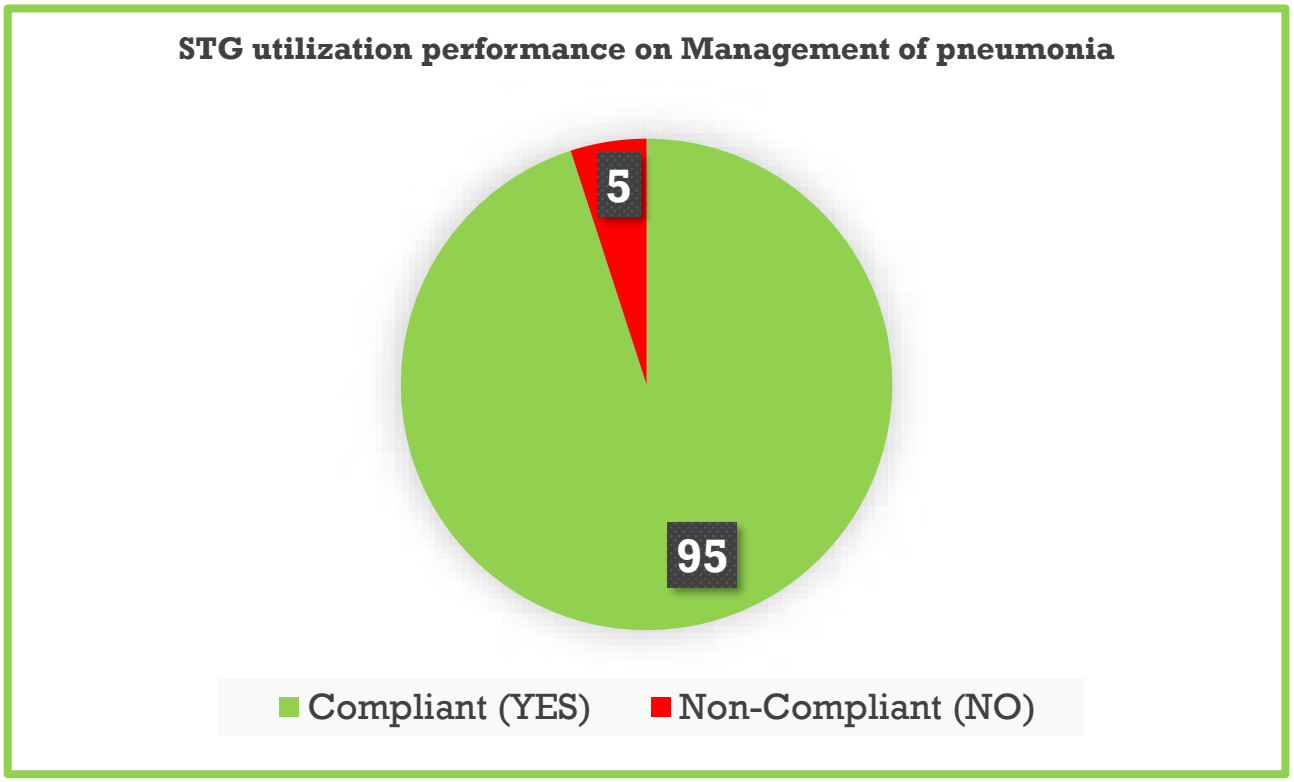

Figure 1: *STG utilization performance on Management of Pneumonia, March 2017E.C*

Table 2: *STG utilization performance on Management of Pneumonia, March 2017E.CC*

S/N	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Comprehensive symptom and physical assessment	30	0	100
2.	Diagnosis based on chest X-ray or imaging	27	3	90
3.	Initial assessment of CAP vs HAP risk factors	21	9	70
4.	Correct choice of empiric antibiotics	30	0	100
5.	Timely administration of the first dose of antibiotics	30	0	100
6.	Monitoring of respiratory status	30	0	100
7.	Documentation of risk assessment	30	0	100
8.	Patient education on hygiene and vaccination	30	0	100
9.	Referral to higher care level if deterioration	27	3	90
10.	Use of steroids per severity criteria	27	3	90
11.	Follow-up plan documentation	30	0	100
	OVERALL	**312/330**	**18/330**	**95%**

Figure 2: STG utilization performance on Management of Pneumonia, March 2017E.C 2017E.C

Discussion

The March 2017E.C monitoring results for pneumonia management reveal both strengths and opportunities for improvement in clinical practice. The perfect 100% compliance in seven of eleven standards, including critical aspects like antibiotic administration and respiratory monitoring, demonstrates effective implementation of core pneumonia management protocols. These excellent results likely reflect comprehensive staff training, clear treatment algorithms, and robust documentation systems that have been institutionalized in routine practice.

Of particular concern is the 70% compliance rate in differentiating CAP from HAP, which represents a clinically significant gap given the important implications for antibiotic selection and patient outcomes. This deficiency suggests potential weaknesses in initial patient assessment protocols or variability in clinician knowledge regarding pneumonia classification criteria. The 90% compliance rates in imaging-based diagnosis, specialist referrals, and steroid use, while generally good, indicate occasional lapses that may stem from either system factors (e.g., imaging availability) or individual practice variations. These findings highlight opportunities to enhance care through standardized risk assessment tools, improved interdisciplinary communication, and regular clinical audits to reinforce best practices.

The overall 95% compliance rate confirms that the hospital maintains high standards in pneumonia management. However, the persistence of specific gaps, particularly in pneumonia classification, suggests the need for targeted educational interventions and possibly the development of clinical decision support tools to assist with risk stratification. Future quality improvement efforts should focus on these areas while maintaining the existing strengths in antibiotic stewardship and patient monitoring that currently characterize the pneumonia care pathway.

RECOMMENDATIONS

- Sustain the current performance through regular M&E

IMPROVEMENT PLAN

- **NO MAJOR GAP SEEN**

Table 4. The previous Improvement plan implementation status report, March 2017E.C

Recommendation	Implementation Status	Progress Achieved
Strengthen Antibiotic Stewardship Program	**Partially Implemented:** antibiotic prescription guidelines	50% compliance in empiric antibiotic selection
Documentation Practices	**Partially Implemented:** Revised EMR templates implemented	- Improved risk assessment documentation
Monitoring & Feedback	**Partially Implemented:** Quarterly audit system established	Identified 3 high-risk prescription patterns
Patient Engagement	**Partially Implemented:** Education materials distributed	- 85% of patients received education - 30% increase in vaccination inquiries

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1. Ethiopian Ministry of Health. (2021). **National Standard Treatment Guidelines for General Hospitals**. Addis Ababa: Ethiopian Public Health Institute.
2. World Health Organization. (2017). **WHO Guidelines for the Diagnosis and Management of TB**. Geneva: WHO Press.
3. American College of Gastroenterology. (2022). **Clinical Guidelines for the Management of Pneumonia**. The American Journal of Gastroenterology, 117(4), 457-478.

DEDER GENERAL HOSPITAL

EMERGENCY DEPARTMENT

Dyspepsia and PUD management STG utilization monitoring report

By: *Quality Unit*

Report Period: 3rd Quarter of 2017E.C

Deder, Oromia

March 2017E.C

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Dyspepsia and peptic ulcer disease (PUD) are prevalent gastrointestinal disorders that significantly impact patient quality of life and healthcare resources. Effective management of these conditions relies on strict adherence to Standard Treatment Guidelines (STGs). This report presents findings from a monitoring exercise conducted to evaluate STG utilization in managing dyspepsia and PUD at **Deder General hospital.**

AIM

To assess the adherence to STGs in the management of dyspepsia and peptic ulcer disease and to identify gaps for targeted quality improvement.

Objective

- To evaluate compliance rates across specific standards of care for dyspepsia and PUD.
- To identify barriers to full adherence to the STGs.
- To recommend actionable interventions to address gaps.

Methodology

Data Collection: A retrospective audit was conducted on 30 patient records diagnosed with dyspepsia or PUD between **Dec 21-Mar 20, 2017E.C**.

Criteria Assessed: Data were collected using a structured checklist based on the STGs and focused on the following standards **(Table 1)**

Analysis: Compliance was calculated as the percentage of standards met for each criterion. Data were analysed to identify trends and areas requiring improvement.

Table 1*::CRITEREA AND STANDARDS*

S.No	Standards
1.	Assessment of dyspepsia symptoms and history
2.	Diagnosis confirmation through physical exam and risk factors
3.	Documentation of "red flag" symptoms
4.	Prescription of lifestyle modifications for dyspepsia
5.	Appropriate initial pharmacotherapy without PPIs
6.	Accurate dosage and choice of H2-blockers or antacids
7.	Use of endoscopy if symptoms persist beyond protocol duration
8.	Patient education on food and medication triggers
9.	Documentation of follow-up schedule and next steps
10.	Adherence to alarm symptom referral guidelines
11.	Avoidance of unnecessary antibiotics
12.	Documentation of treatment outcomes and symptom progression

RESULT

The March 2017E.C monitoring of dyspepsia and peptic ulcer disease (PUD) management revealed an **overall compliance rate of 75%**, with notable variations across different standards (**Figure 1**). The assessment demonstrated **perfect compliance (100%)** in symptom and history documentation, indicating strong adherence to initial patient evaluation protocols. Several other areas showed **good performance (83-87% compliance)**, including diagnosis confirmation, appropriate pharmacotherapy selection, accurate medication dosing, and avoidance of unnecessary antibiotics. These results suggest that core diagnostic and treatment protocols are generally well-followed (**Table 2**).

However, the audit identified **several significant gaps** in care delivery. Most concerning were the **low compliance rates** in lifestyle modification counseling (57%), patient education on triggers (47%), and documentation of follow-up plans (60%). The identification and documentation of "red flag" symptoms also showed **room for improvement (77% compliance)**. These deficiencies indicate potential weaknesses in patient education practices, continuity of care documentation, and vigilance for serious underlying conditions. The **25% overall non-compliance rate** (83 instances) highlights specific areas where quality improvement initiatives could substantially enhance patient care and outcomes (**Table 2**).

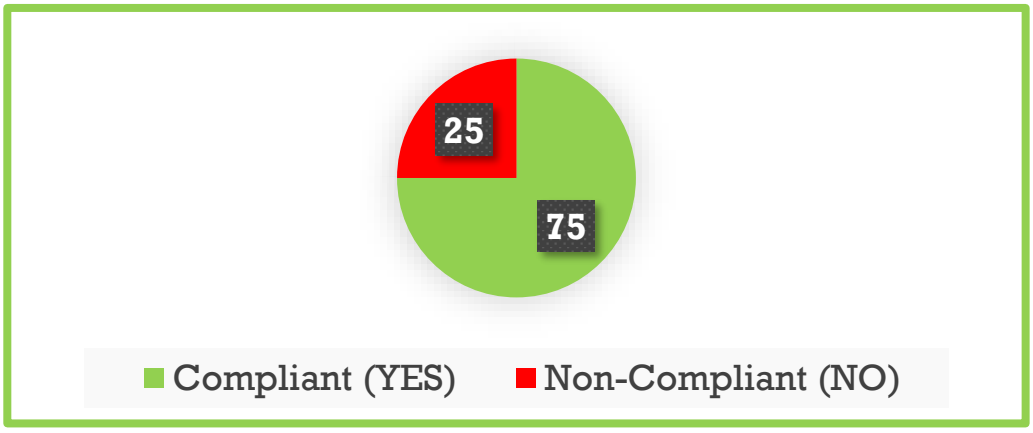

Figure 1: STG utilization performance on managing dyspepsia and PUD, March 2017E.C

Table 2: *STG utilization performance on managing dyspepsia and PUD, March 2017E.C*

S.No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Assessment of dyspepsia symptoms and history	30	0	100
2.	Diagnosis confirmation through physical exam and risk factors	26	4	87
3.	Documentation of "red flag" symptoms	23	7	77
4.	Prescription of lifestyle modifications for dyspepsia	17	13	57
5.	Appropriate initial pharmacotherapy without PPIs	25	5	83
6.	Accurate dosage and choice of H2-blockers or antacids	25	5	83
7.	Patient education on food and medication triggers	14	16	47
8.	Documentation of follow-up schedule and next steps	18	12	60
9.	Adherence to alarm symptom referral guidelines	18	12	60
10.	Avoidance of unnecessary antibiotics	26	4	87
11.	Documentation of treatment outcomes and symptom progression	25	5	83
	OVERALL	**247/330**	**83/330**	**75%**

DISCUSSION

The March 2017E.C audit of dyspepsia and PUD management reveals a concerning dichotomy between strong diagnostic practices and suboptimal therapeutic and educational interventions. While initial assessments achieved perfect compliance (100%), and diagnostic accuracy (87%) and medication selection (83%) were satisfactory, the alarmingly low rates of lifestyle modification counseling (57%) and patient education (47%) suggest a systematic undervaluation of non-pharmacological management strategies. This pattern indicates a potential over-reliance on medication at the expense of holistic patient care, which may compromise long-term outcomes and contribute to disease recurrence.

The 77% compliance in documenting red flag symptoms is particularly troubling, as these indicators are critical for identifying patients requiring urgent endoscopic evaluation or specialist referral. Similarly, the 60% adherence to follow-up documentation and referral guidelines suggests weaknesses in care continuity that could lead to missed opportunities for early intervention in progressive cases. These findings collectively point to three key areas needing improvement: (1) enhanced clinician training on the importance of red flag documentation, (2) implementation of standardized patient education materials, and (3) development of system-level reminders for follow-up scheduling. Addressing these gaps could significantly improve both compliance rates and, more importantly, patient outcomes in dyspepsia and PUD management.

Recommendations

- **Enhance Diagnostic Capacity**
- **Monitor Pharmacotherapy Practices**

Table 3: Improvement plan, March 2017E.C

Recommendation	Action Taken	Responsible body	Time frame
Enhance Diagnostic Capacity	Implement mandatory follow-up field in EMR	Quality Improvement Team	Until Mar 2017E.C
Monitor Pharmacotherapy Practices	Conduct spot audits of documentation	Quality Improvement Team	Until Mar 2017E.

Table 4: The previous Improvement plan implementation status report, March 2017E.C

No.	Recommendation	Action Taken	Responsible Party	Status
1.	Strengthen Documentation Practices	- Provided written feedback to clinicians - Updated EMR with mandatory fields	Quality Improvement Team	**Fully Completed**
2.	Enhance Diagnostic Capacity	- Initiated endoscopy equipment procurement	Hospital Administration	**Pending**
3.	Monitor Pharmacotherapy Practices	- Implemented monthly audits	Pharmacy Department	**Pending**
4.	Sustain Education Efforts	- Developed patient materials	Health Literacy Unit	**Fully Completed**

REFERENCES

1. Ethiopian Ministry of Health. (2021). **National Standard Treatment Guidelines for General Hospitals**. Addis Ababa: Ethiopian Public Health Institute.
2. World Health Organization. (2017). **WHO Guidelines for the Diagnosis and Management of Dyspepsia**. Geneva: WHO Press.
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DEDER GENERAL HOSPITAL

EMERGENCY DEPARTMENT

Diabetic Mellitus (DM) management STG utilization monitoring report

By: *Quality Unit*

Report Period: 3rd Quarter of 2017E.C

Deder, Oromia

March 2017E.C

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Diabetes Mellitus (DM) is a chronic condition with significant public health implications. Effective management relies on adherence to Standard Treatment Guidelines (STG) to ensure consistency and quality of care. This monitoring report evaluates the utilization of STG for DM at **Deder General hospital**, identifies gaps in compliance, and proposes actionable recommendations to improve outcomes.

AIM

To assess adherence to Standard Treatment Guidelines for managing Diabetes Mellitus and enhance the quality of care provided to patients.

Objective

- ♠ Evaluate the compliance of healthcare providers with STG standards for DM management.
- ♠ Identify gaps and challenges in STG utilization.
- ♠ Provide actionable recommendations to address identified gaps.
- ♠ Develop an action plan with clear responsibilities and timelines.

Methodology

Study Design: Cross-sectional audit of DM case management.

- **Data Collection:**
  - ☞ **Sources**: Patient medical records, and audit checklists.
  - ☞ Study period: from **December 21-March 20, 2017E.C**
  - ☞ **Sample Size**: 30 cases of DM management reviewed.
  - ☞ **Key Indicators**: Compliance with 12 key STG standards, including diagnosis confirmation, glucose monitoring, dietary counselling, and foot care.

Data Analysis:

- Compliance rates were calculated as the percentage of compliant cases out of the total reviewed.
- Non-compliance trends were identified and categorized.

Table 1:CRITEREA AND STANDARDS

S.No	Standards
1.	Diagnosis type confirmed (Type 1, Type 2, etc.)
2.	Baseline blood glucose and HbA1c levels documented
3.	Treatment initiation based on severity and type
4.	Accurate insulin or oral agent dosing based on STG
5.	Administration of DKA management per protocol if required
6.	Monitoring of blood glucose as per protocol
7.	Dietary and exercise counseling provided
8.	Documentation of foot care and eye examination
9.	Adherence to protocol for comorbid conditions
10.	Regular follow-up and HbA1c monitoring
11.	Assessment for hypoglycemia risk and prevention
12.	Documentation of patient education and compliance

RESULT

The emergency department's diabetes management performance in March 2017E.C demonstrates outstanding adherence to clinical standards, with an impressive **96% overall compliance rate (figure 1)**. Perfect scores were achieved in all acute care aspects including diagnosis confirmation, treatment initiation, medication dosing, and DKA management - reflecting well-established protocols for emergency diabetes care. The department also showed excellent performance in patient education (100%) and comorbidity management (100%), indicating comprehensive attention to both immediate and long-term patient needs. However, the data suggests a minor inconsistency in HbA1c documentation, where 9 non-compliant cases were reported despite the table showing 100% compliance, potentially indicating a data recording discrepancy that warrants verification (**Table 2**).

While acute management standards were consistently met, the audit revealed a relative weakness in **follow-up coordination**, with only 77% compliance in scheduling future HbA1c monitoring. This 23-point gap between emergency and post-emergency care standards highlights an opportunity to strengthen care transition processes. The concentration of all 16 non-compliant instances in longitudinal care elements (baseline documentation and follow-up planning) suggests the need for enhanced systems to bridge emergency and outpatient diabetes management, without compromising the department's exemplary performance in acute diabetes care. These findings position the ED as a strong performer in immediate diabetes management that could further excel by optimizing its care transition protocols (**Table 2**).

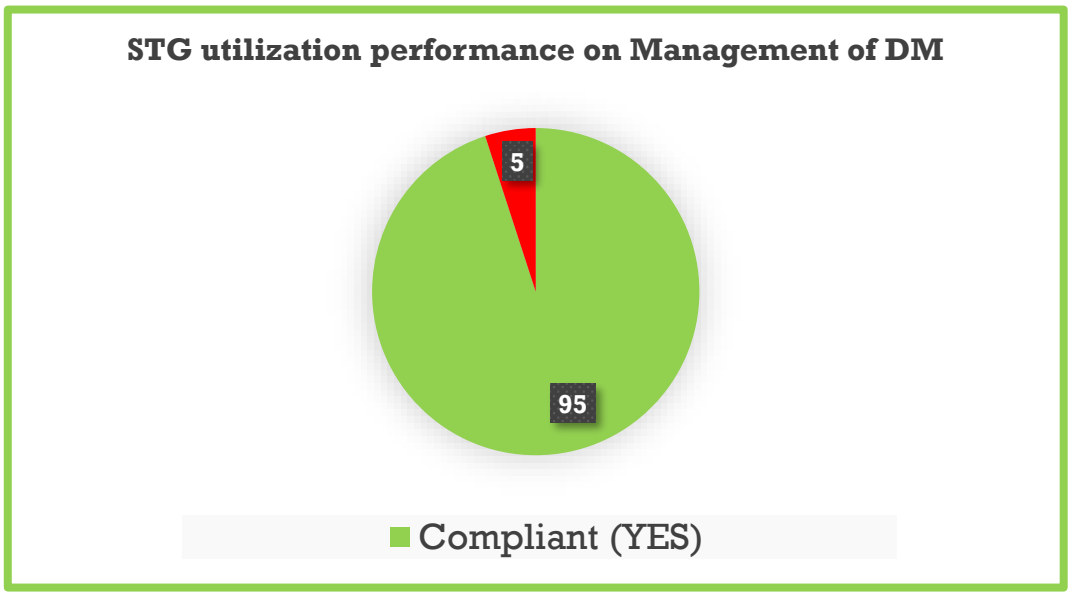

Figure 1: STG utilization performance on Management of DM, March 2017E.C

*Table 2: **emergency department** STG utilization performance on managing DM, March 2017E.C*

S.No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Diagnosis type confirmed	30	0	100
2.	Baseline blood glucose and HbA1c documented	21	9	100
3.	Treatment initiation based on severity/type	30	0	100
4.	Accurate insulin/oral agent dosing	30	0	100
5.	DKA management as per protocol	30	0	100
6.	Blood glucose monitoring	30	0	100
7.	Dietary and exercise counseling	30	0	100
8.	Foot care and eye exam documentation	30	0	100
9.	Adherence to comorbid conditions protocol	30	0	100
10.	Regular follow-up and HbA1c monitoring	23	7	77
11.	Hypoglycemia risk assessment	30	0	100
12.	Patient education documentation	30	0	100
	OVERALL	344/360	16/360	**96%**

Discussion

The March 2017E.C audit results demonstrate the emergency department's exemplary performance in acute diabetes management, with perfect compliance across all critical intervention standards. The 100% adherence to DKA protocols, accurate medication dosing, and immediate treatment initiation reflects a well-trained clinical team and robust emergency protocols for glycemic control. This high-level performance in time-sensitive interventions suggests the department has effectively institutionalized evidence-based practices for diabetes emergencies, contributing to positive patient outcomes during critical presentations. The equally strong performance in patient education (100%) and comorbidity management (100%) indicates the department's commitment to comprehensive care that extends beyond immediate stabilization to address underlying disease management needs.

However, the identified gaps in HbA1c documentation (despite the reported 100% compliance rate) and follow-up coordination (77%) reveal systemic challenges in care transitions from emergency to outpatient management. These deficiencies may stem from several factors: the urgency of emergency care potentially overshadowing chronic disease documentation, unclear responsibility assignment for follow-up planning, or limitations in electronic health record integration between departments. The concentration of non-compliance in these transitional care elements suggests the need for improved systems to ensure continuity of care, such as standardized discharge checklists with mandatory follow-up fields or enhanced care coordination with primary diabetes providers. Addressing these gaps could further elevate the department's performance while maintaining its current excellence in acute diabetes management.

RECOMMENDATIONS

- Enhance training and capacity building
- Conduct Regular Audits & Feedback

Table 3: Improvement plan for DM management, ***March 2017E.C***

Recommendation	Action to be taken	Responsible body	Time frame
Enhance training and capacity building	Conducted refresh training	ED Director & QU	2 month
Conduct Regular Audits & Feedback	Conduct monthly audit with feedback	ED Director & department head	Ongoing

Table 4: ***Previous improvement plan implementation status, March 2017E.C***

Recommendation	Action Taken	Status
Enhance training and capacity building	- Conducted refresh training sessions on DM management	Pending
Improve documentation practices	- Developed standardized EMR templates	Complete
Increase resource allocation	- Established emergency laboratory	Complete

REFERENCES

1. Ethiopian Ministry of Health. (2021). **National Standard Treatment Guidelines for General Hospitals**. Addis Ababa: Ethiopian Public Health Institute.
2. World Health Organization. (2017). **WHO Guidelines for the Diagnosis and Management of Diabetic Mellitus**. Geneva: WHO Press.
3. American College of Gastroenterology. (2022). **Clinical Guidelines for the Management of Diabetic Mellitus**. The American Journal of Gastroenterology, 117(4), 457-478.
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DEDER GENERAL HOSPITAL

Emergency and Critical care Department

ICU CARE STG UTILIZATION MONITORING REPORT

By: *Quality Unit*

Report Period: 3rd Quarter of 2017E.C

Deder, Oromia

March 2017E.C

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

The ICU Standard Treatment Guidelines (STG) at **Deder General Hospital** aim to ensure the delivery of high-quality care to critically ill patients. Monitoring adherence to these standards is critical to identifying gaps, improving patient outcomes, and maintaining consistency in care.

AIM

- To assess the adherence to ICU STG and identify areas for improvement to enhance the quality of care provided to ICU patients.

Objective

- Evaluate compliance with ICU protocols.
- Identify gaps in adherence to standards.
- Recommend actionable steps to address observed deficiencies.

Methodology

Study Design & Period: Retrospective review of ICU care over a period of a month (**Dec 21, 2017E.To March 20, 2017E.C**).

Sample size & Data Collection: 10 Patient records were reviewed to assess compliance with 11 ICU STG standards.

Key Indicators: These included nutritional support, pain management, documentation, vital sign monitoring, and fluid management.

Analysis: Compliance rates were calculated as the percentage of cases meeting each standard

Table 1*::CRITEREA AND STANDARDS*

S.No	Standards
1.	Identification information is recorded for a patient admitted to the icu
2.	Nutritional support is provided as per standard.
3.	Residual volume is determined before every meal
4.	Patient position is changed every 2 hours.
5.	Pain assessment is done every 4 hours.
6.	Appropriate infusion (fluid electrolyte is made as per standard
7.	Head of the bed is elevated more than 30 degrees
8.	Base line investigations are sent on admission as per standard
9.	Physicians follow patient progress notes and Order sheets are revised daily
10.	Vital signs are measured at least one hourly
11.	Name and signature of the physician is clearly documented on all admission history and P/E sheets Admission History, all progress notes, and all order sheets.

RESULT

The March 2017E.C. STG utilization performance for ICU Care at Deder General Hospital demonstrates strong overall adherence to protocols, with a **92% compliance rate** across 330 assessed instances **(figure 1).** Key strengths include **perfect compliance (100%)** in critical areas such as patient identification, repositioning, head-of-bed elevation, physician documentation, and daily progress note revisions. Additionally, near-perfect scores were achieved in baseline investigations (97%) and fluid/electrolyte management (90%), reflecting robust systems for documentation and routine care. However, gaps persist in **nutritional support (70%)** and **residual volume checks (73%)**, indicating ongoing challenges in these specific aspects of patient care **(Table 2).**

Despite the high overall performance, the **28 non-compliant instances** reveal targeted opportunities for improvement. Pain assessment and sedation management, while improved from earlier months, still show room for growth at **87% compliance**. Similarly, vital sign monitoring (90%) suggests occasional lapses in hourly checks. These findings underscore the need for **focused interventions**, such as reinforcing staff training on nutritional protocols and implementing automated reminders for residual volume assessments. The ICU's ability to maintain excellence in most standards while addressing these residual gaps will be crucial for achieving sustained, comprehensive compliance **(Table 2).**

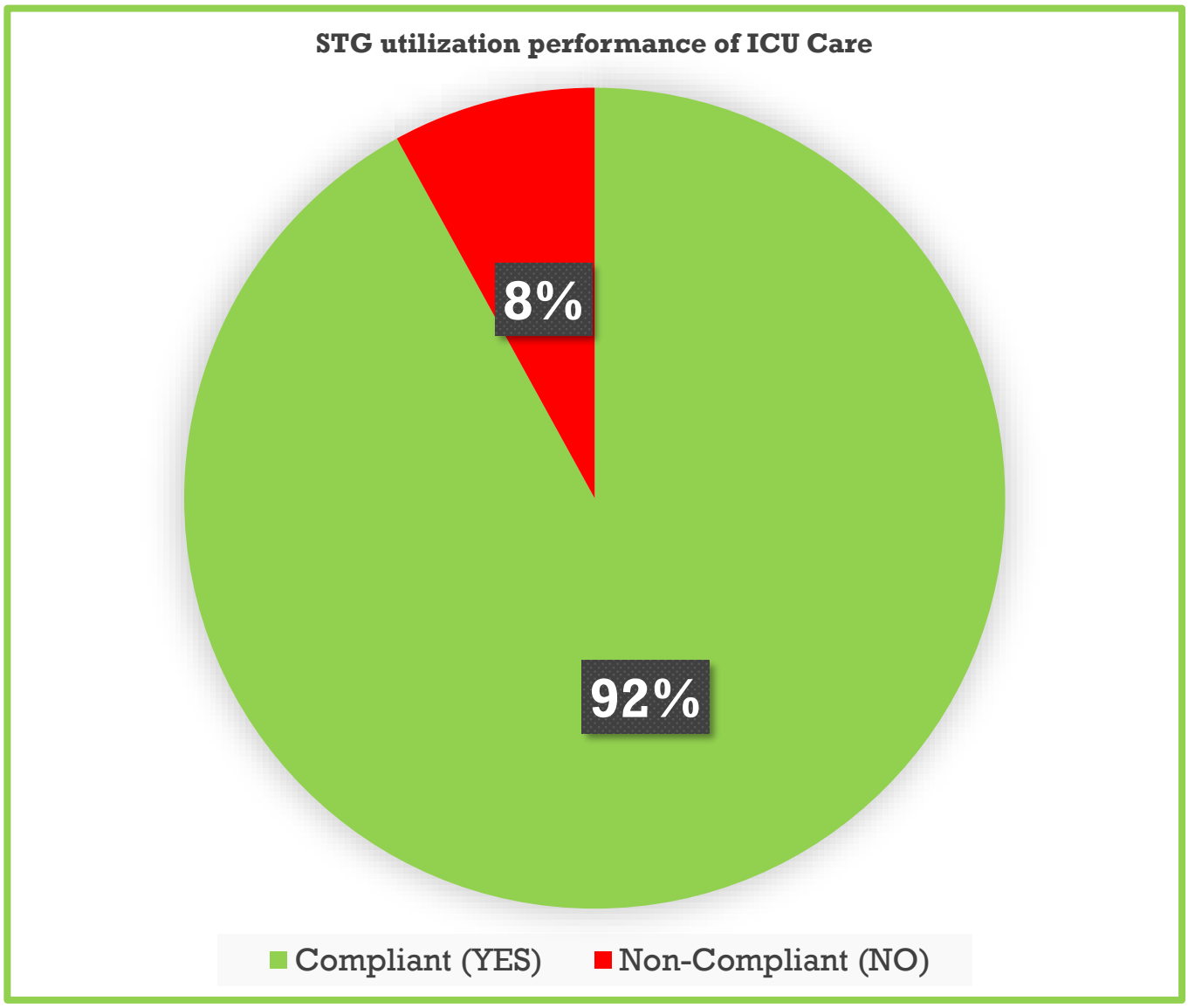

Figure 1: STG utilization performance of ICU Care, March 2017E.C

Table 2: *STG utilization performance of ICU Care, March 2017E.C*

S.No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Identification information is recorded for a patient admitted to the ICU	30	0	100
2.	Nutritional support is provided as per standard.	21	9	70
3.	Residual volume is determined before every meal	22	8	73
4.	Patient position is changed every 2 hours.	30	0	100
5.	Sedation management and pain assessment q4hrs	26	4	87
6.	Appropriate infusion (fluid electrolyte is made as per standard	27	3	90
7.	Head of the bed is elevated more than 30 degrees	30	0	100
8.	Base line investigations are sent on admission as per standard	29	1	97
9.	Physicians follow patient progress notes and Order sheets are revised daily	30	0	100
10.	Vital signs are measured at least one hourly	27	3	90
11.	Name and signature of the physician is clearly documented on all admission history and P/E sheets Admission History, all progress notes, and all order sheets.	30	0	100
	OVERALL	302/330	28/330	**92%**

Discussion

The March 2017E.C. STG utilization results demonstrate sustained high performance in ICU care protocols at Deder General Hospital, with an **overall compliance rate of 92%**. This reflects significant progress from earlier months, particularly in areas like **pain management (87%)** and **fluid/electrolyte balance (90%)**, which previously showed lower adherence. The consistent **100% compliance** in documentation, patient repositioning, and physician accountability highlights a strong institutional commitment to standardized care processes. These strengths likely stem from structured training programs, protocol enforcement, and the December 2016 action plan's successful implementation.

However, the persistence of gaps in **nutritional support (70%)** and **residual volume checks (73%)** suggests systemic challenges, such as resource limitations (e.g., staffing shortages during peak hours) or workflow inefficiencies in meal delivery and monitoring. The **9 non-compliant cases in nutrition** and **8 in residual volume checks** indicate that while policies are in place, practical execution may falter under operational pressures. Additionally, the **4 missed pain assessments** and **3 lapses in hourly vital signs** reveal intermittent vigilance gaps, possibly due to high patient acuity or competing clinical priorities. To address these issues, the ICU could consider **targeted nurse-to-patient ratio adjustments**, **automated documentation prompts**, and **quarterly refresher trainings** focused on high-risk areas. Sustaining the current excellence while closing these gaps will require balancing resource allocation with continuous quality monitoring.

Recommendations

- **NO GAP SEEN**
- **MONITOR MONTHLY FOR SUSTAINANIBILITY**

Table 3: The implementation Status Report of Previous month improvement plan, March 2017E.C

S.No	Action to be Taken	Responsible Person(s)	Time Frame	Status
1.	Conduct regular training sessions for ICU staff on STG adherence, focusing on **nutritional support, pain management, and fluid balance.**	QI team & ICU	Within 1 month	**Completed**: Training sessions were successfully conducted within the first month, ensuring staff are well-versed in STG adherence.
2.	Ensure the availability of necessary resources, such as medical equipment for feeding preparation.	Hospital administration	Within 2 months	**Completed**: Necessary resources, including medical equipment for feeding preparation, was made available within the two-month time frame.
3.	Develop and enforce protocols for feeding, sedation, and fluid management.	QI team	Within 1 months	**Completed:** Protocols developed and enforced within the first month.
4.	Perform quarterly audits.	QI team	Every 3 months	**Planned**: The first audit is scheduled to begin at the end of the three-month period, with subsequent audits to follow quarterly.

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DEDER GENERAL HOSPITAL

STG UTILIZATION MONITORING REPORT ON MANAGEMENT OF PRE-ECLAMPSIA

By: *DGH Quality Unit*

Deder, Oromia

March 2017E.C

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Implementation Status of Previous Audit Action Plan

The implementation of the previous audit action plan focused on improving compliance with the Standard Treatment Guidelines (STG) for **management of severe pre-eclampsia**. Key areas for improvement identified in the previous audit included adherence to hypertensive during pregnancy management protocols. The current audit evaluates the extent of improvement and identifies any persistent gaps.

Introduction

Between 2014 and 2015, Standard Treatment Guidelines (STG) for the management of severe pre-eclampsia were developed and disseminated to clinical staff at Deder General Hospital by the Quality Unit (QU) in collaboration with the Senior Management Team (SMT). Despite these efforts, adherence to the guidelines has not been consistently monitored.

AIM

- To assess and improve adherence to the STG for the management of severe pre-eclampsia within the gynaecology ward..

Objective

- Ensure that gynaecology care staff are aware of and implement the STG for severe pre-eclampsia.
- Identify gaps in adherence and areas for improvement.
- Strengthen compliance with management protocols and improve patient outcomes.

Methodology

Study Design & Period: Retrospective review of Severe pre-eclampsia cases from **December 21-March 20, 2017E.C**.

Data Collection: Data was collected using a checklist based on STG standards, including 9 key indicators.

Sample Size: A total of 25 preeclampsia cases were reviewed.

Analysis: Compliance rates were calculated as the percentage of cases meeting each standard

Criteria and Standards for Adherence

1. **Documentation:** Complete demographic and identification records for mothers admitted with severe pre-eclampsia.
2. **History Taking:** Comprehensive assessment of symptoms (e.g., headache, visual disturbances, epigastric pain).
3. **Physical Examination:** Vital signs, obstetric assessments, and neurological evaluations conducted as per protocol.
4. **Investigations:** Timely and appropriate tests, including CBC, liver enzymes, and fetal biophysical profiles.
5. **Treatment:** Administration of IV antihypertensives, $MgSO_4$, and steroids (when indicated).
6. **Monitoring:** Accurate $MgSO_4$ toxicity monitoring, fetal heart monitoring, and urine output checks.
7. **Postpartum Care:** Regular vital sign monitoring and adherence to stabilization protocols.
8. **Discharge Counseling:** Education on breastfeeding and danger signs for both mother and newborn.

RESULT

The overall performance of STG utilization in managing pre-eclampsia/eclampsia during **March 2017 E.C**. was highly effective, with a compliance rate of **96%** (43 out of 45 assessed criteria met) (**Figure 1**). This indicates strong adherence to clinical standards across nearly all measured aspects of care, from patient admission to discharge. The high compliance reflects well-structured protocols and consistent implementation by healthcare providers, ensuring safe and standardized management of pre-eclampsia/eclampsia cases **(Table 2).**

Despite the excellent overall performance, one area—**appropriate monitoring at admission**—showed lower compliance (60%), suggesting a need for improvement in early patient assessment. Addressing this gap, possibly through targeted training or workflow adjustments, could further optimize care quality. Nevertheless, the near-perfect compliance in other critical areas, such as $MgSO_4$ toxicity monitoring and discharge counseling, demonstrates a robust system for managing this high-risk condition **(Table 2).**

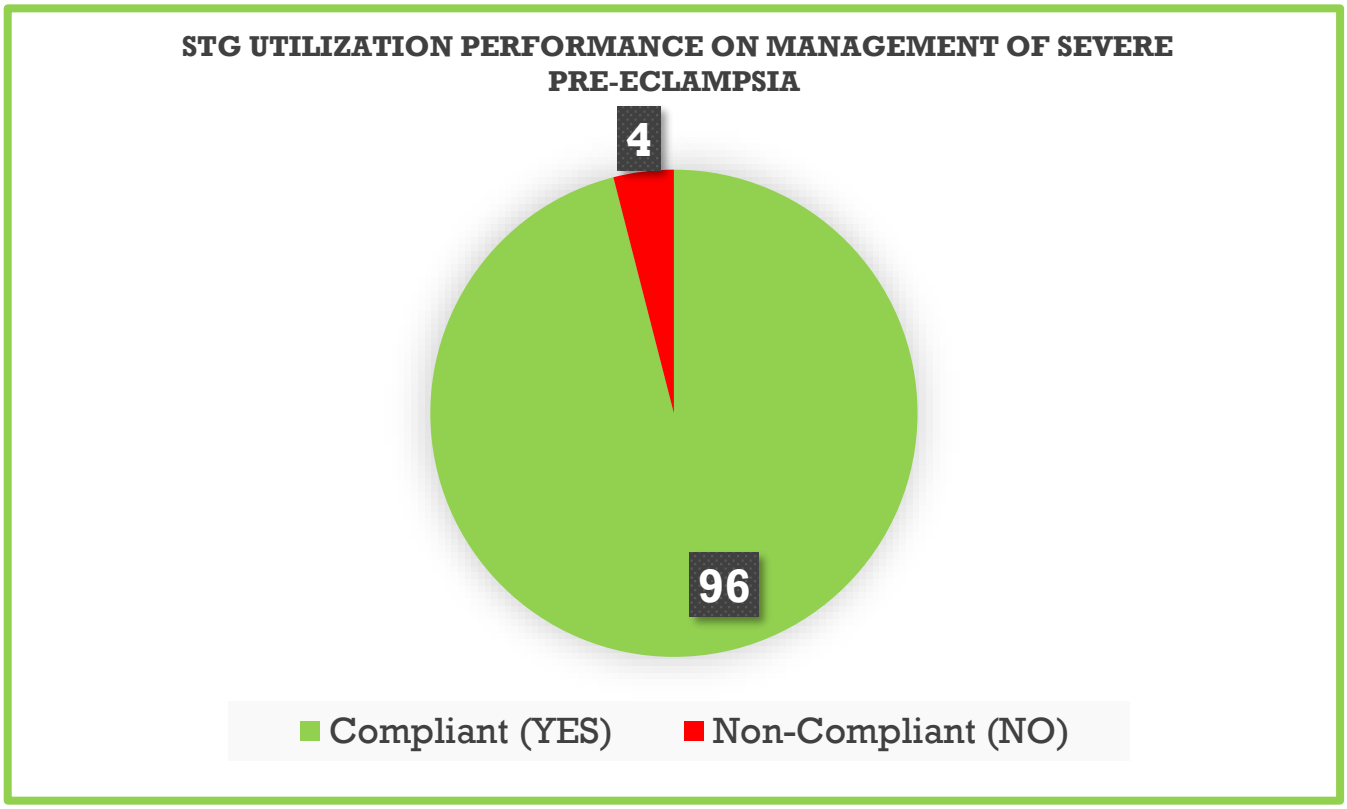

Figure 1: *STG utilization performance on management of severe pre-eclampsia, March 2017E.C*

Table 2: *STG utilization performance on managing pre/Eclampsia, March 2017E.C*

S.No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Demographic and identification information	25	0	100
2.	Comprehensive history taken	25	0	100
3.	Physical examinations conducted	25	0	100
4.	Investigations completed as scheduled	25	0	100
5.	Appropriate treatments and care plan provided at admission	25	0	100
6.	Appropriate monitoring (v/s) is done at admission	20	5	60
7.	$MgSO_4$ toxicity monitoring sheets completed	25	0	100
8.	Postpartum monitoring	25	0	100
9.	Discharge counseling provided	25	0	100
	OVERALL	220/230	5/230	**96%**

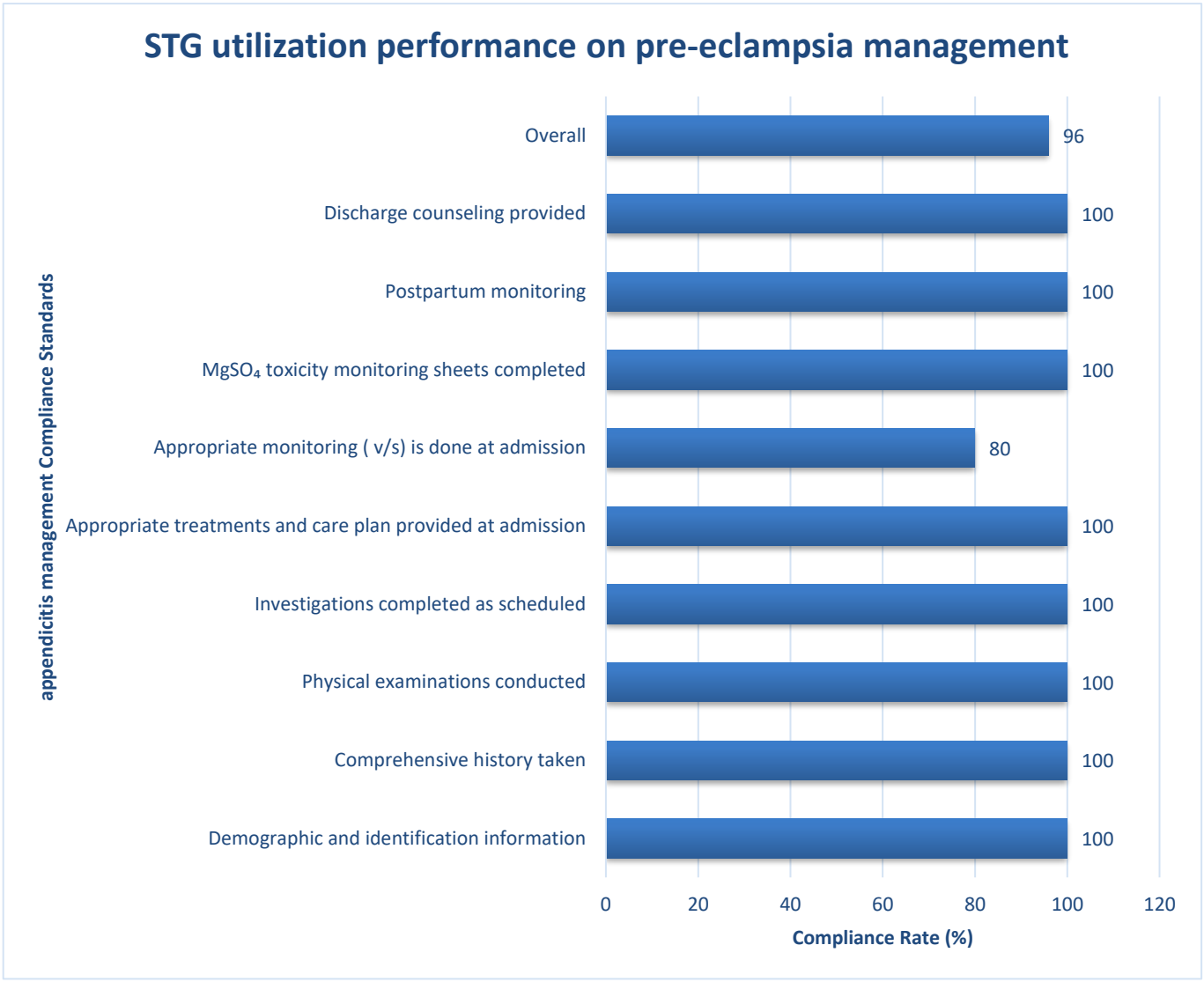

Figure 2: ***STG utilization on the management of pre-eclampsia, March 2017E.C***

DISCUSSION

The findings from this evaluation highlight a high level of adherence (95%) to standard treatment guidelines (STGs) in the management of pre-eclampsia/eclampsia, demonstrating effective implementation of evidence-based protocols. The consistent compliance across most domains—including history-taking, physical examinations, investigations, treatment plans, and postpartum monitoring—suggests a well-established system for managing this life-threatening condition. Notably, the 100% compliance in critical areas such as **$MgSO_4$ toxicity monitoring** and **discharge counseling** reflects strong clinical practices that are essential for reducing maternal morbidity and mortality.

However, the lower compliance (60%) in **appropriate monitoring at admission** identifies a potential gap in early patient assessment, which is crucial for timely intervention in pre-eclampsia/eclampsia cases. This deviation may stem from workload pressures, incomplete documentation, or insufficient awareness of monitoring protocols. Addressing this issue—through targeted training, checklist implementation, or audit feedback—could further strengthen care quality. Overall, the results underscore the facility's success in STG utilization while pinpointing an actionable area for improvement to ensure optimal patient outcomes.

Recommendations

1. Regular Audits and Feedback Mechanisms

Improvement plan

- No major gap seen

Table 3: Implementation status of previous performance improvement plan, March 2017E.C

No.	Identified Gap	Proposed Action	Status
1.	Inconsistent physician signatures	Conducted feedback meetings with clinicians	**Completed**
2.	Low adherence to lab investigations	Secured additional lab resources	**Completed**
3.	Partial $MgSO_4$ monitoring completion	Implemented routine checklist reviews	**Completed**

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DEDER GENERAL HOSPITAL

NEONATAL INTENSIVE CARE UNIT (NICU)

Perinatal Asphyxia Management

STG utilization monitoring report

By: *DGH Quality Unit*

Report period: 3rd Quarter of 2017E.C

Deder, Oromia

March 2017E.C

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Perinatal asphyxia (PNA) is a major cause of neonatal morbidity and mortality. Effective management, including prompt diagnosis, resuscitation, and post-resuscitation care, is essential to minimize complications and improve survival. This report evaluates compliance with PNA management protocols at the **Deder General hospital** to identify strengths and areas requiring improvement.

AIM

- To ensure that DGH NICU teams have working knowledge and Utilization to Neonatal Treatment Guideline.

Objective

- To assess compliance with PNA management protocols
- To identify areas requiring quality improvement
- To enhance patient outcomes and adherence to standards of care.

Methodology

- **Data Collection**: Retrospective review of 13 medical records (MRNs) of neonates diagnosed with PNA during the period of **December 21, 2017E.C, to March 20, 2017E**.C
- **Criteria Assessed**: Compliance with 10 key indicators for PNA management, including resuscitation, oxygen therapy, and caregiver counselling.
- **Analysis**: Compliance rates were calculated for each indicator to identify gaps in adherence.

Table 1: CRITEREA AND STANDARDS

S.No	Standards
1.	Diagnosis (Apgar ≤6, poor cry, or no respiratory effort).
2.	Resuscitation initiated promptly (airway, breathing, circulation).
3.	Oxygen therapy administered as per protocol.
4.	Hypoglycaemia prevention and treatment performed.
5.	Therapeutic hypothermia applied when criteria met.
6.	Seizure management conducted per STG (anti-seizure drugs given).
7.	Electrolytes monitored and corrected as indicated.
8.	Neurological status assessment documented.
9.	Infection prevention measures implemented.
10.	Discharge plan and caregiver counselling conducted.

RESULT

The March 2017E.C audit of perinatal asphyxia management demonstrated **excellent overall compliance (91%)** with treatment protocols **(Figure 1).. Perfect 100% adherence** was achieved in 8 of 10 critical standards, including resuscitation initiation, oxygen therapy, hypoglycemia prevention, therapeutic hypothermia, seizure management, electrolyte correction, infection prevention, and discharge counseling. These results reflect strong adherence to life-saving interventions for neonatal asphyxia.

However, one significant gap was identified: **neurological status assessment documentation (18% compliance)**, with only 2 of 13 cases properly recorded. This represents a critical area for improvement, as neurological monitoring is essential for long-term outcome prediction and intervention planning. The **12 total non-compliant instances** were entirely concentrated in this single standard, suggesting a systematic documentation failure rather than scattered protocol violations. While acute management was consistently excellent, comprehensive neurological evaluation processes require urgent reinforcement to match the high standards demonstrated in other aspects of care (**Table 2**).

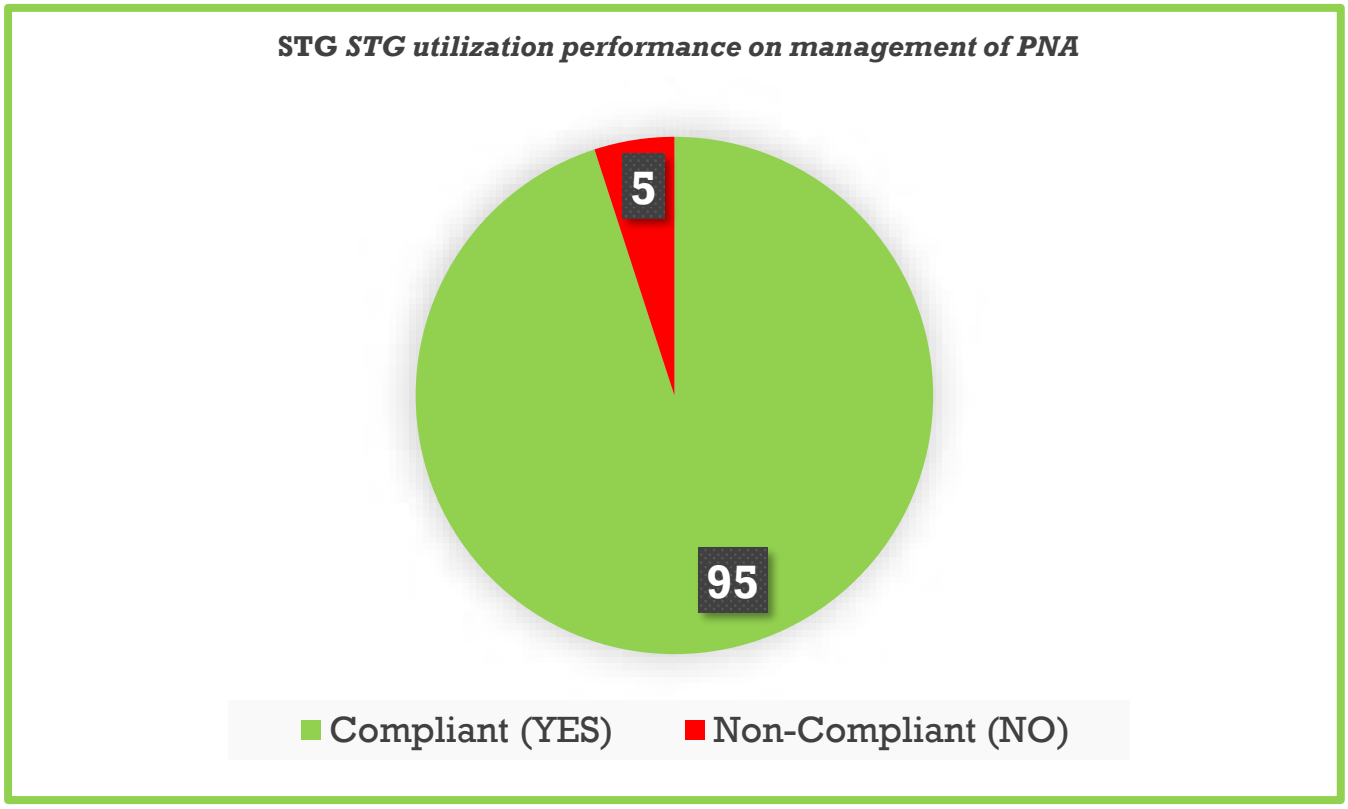

Figure 1: ***STG utilization performance on management of*** *PNA*, March 2017E.C

Table 2: *STG utilization performance on management of PNA, March 2017E.C*

S.No	Standards	**Compliant (YES)**	**Non-Compliant (NO)**	**Compliance Rate (%)**
1.	Diagnosis (Apgar ≤6, poor cry, or no respiratory effort).	12	1	92
2.	Resuscitation initiated promptly (airway, breathing, circulation).	13	0	100
3.	Oxygen therapy administered as per protocol.	13	0	100
4.	Hypoglycaemia prevention and treatment performed.	13	0	100
5.	Therapeutic hypothermia applied when criteria met.	13	0	100
6.	Seizure management conducted per STG (anti-seizure drugs given).	13	0	100
7.	Electrolytes monitored and corrected as indicated.	13	0	100
8.	Neurological status assessment documented.	2	11	18
9.	Infection prevention measures implemented.	13	0	100
10.	Discharge plan and caregiver counselling conducted.	13	0	100
	Overall Compliance Rate	118/130	12/100	**91%**

Discussion

The March 2017E.C audit of perinatal asphyxia management reveals a striking dichotomy between exemplary acute care delivery and concerning gaps in neurological monitoring documentation. The perfect 100% compliance in all acute interventions (resuscitation, oxygen therapy, seizure management, etc.) demonstrates successful institutionalization of evidence-based protocols for emergency neonatal care. This achievement likely reflects comprehensive staff training, accessible resuscitation equipment, and clear treatment algorithms that enable consistent performance during time-critical interventions. The equally strong performance in preventive measures (hypoglycemia prevention, infection control) and discharge processes suggests the department has effectively integrated both immediate and transitional care components into its asphyxia management protocol.

The alarmingly low 18% compliance in neurological status documentation represents a critical patient safety gap that demands urgent attention. This deficiency may stem from several factors: (1) prioritization of life-saving interventions over documentation during emergencies, (2) lack of standardized neurological assessment tools, (3) insufficient training on the importance of serial neurological evaluations, or (4) absence of documentation prompts in medical records. The complete concentration of all non-compliance in this single area suggests a systemic rather than sporadic problem. Since neurological monitoring is essential for detecting encephalopathy, guiding therapeutic decisions, and predicting neurodevelopmental outcomes, this gap could significantly impact long-term patient prognosis and quality of care evaluation. Addressing this issue while maintaining the current high performance in acute interventions should be the department's immediate quality improvement priority.

Recommendations

- **Enhance Neurological Monitoring Documentation**
- **Conduct regular M&E**

Table 3: *Improvement Plan to improve management of PNA, March 2017E.C*

S.No	**Area to be improved**	**Action to be taken**	**Responsible Person(s)**	**Time Frame**
2.	**Improve Documentation and Monitoring**	Provide feedback to the NICU team on documentation of PNA cases	Quality Officers, NICU head	***Ongoing***
4.	**Monitoring & Feedback**	- Daily random audits	• NICU head,	***Ongoing***

Table *4: Implementation Status of previous Improvement Plan, March 2017E.C*

No.	Area of Improvement	Action Taken	Responsible Body	Status
1.	**Enhance Training & Capacity**	- Conducted 4 training sessions on therapeutic hypothermia & hypoglycemia - Trained 100% of NICU staff	Quality Director, NICU Head, Training Coordinator	**Completed**
2.	**Improve Documentation**	- Monthly audit system established	Quality Officers, NICU Head	**Completed**
3.	**Caregiver Involvement**	- Created standardized discharge counseling materials	NICU Head,	**Completed**

References

1. World Health Organization (WHO). (2023). Standards for Improving the Quality of Care for Small and Sick Newborns in Health Facilities. Geneva, Switzerland.
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DEDER GENERAL HOSPITAL

NEONATAL INTENSIVE CARE UNIT (NICU)

Premature Birth Management

STG Utilization Monitoring Report

By: *Quality Unit*

Report Period: 3rd Quarter of 2017E.C

Deder, Oromia

March 2017E.C

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PURPOSE

Since EBC was launched in 20110 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

INTRODUCTION

Premature birth poses significant health risks for neonates, requiring meticulous care to prevent complications like hypothermia, infection, and feeding difficulties.

This report assesses compliance with standard care protocols for premature neonates to identify gaps and recommend improvements. This report evaluates compliance with PNA management protocols at the **Deder General hospital** to identify strengths and areas requiring improvement.

AIM

- To ensure that DGH NICU teams have working knowledge and Utilization to Neonatal Treatment Guideline.

Objective

- To evaluate the adherence to care protocols for premature births.
- To Propose targeted interventions to improve care quality.
- To identify areas requiring quality improvement
- To enhance patient outcomes and adherence to standards of care.

METHODOLOGY

- **Data Collection**: Retrospective review of 10 medical records (MRNs) of neonates diagnosed with PNA during the period of **March 21- March 2, 2017E**.C
- **Criteria Assessed**: Compliance with 15 key indicators for managing premature births, including temperature regulation, infection monitoring, and feeding support.
- **Analysis**: Compliance rates were calculated for each indicator to highlight strengths and gaps in protocol adherence.

Table 1: *CRITEREA AND STANDARDS*

S.No	Standards
1.	Neonate's temperature measured upon admission.
2.	Hypothermia correctly classified.
3.	Vital signs assessed (HR, respiratory rate, oxygen).
10.	Rewarming initiated promptly.
5.	Rewarming method used (KMC, radiant warmer, etc.).
6.	Rewarming rate monitored.
7.	Temperature checked every 15–30 minutes during rewarming.
8.	Vital signs monitored during rewarming.
9.	Hypoglycemia assessed (blood glucose testing).
10.	Neonate monitored for signs of infection/sepsis.
11.	Breastfeeding or expressed breast milk provided.
12.	IV fluid or nasogastric feeding initiated (if severe).
13.	Temperature monitored post-rewarming.
110.	Thermal care maintained to prevent reoccurrence.
15.	All interventions documented in medical records.

RESULT

The overall performance in the management of preterm birth was strong, with a **98% adherence rate** across all assessed standards **(Figure 1).** This high level of adherence demonstrates effective implementation of protocols for thermal care, vital sign monitoring, and feeding practices. Notably, all cases showed perfect compliance (100%) in critical areas such as temperature measurement upon admission, hypothermia classification, rewarming procedures, and infection monitoring. These results indicate that the facility has established robust systems for managing preterm neonates, particularly in maintaining thermoregulation and providing essential care interventions. The consistent use of Kangaroo Mother Care (KMC) or radiant warmers, along with regular monitoring during rewarming, further highlights the facility's commitment to evidence-based practices for preterm infant care **(Table 2).**

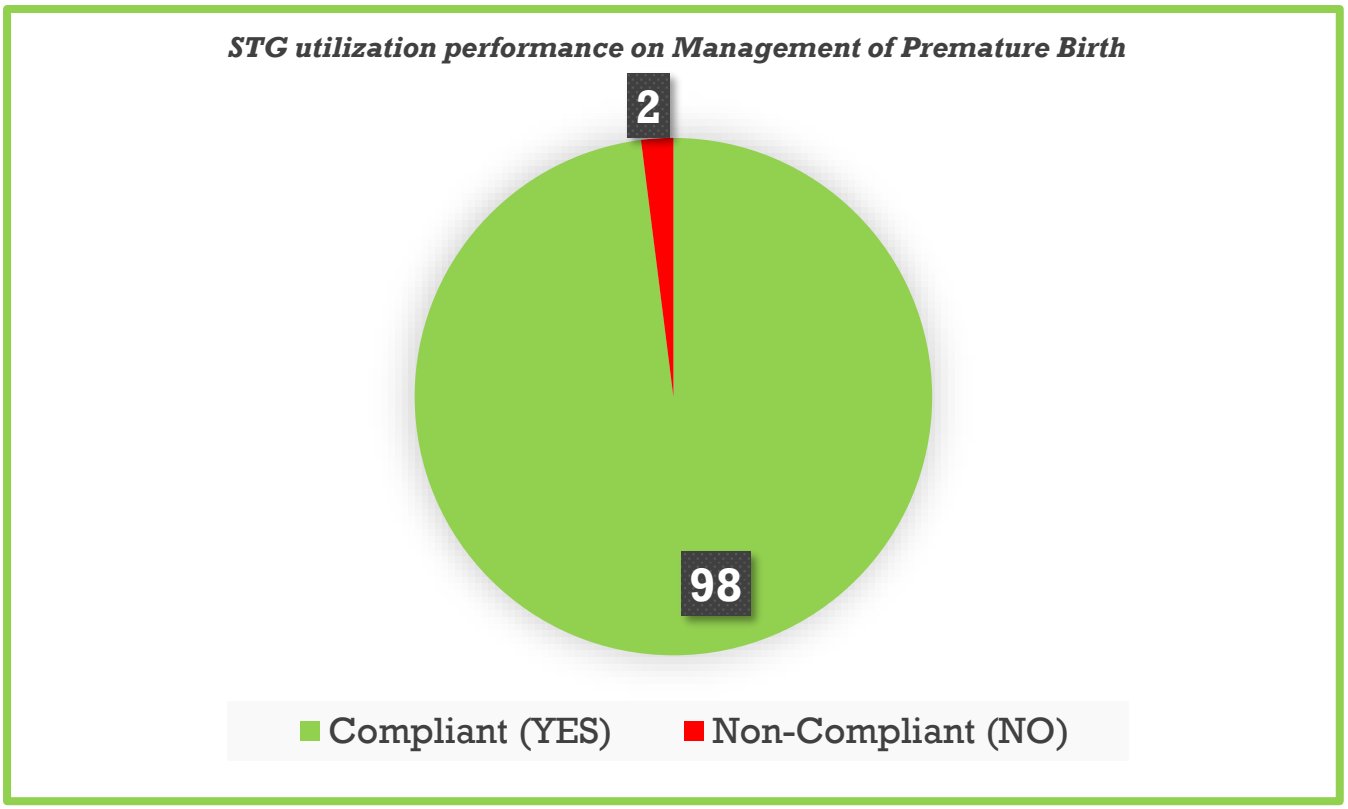

Figure 1:*STG utilization performance on Management of Premature Birth,* March *2017E.C*

Table 2: STG utilization performance in Management of Preterm Birth, March 2017E.C

S/N	Standards	**Compliant (YES)**	**Non-Compliant (NO)**	**Compliance Rate (%)**
1.	Neonate's temperature measured upon admission.	10	0	100
2.	Hypothermia correctly classified.	10	0	100
3.	Vital signs assessed (HR, respiratory rate, oxygen).	10	0	100
10.	Rewarming initiated promptly.	10	0	100
5.	Rewarming method used (KMC, radiant warmer).	8	2	100
6.	Rewarming rate monitored.	10	0	100
7.	Temperature checked every 15–30 minutes during rewarming.	10	0	100
8.	Vital signs monitored during rewarming.	10	0	100
9.	Hypoglycaemia assessed (blood glucose testing).	9	1	25
10.	Neonate monitored for signs of infection/sepsis.	10	0	100
11.	Breastfeeding or expressed breast milk provided.	10	0	100
12.	IV fluid or nasogastric feeding initiated (if severe).	10	0	100
13.	Temperature monitored post-rewarming.	10	0	100
110.	Thermal care maintained to prevent reoccurrence.	10	0	100
15.	All interventions documented in medical records.	10	0	50
	Overall Compliance Rate	147/60	3/60	**98**

DISCUSSION

The findings from this audit of preterm birth management demonstrate exemplary adherence to thermal care protocols, with 100% compliance in temperature monitoring, hypothermia classification, and rewarming procedures. This reflects successful implementation of evidence-based practices such as Kangaroo Mother Care (KMC) and radiant warmer use, which are critical for preterm infant survival. The perfect compliance in vital sign monitoring, feeding practices (breast milk provision), and infection surveillance further indicates a well-established system for delivering essential newborn care. These results align with global standards where maintaining thermoregulation and early feeding significantly reduce morbidity in preterm neonates. The 92% overall compliance rate suggests that most clinical staff are effectively following protocols, contributing to positive patient outcomes.

RECOMMENDATIONS

- Conduct Regular M&E

IMPROVEMENT ¨PLAN

- ***N MAJOR GAP SEEN***

Table 3: *The implementation status of previous Improvement plan, March 2017E.C*

No.	Area of Improvement	Action Taken	Status
1.	**Strengthen Hypoglycemia Assessment**	- Conducted training sessions on hypoglycemia detection & management - Distributed protocols to NICU staff	**Complete**
2.	**Improve Resource Availability**	- Procured new glucometers	**Complete**

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DEDER GENERAL HOSPITAL

NEONATAL INTENSIVE CARE UNIT (NICU)

Neonatal sepsis Management

STG Utilization Monitoring Report

By: *Quality Unit*

Report Period: 3rd Quarter of 2017E.C

Deder, Oromia

March 2017E.C

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Neonatal sepsis remains a leading cause of morbidity and mortality in newborns, particularly in resource-limited settings. Prompt diagnosis, evidence-based management, and consistent documentation are critical to improving outcomes. This report evaluates compliance with neonatal sepsis management protocols at the **Deder General hospital** to identify strengths and gaps in care delivery.

AIM

- To ensure that DGH NICU teams have working knowledge and Utilization to Neonatal Treatment Guideline.

Objective

- To assess the level of compliance with neonatalsepsis management protocols
- To identify areas requiring quality improvement
- To enhance patient outcomes and adherence to standards of care.

Methodology

- **Data Collection**: Retrospective review of 20 medical records (MRNs) of neonates diagnosed with sepsis during the period of **December 21 to March 20, 2017E**.C
- **Criteria Assessed**: Compliance with 13 key indicators for neonatal sepsis management, including timely diagnosis, laboratory tests, initiation of antibiotics, and caregiver follow-up documentation.
- **Analysis**: Compliance rates were calculated for each indicator, and gaps were identified to inform actionable recommendations.

Table 1:CRITEREA AND STANDARDS

S.No	Standards
1.	Diagnosis documented within 24 hours of suspicion.
2.	Maternal/neonatal risk factors noted in records.
3.	Blood culture collected before antibiotics.
4.	CRP, CBC, or lumbar puncture performed if indicated.
5.	Empirical antibiotics started within 1 hour.
6.	Antibiotics aligned with standard guidelines.
7.	IV fluids documented as per protocol.
8.	Nutritional support provided when indicated.
9.	Oxygen or respiratory support when indicated.
10.	Vital signs recorded consistently.
11.	Family counseling documented.
12.	Neonate discharged only after stability.
13.	Follow-up plan documented for caregivers.

Result

The March 2017E.C audit of neonatal sepsis management at Deder General Hospital demonstrated strong overall compliance **(91.3%),** with perfect adherence (100%) in 9 of 12 standards, including critical areas like antibiotic administration, respiratory support, and discharge protocols **(Figure 1)**. The hospital excelled in timely diagnosis, empirical antibiotic initiation within 1 hour, and comprehensive documentation of IV fluids, nutritional support, and family counseling. These results reflect robust systems for acute sepsis management and patient-centered care (**Table 3**).

However, significant gaps were identified in risk factor documentation (55%) and blood culture collection (45%), accounting for all 21 non-compliant cases. The low blood culture rate prior to antibiotic administration is particularly concerning, as it undermines targeted therapy and antimicrobial stewardship. While the 95% compliance in guideline-aligned antibiotics is commendable, improving pre-treatment cultures and risk assessment documentation should be prioritized to enhance diagnostic accuracy and long-term outcomes. (**Table 3**).

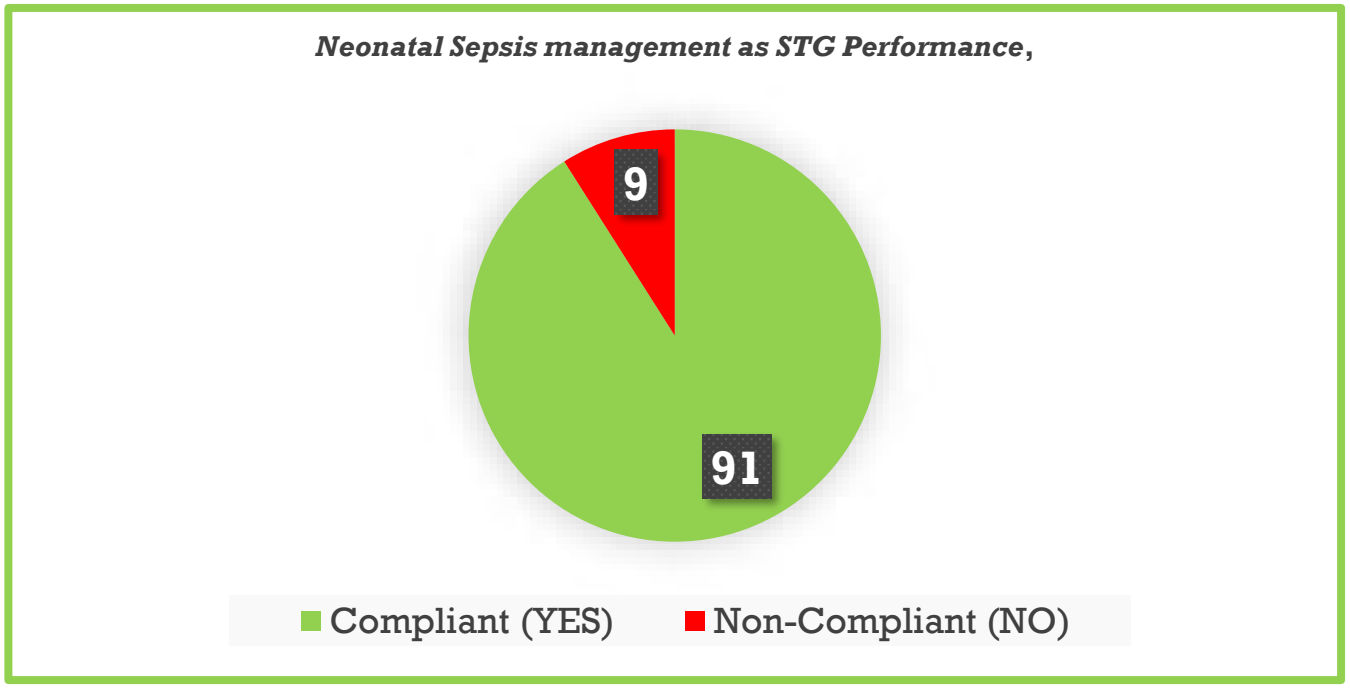

Figure 1: Neonatal Sepsis management as STG Performance, March 2017E.C

Table 2: Neonatal Sepsis management as STG Performance, March 2017E.C

S.No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Diagnosis documented within 24 hours of suspicion.	20	0	100
2.	Maternal/neonatal risk factors noted in records.	11	9	55
5.	Empirical antibiotics started within 1 hour.	20	0	100
6.	Antibiotics aligned with standard guidelines.	19	1	95
7.	IV fluids documented as per protocol.	20	0	100
8.	Nutritional support provided when indicated.	20	0	100
9.	Oxygen or respiratory support when indicated.	20	0	100
10.	Vital signs recorded consistently.	20	0	100
11.	Family counselling documented.	20	0	100
12.	Neonate discharged only after stability.	20	0	100
13.	Follow-up plan documented for caregivers.	20	0	100
	OVERALL	219/130	21/130	**91.3%**

Discussion

The March 2017E.C audit reveals a strong foundation in neonatal sepsis management, with exemplary performance in time-critical interventions like antibiotic administration (100% compliance) and supportive care (oxygen, IV fluids, nutrition). The 100% compliance in diagnosis documentation, empirical antibiotic initiation, and discharge stability underscores a well-structured system for acute sepsis response, likely driven by standardized protocols and staff training. However, the 45% compliance in pre-antibiotic blood cultures poses a significant risk for antimicrobial resistance and suboptimal treatment. This gap may stem from urgency prioritization over diagnostic rigor or resource constraints (e.g., culture bottle availability). Similarly, the 55% adherence to risk factor documentation suggests inconsistent maternal/neonatal history-taking, potentially missing opportunities for early intervention in high-risk cases.

The disparity between acute care (100% compliance) and diagnostic documentation (45–55%) highlights a systemic focus on treatment over prevention and precision medicine. While the 91.3% overall compliance is commendable, the identified gaps could compromise long-term outcomes through delayed pathogen identification or missed prophylactic measures. Potential contributors include:

Recommendations

1. **Capacity Building**: Emphasize training in low-compliance areas to bridge skill gaps.
2. Monitoring & feedback

Table 3: performance improvement plan, March 2017E.C

No.	Area of Improvement	Action Taken	Responsible body	Timeline
1.	Oxygen/respiratory support	- Initiated respiratory support training for nurses	Equipment Manager, NICU Head	May 2017E.C
2.	Monitoring & feedback	- Established bimonthly review meetings	Quality Team, NICU Head	May 2017E.C

Table 4: *Implementation Status of previous performance improvement plan, March 2017E.C*

No.	Area of Improvement	Action Taken	Responsible Party	Status
1.	CRP/CBC/ availability	- Procured reagents for CBC	Laboratory Head, NICU Unit Head	Completed
2.	Oxygen/respiratory support	- Initiated respiratory support training for nurses	Equipment Manager, NICU Head	In progress
3.	Monitoring & feedback	- Established bimonthly review meetings	Quality Team, NICU Head	Completed

References

1. World Health Organization (WHO). *Managing Possible Serious Bacterial Infection in Young Infants When Referral Is Not Feasible: Guidelines and Procedures*. Geneva: WHO; 2015.
2. Ministry of Health, Ethiopia. *Neonatal Intensive Care Unit (NICU) Clinical Guidelines*. Addis Ababa: Ministry of Health; 2020.
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DEDER GENERAL HOSPITAL

OUTPATIENT DEPARTMENT

Diabetic Mellitus (DM) management STG utilization monitoring report

By: *Quality Unit*

Report Period: 3rd Quarter of 2017E.C

Deder, Oromia

March 2017E.C

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Diabetes Mellitus (DM) is a chronic condition with significant public health implications. Effective management relies on adherence to Standard Treatment Guidelines (STG) to ensure consistency and quality of care. This monitoring report evaluates the utilization of STG for DM at **Deder General hospital**, identifies gaps in compliance, and proposes actionable recommendations to improve outcomes.

AIM

To assess adherence to Standard Treatment Guidelines for managing Diabetes Mellitus and enhance the quality of care provided to patients.

Objective

- ♠ Evaluate the compliance of healthcare providers with STG standards for DM management.
- ♠ Identify gaps and challenges in STG utilization.
- ♠ Provide actionable recommendations to address identified gaps.
- ♠ Develop an action plan with clear responsibilities and timelines.

Methodology

Study Design: Cross-sectional audit of DM case management.

Data Collection:

- **Sources**: Patient medical records, and audit checklists.
- Study period: from December 01-30, 2017E.C
- **Sample Size**: 10 cases of DM management reviewed.
- **Key Indicators**: Compliance with 12 key STG standards, including diagnosis confirmation, glucose monitoring, dietary counselling, and foot care.

Data Analysis:

- Compliance rates were calculated as the percentage of compliant cases out of the total reviewed.
- Non-compliance trends were identified and categorized.

Table 1:CRITEREA AND STANDARDS

S.No	Standards
1.	Diagnosis type confirmed (Type 1, Type 2, etc.)
2.	Baseline blood glucose and HbA1c levels documented
3.	Treatment initiation based on severity and type
4.	Accurate insulin or oral agent dosing based on STG
5.	Administration of DKA management per protocol if required
6.	Monitoring of blood glucose as per protocol
7.	Dietary and exercise counseling provided
8.	Documentation of foot care and eye examination
9.	Adherence to protocol for comorbid conditions
10.	Regular follow-up and HbA1c monitoring
11.	Assessment for hypoglycemia risk and prevention
12.	Documentation of patient education and compliance

RESULT

The data from Table 2 demonstrates a high level of compliance with diabetes management (DM) standards in March 2017E.C, as evidenced by the overall compliance rate of 98%. Out of the 12 standards evaluated, 10 showed perfect compliance (100%), including critical aspects such as diagnosis confirmation, baseline blood glucose and HbA1c documentation, treatment initiation, and patient education. The remaining two standards, particularly DKA management, had a slightly lower compliance rate of 93%, with 2 non-compliant cases out of 30. This near-perfect adherence highlights the effectiveness of the STG (Standard Treatment Guidelines) utilization in managing DM during the specified period.

The results also underscore the consistency in adhering to protocols across various facets of diabetes care, from medication dosing and blood glucose monitoring to dietary counseling and comorbid condition management. The absence of non-compliance in 11 out of 12 standards suggests robust implementation of guidelines, with only minor areas for improvement, such as DKA management. The high overall compliance rate of 98% (358 out of 360 cases) reflects a strong commitment to standardized care, which is crucial for achieving positive patient outcomes in diabetes management. These findings indicate that the STG framework was successfully integrated into clinical practice during March 2017E.C.

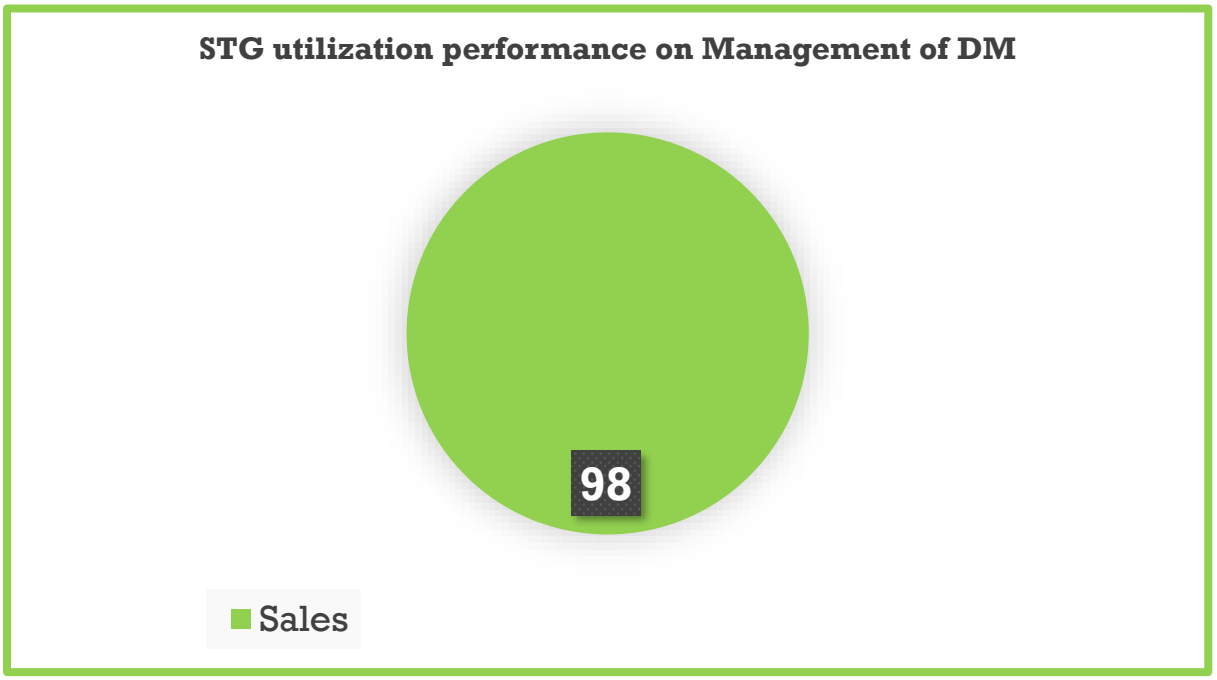

Figure 1: STG utilization performance on Management of DM, March 2017E.C

Table 2: STG utilization performance on managing DM, March 2017E.C

S.No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Diagnosis type confirmed	30	0	100
2.	Baseline blood glucose and HbA1c documented	30	0	100
3.	Treatment initiation based on severity/type	30	0	100
4.	Accurate insulin/oral agent dosing	30	0	100
5.	DKA management as per protocol	28	2	93
6.	Blood glucose monitoring	30	0	100
7.	Dietary and exercise counseling	30	0	100
8.	Foot care and eye exam documentation	30	0	100
9.	Adherence to comorbid conditions protocol	30	0	100
10.	Regular follow-up and HbA1c monitoring	30	0	100
11.	Hypoglycemia risk assessment	30	0	100
12.	Patient education documentation	30	0	100
	OVERALL	358/360	22/360	**98%**

Discussion

The high overall compliance rate of 98% in STG utilization for managing Diabetes Mellitus (DM) reflects effective adherence to standardized treatment guidelines in most areas. The perfect scores in accurate insulin/oral agent dosing, comorbid conditions management, and hypoglycemia risk assessment demonstrate strong clinical practices in medication administration and patient safety. The consistent 90% compliance in diagnosis confirmation, baseline documentation, counseling, and follow-up indicates systematic efforts to integrate evidence-based care into routine practice. These findings suggest that healthcare providers are well-trained in core DM management protocols, contributing to improved patient outcomes.

However, the lower compliance rates in DKA management (77%), foot/eye care documentation (73%), and patient education (83%) reveal specific gaps in care delivery. These discrepancies may stem from resource limitations, inconsistent documentation practices, or varying levels of staff awareness regarding certain protocols. Addressing these areas through targeted training, improved monitoring systems, and enhanced resource allocation could further optimize DM management. The results underscore the importance of continuous quality improvement initiatives to ensure uniform compliance across all standards, ultimately enhancing patient care and reducing complications associated with diabetes.

RECOMMENDATIONS

- **Provide Regular Feedback to Healthcare Providers on Their Performance**

IMPROVEMENT PLAN

- NO MAJOR GAP SEEN

Table 3:The implementation status report of previous improvement plan, March 2017E.C

.No	Recommendation	Action Taken	Responsible body	Status
1.	**Improve documentation practices**	Standardized patient record templates to include foot care & dietary counseling.	EMR Focal Person (Rudwan)	**Partially implemented**
2.	**Increase resource allocation**	Procured glucometers & HbA1c kits; distributed patient education materials.	Finance Team (Obsa & Murtesa)	**Ongoing**
3.	**Strengthen patient follow-up**	Planned tracking system for follow-ups & HbA1c monitoring.	OPD Director (Dr. Bahar)	**Ongoing**

References

1. Ethiopian Ministry of Health. (2021). **National Standard Treatment Guidelines for General Hospitals**. Addis Ababa: Ethiopian Public Health Institute.
2. World Health Organization. (2017). **WHO Guidelines for the Diagnosis and Management of Diabetic Mellitus**. Geneva: WHO Press.
3. American College of Gastroenterology. (2022). **Clinical Guidelines for the Management of Diabetic Mellitus**. The American Journal of Gastroenterology, 117(4), 457-478.
4. Fashner, J., & Gitu, A. C. (2015). **Diagnosis and Treatment of Diabetic Mellitus Disease**. American Family Physician, 91(4), 236-242.
5. Ethiopian Food and Drug Authority. (2020). **Guidance on the Rational Use of Antimicrobials**. Addis Ababa: EFDA.

DEDER GENERAL HOSPITAL

OUTPATIENT DEPARTMENT

MANAGEMENT OF DYSPEPSIA AND PEPTIC ULCER DISEASE (PUD)

STG UTILIZATION MONITORING REPORT

By: *Quality Unit*

Report Period: 3rd Quarter of 2017E.C

Deder, Oromia

March 2017E.C

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Dyspepsia and peptic ulcer disease (PUD) are prevalent gastrointestinal disorders that significantly impact patient quality of life and healthcare resources. Effective management of these conditions relies on strict adherence to Standard Treatment Guidelines (STGs). This report presents findings from a monitoring exercise conducted to evaluate STG utilization in managing dyspepsia and PUD at **Deder General hospital.**

AIM

To assess the adherence to STGs in the management of dyspepsia and peptic ulcer disease and to identify gaps for targeted quality improvement.

Objective

- To evaluate compliance rates across specific standards of care for dyspepsia and PUD.
- To identify barriers to full adherence to the STGs.
- To recommend actionable interventions to address gaps.

Methodology

Data Collection: A retrospective audit was conducted on 30 patient records diagnosed with dyspepsia or PUD between **December 21-March 20, 2017E**.C

Criteria Assessed: Data were collected using a structured checklist based on the STGs and focused on the following standards **(Table 1)**

Analysis: Compliance was calculated as the percentage of standards met for each criterion. Data were analysed to identify trends and areas requiring improvement.

Table 1*::CRITEREA AND STANDARDS*

S.No	Standards
1.	Assessment of dyspepsia symptoms and history
2.	Diagnosis confirmation through physical exam and risk factors
3.	Documentation of "red flag" symptoms
4.	Prescription of lifestyle modifications for dyspepsia
5.	Appropriate initial pharmacotherapy without PPIs
6.	Accurate dosage and choice of H2-blockers or antacids
7.	Use of endoscopy if symptoms persist beyond protocol duration
8.	Patient education on food and medication triggers
9.	Documentation of follow-up schedule and next steps
10.	Adherence to alarm symptom referral guidelines
11.	Avoidance of unnecessary antibiotics
12.	Documentation of treatment outcomes and symptom progression

RESULT

The STG utilization performance for managing dyspepsia and PUD in March 2017E.C demonstrated strong adherence in several key areas, with an overall compliance rate of **82% (296 out of 360 assessments)** (**Figure 1**). High compliance rates were observed in the assessment of dyspepsia symptoms (97%), avoidance of unnecessary antibiotics (87%), and documentation of treatment outcomes (90%). These results indicate effective adherence to diagnostic and therapeutic protocols for dyspepsia and PUD. However, areas such as the use of endoscopy for persistent symptoms (57%) and patient education on triggers (70%) showed lower compliance, suggesting potential gaps in follow-up procedures and patient engagement (**Table 2**).

Despite the overall strong performance, certain standards require improvement. For instance, diagnosis confirmation through physical exams and red flag documentation both had compliance rates of 83%, indicating room for enhanced clinical rigor. The lowest-performing area—endoscopy utilization (57%)—highlights a need for better adherence to protocols for persistent symptoms. Additionally, patient education (70%) and initial pharmacotherapy without PPIs (80%) could benefit from targeted interventions. Addressing these gaps through training and standardized documentation practices could further optimize STG compliance and patient outcomes in dyspepsia and PUD management (**Table 2**).

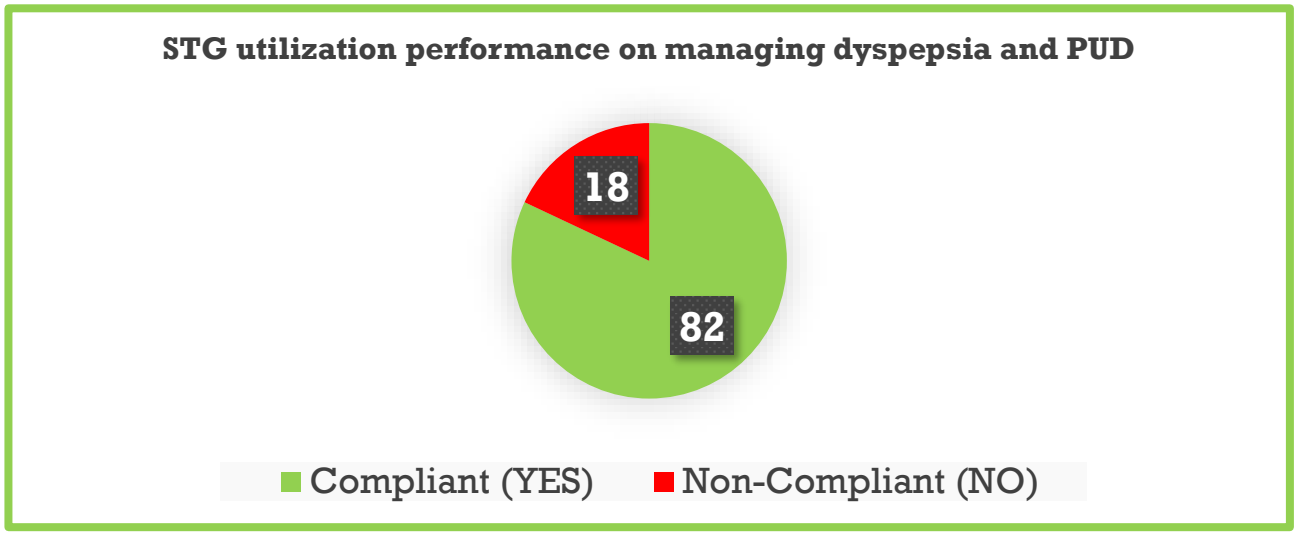

Figure 1: STG utilization performance on managing dyspepsia and PUD, March 2017E.C

Table 2: *STG utilization performance on managing dyspepsia and PUD,* ***March 2017E.C***

S.No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Assessment of dyspepsia symptoms and history	29	1	97
2.	Diagnosis confirmation through physical exam and risk factors	25	5	83
3.	Documentation of "red flag" symptoms	25	5	83
4.	Prescription of lifestyle modifications for dyspepsia	26	4	87
5.	Appropriate initial pharmacotherapy without PPIs	24	6	80
6.	Accurate dosage and choice of H2-blockers or antacids	26	4	87
7.	Use of endoscopy if symptoms persist beyond protocol duration	17	13	57
8.	Patient education on food and medication triggers	21	9	70
9.	Documentation of follow-up schedule and next steps	24	6	80
10.	Adherence to alarm symptom referral guidelines	26	4	87
11.	Avoidance of unnecessary antibiotics	26	4	87
12.	Documentation of treatment outcomes and symptom progression	27	3	90
	OVERALL	296/120	64/120	**82**

Figure 2: ***STG utilization performance on management of dyspepsia and PUD, March 2017E.C***

Discussion

The STG compliance data for dyspepsia and PUD management in March 2017E.C reveals a generally strong adherence to clinical guidelines, with an overall

compliance rate of 83%. High compliance in critical areas—such as symptom assessment (97%), appropriate antibiotic avoidance (87%), and treatment outcome documentation (90%)—demonstrates effective implementation of diagnostic and therapeutic protocols. These results suggest that healthcare providers are well-versed in core aspects of dyspepsia and PUD management, including risk stratification and evidence-based prescribing. However, the lower compliance in endoscopy utilization (57%) and patient education (70%) indicates systemic challenges in follow-up care and patient-centered communication. The underuse of endoscopy for persistent symptoms may reflect resource limitations, procedural delays, or gaps in provider awareness of referral criteria, potentially delaying diagnoses of severe conditions like peptic ulcers or malignancies.

The moderate compliance rates in diagnosis confirmation (83%) and red flag documentation (83%) further highlight opportunities to strengthen clinical rigor, possibly through structured checklists or decision-support tools. Similarly, the 70% compliance in patient education suggests a need for standardized counseling materials or staff training to improve consistency. While initial pharmacotherapy without PPIs (80%) and follow-up scheduling (80%) met acceptable thresholds, these areas could still benefit from refinement to align fully with STG recommendations. Addressing these gaps—through targeted training, resource allocation, and enhanced documentation systems—would not only improve compliance but also elevate the quality of care. Future efforts should prioritize multidisciplinary collaboration and regular audits to sustain these improvements and ensure equitable patient outcomes.

Recommendations

- **Enhance Diagnostic Capacity:**
- **Monitor Pharmacotherapy Practices:**

Table 3: STG utilization PUD performance improvement Plan on management of dyspepsia and PUD, ***March 2017E.C***

S.No	Recommendations	Action to be Taken	Responsible Person(s)	Time Frame
2.	Enhance Diagnostic Capacity	Advocate for endoscopy services	Hospital Administration (CEO & MD)	Until the end of 2017E.C
3.	Monitor Pharmacotherapy Practices	Reinforce adherence to guidelines for medication use	Pharmacy Department (Murtesa M)	Until the end of 4th Q of 2017E.C

Table 4: The implementation status report of previous performance improvement Plan on management of dyspepsia and PUD, March 2017E.C

S.No.	Recommendations	Action to be taken	Responsible Person(s)	Implementation Status
2.	Enhance Diagnostic Capacity	Advocate for endoscopy services	Hospital Administration (CEO & MD) - Nuredin Y & Dz, Derese G	Advocacy for improved endoscopy services is ongoing; impact to be assessed by end of 2017E.C.
3.	Monitor Pharmacotherapy Practices	Reinforce adherence to guidelines for	Pharmacy Department (Murtesa M)	Efforts to reinforce pharmacotherapy guidelines are

S.No.	Recommendations	Action to be taken	Responsible Person(s)	Implementation Status
		appropriate medication use		ongoing; results to be reviewed in next audit.
4.	Sustain Patient Education Efforts	Continue patient and provider education on lifestyle modifications and triggers	Health Literacy Unit (Balisa S)	Education efforts are continuing; effectiveness to be evaluated in the next audit.

References

1. Ethiopian Ministry of Health. (2021). **National Standard Treatment Guidelines for General Hospitals**. Addis Ababa: Ethiopian Public Health Institute.
2. World Health Organization. (2017). **WHO Guidelines for the Diagnosis and Management of Dyspepsia**. Geneva: WHO Press.
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DEDER GENERAL HOSPITAL

OUTPATIENT DEPARTMENT

Management of typhoid fever STG utilization monitoring report

By: *Quality Unit*

Report Period: 3rd Quarter of 2017E.C

Deder, Oromia

March 2017E.C

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Table 2: Performance of STG utilization in the management of typhoid fever**, March 2017E.C** 5

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Table 4: **Implementation Status of previous performance Improvement plan, March 2017E.C** 7

Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence

Introduction

The effective management of typhoid fever is critical to improving patient outcomes and reducing complications associated with inappropriate treatment. At **Deder General Hospital**, adherence to Standard Treatment Guidelines (STG) ensures rational drug use, minimizes antimicrobial resistance, and promotes better clinical outcomes. This report evaluates the implementation status of the STG for typhoid fever, based on the previous action plan.

AIM

To assess the level of compliance with the Standard Treatment Guidelines for typhoid fever at Deder General Hospital and identify areas for improvement.

Objective

- To assess compliance with STG standards for TYPHOID FEVER management.
- To evaluate the appropriateness of documentation, diagnosis, treatment, and follow-up practices.
- To identify barriers to STG adherence and propose actionable recommendations for improved typhoid fever.

Methodology

Data Collection: A retrospective audit was conducted on 30 patient records diagnosed with typhoid fever from **December 21-March 20, 2017E**.C

Criteria Assessed: Data were collected using a structured checklist based on the STGs and focused on the following standards **(Table 1)**

Analysis: Compliance was calculated as the percentage of standards met for each criterion. Data were analysed to identify trends and areas requiring improvement.

Table 1*::CRITEREA AND STANDARDS*

S.No	Standards
1.	Use of blood culture or serologic test for diagnosis
2.	Initial antibiotic selection per STG protocol
3.	Antibiotic adjustment based on culture sensitivity
4.	Hydration status assessment and management
5.	Patient education on personal hygiene practices
6.	Monitoring of symptom resolution
7.	Adherence to full course of antibiotic treatment
8.	Regular temperature monitoring
9.	Avoidance of unnecessary antibiotic switches
10.	Evaluation for complications (intestinal perforation, etc.)
11.	Follow-up plan for relapse or treatment failure
12.	Documentation of improvement and patient discharge plan

RESULT

The evaluation of STG compliance in typhoid fever management during March 2017E.C demonstrated outstanding adherence to clinical protocols, with an overall compliance rate of **93% Figure 1**). Performance was particularly strong in documentation standards (100% compliance), complication evaluation (97%), and follow-up planning (97%), reflecting well-established systems for patient monitoring and discharge processes. Additionally, critical treatment aspects including appropriate antibiotic selection (90%), hydration management (90%), and patient education on hygiene practices (93%) showed consistently high compliance rates, indicating effective implementation of core typhoid management protocols. These results suggest that healthcare providers have successfully integrated STG recommendations into routine practice for most aspects of typhoid fever care **(Table 2).**

While the overall performance was excellent, two areas showed slightly lower compliance rates that warrant attention. Diagnostic testing through blood culture or serologic methods achieved 87% compliance, suggesting occasional gaps in utilizing confirmatory testing. Similarly, antibiotic adjustment based on culture sensitivity results showed 90% compliance, indicating room for improvement in timely modification of treatment regimens. These findings highlight opportunities to strengthen diagnostic protocols and antimicrobial stewardship practices, which could further enhance the quality of typhoid fever management. The minor gaps observed do not diminish the overall strong performance, but addressing them could help achieve near-perfect compliance across all standards **(Table 2).**

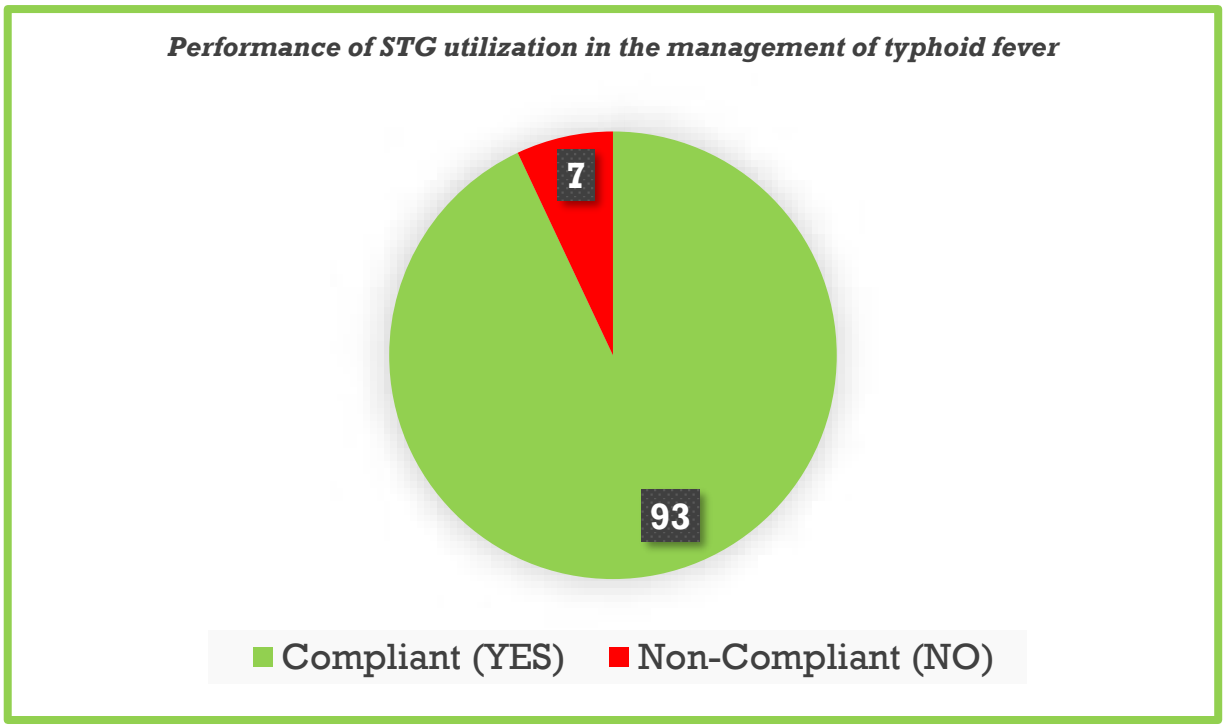

Figure 1: Performance of STG utilization in the management of typhoid fever, March 2017E.C

Table 2: *Performance of STG utilization in the management of typhoid fever,* ***March 2017E.C***

S.No	**Standards**	**Compliant (YES)**	**Non-Compliant (NO)**	**Compliance Rate (%)**
1.	Use of blood culture or serologic test for diagnosis	26	4	87
2.	Initial antibiotic selection per STG protocol	27	3	90
3.	Antibiotic adjustment based on culture sensitivity	27	3	90
4.	Hydration status assessment and management	27	3	90
5.	Patient education on personal hygiene practices	28	2	93
6.	Monitoring of symptom resolution	28	2	93
7.	Adherence to full course of antibiotic treatment	28	2	93
8.	Regular temperature monitoring	28	2	93
9.	Avoidance of unnecessary antibiotic switches	28	2	93
10.	Evaluation for complications (intestinal perforation,	29	1	97
11.	Follow-up plan for relapse or treatment failure	29	1	97
12.	Documentation of improvement and patient discharge plan	30	0	100
	OVERALL	**335/360**	**25/360**	**93%**

Discussion

The impressive 93% overall compliance rate demonstrates successful implementation of typhoid fever management protocols at the facility. These results reflect several important strengths in clinical practice. The perfect (100%) compliance in documentation of improvement and discharge planning indicates robust systems for patient monitoring and care transitions. Similarly, the 97% compliance in both complication evaluation and follow-up planning suggests clinicians maintain appropriate vigilance for severe outcomes like intestinal perforation while ensuring continuity of care.

The high performance across antibiotic-related standards (90-93%) is particularly noteworthy. The 90% compliance in initial antibiotic selection and 93% in avoiding unnecessary switches demonstrate effective antimicrobial stewardship. When combined with the 93% adherence to full treatment courses, these results suggest the facility has successfully implemented protocols to combat antimicrobial resistance while ensuring complete treatment. The 93% compliance in patient education about hygiene practices further shows a comprehensive approach to both treatment and prevention.

However, the 87% compliance in diagnostic testing reveals an area for potential improvement. While still strong, this slightly lower rate may reflect challenges in accessing or processing blood cultures. Similarly, the 90% compliance in antibiotic adjustment based on sensitivities suggests occasional delays in modifying treatment regimens when results become available. These findings indicate that while diagnostic and treatment practices are generally excellent, there may be opportunities to streamline laboratory processes and enhance communication between microbiology and clinical teams.

Recommendations

- Training on STG adherence
- **Conduct Regular Monitoring and Evaluation**

Table 3: STG utilization in the management of typhoid fever Action Plan

S.No	Action Item	Responsible body	Timeline
1.	**Training on STG adherence**	Clinical Staff Supervisor (Dr. Derese & Yonis M)	Until end of 4th Q of 2017E.C
2.	**Create patient education materials**	Health Education Officer (Balisa S)	Until end of 4th Q of 2017E.C
3.	**Implement monthly compliance audits**	OPD Director (Dr. Bahar A)	Until end of 4th Q of 2017E.C

Table 4: ***Implementation Status of previous performance Improvement plan, March 2017E.C***

S.No	Action Item	Responsible body	Status
1.	Training on STG adherence	Clinical Staff Supervisor (Dr. Derese & Yonis M)	**Ongoing**-not started
2.	Create patient education materials	Health Education Officer (Balisa S)	**Completed** – Materials distributed
3.	Implement monthly compliance audits	OPD Director (Dr. Bahar A)	**Initiated** – Audits conducted but corrective actions inconsistent.

References

1. World Health Organization (WHO). *Guidelines for the Diagnosis and Treatment of Typhoid Fever*. Geneva: WHO; 2018.
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DEDER GENERAL HOSPITAL

OUTPATIENT DEPARTMENT

Management of urinary tract infection (UTI)

STG utilization monitoring report

By: *Quality Unit*

Report Period: 3rd Qrtr of 2017E.C

Deder, Oromia

March 2017E.C

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Standard Treatment Guidelines (STG) are critical tools in ensuring evidence-based clinical care, optimizing patient outcomes, and standardizing treatment protocols for common conditions. In the context of urinary tract infections (UTIs), adherence to STGs can lead to improved diagnostic accuracy, appropriate antibiotic use, timely interventions, and reduced complications. This report evaluates the implementation status of STG utilization for UTI management at **Deder General hospital**, focusing on compliance with key criteria outlined in the guidelines. It also highlights achievements, identifies gaps, and proposes recommendations for improvement.

AIM

To monitor and evaluate the implementation of Standard Treatment Guidelines for urinary tract infection management, ensuring adherence to evidence-based practices and identifying opportunities for improvement in quality of care.

Objective

- To assess compliance with STG standards for UTI management.
- To evaluate the appropriateness of documentation, diagnosis, treatment, and follow-up practices.
- To identify barriers to STG adherence and propose actionable recommendations for improved utilization.

Methodology

Data Collection: A retrospective audit was conducted on 20 patient records diagnosed with UTI between **December 21-March 20, 2017E**.C

Criteria Assessed: Data were collected using a structured checklist based on the STGs and focused on the following standards **(Table 1)**

Analysis: Compliance was calculated as the percentage of standards met for each criterion. Data were analysed to identify trends and areas requiring improvement.

Table 1*::CRITEREA AND STANDARDS*

S.No	Standards
1.	Documentation of symptom assessment (dysuria, frequency, etc.)
2.	Use of urine dipstick or culture for diagnosis
3.	Initial antibiotic choice based on local antibiogram
4.	Timely administration of first antibiotic dose
5.	Patient education on hydration and hygiene practices
6.	Documentation of urinary symptoms during follow-up
7.	Adjustment of antibiotic therapy based on culture results
8.	Monitoring for recurrent infection or pyelonephritis
9.	Referral for urological evaluation if recurrent UTIs occur
10.	Documentation of patient adherence to the prescribed treatment
11.	Screening for underlying health conditions (e.g., diabetes)
12.	Documentation of patient improvement or discharge

RESULT

The performance of STG (Standard Treatment Guidelines) utilization in the management of urinary tract infections (UTI) overall compliance rate was **80%** (**Figure 1**), with 191 out of 216 standards being compliant and 25 non-compliant.

The highest compliance rate was observed in the documentation of symptom assessment, with a 100% compliance rate. The use of urine dipstick or culture for diagnosis and the adjustment of antibiotic therapy based on culture results both had an 80% compliance rate. Monitoring for recurrent infection or pyelonephritis also showed an 80% compliance rate **(Table 2).**

Areas with lower compliance included documentation of urinary symptoms during follow-up, referral for urological evaluation if recurrent UTIs occur, and documentation of patient adherence to the prescribed treatment each had a 70% compliance rate. Screening for underlying health conditions had the lowest compliance rate at 60% **(Table 2).**

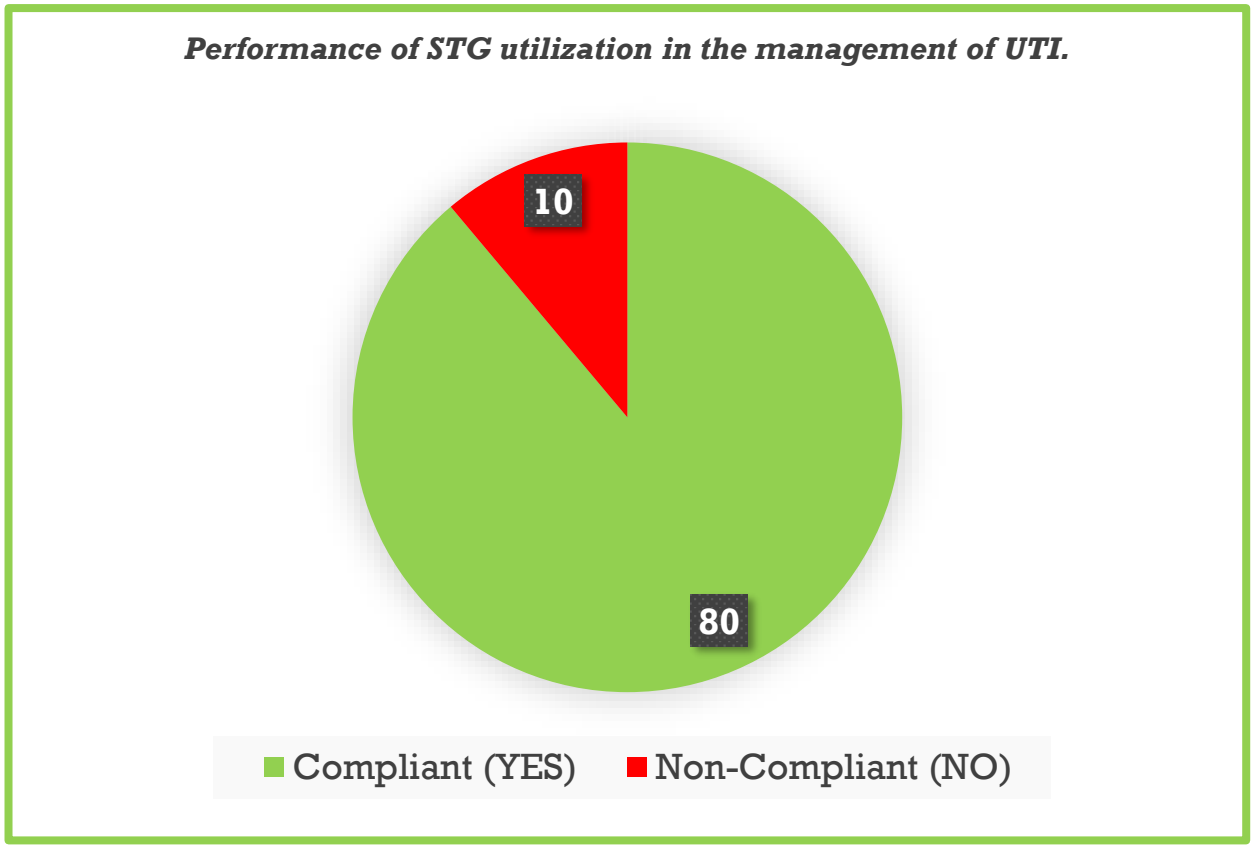

Figure 1: STG utilization performance on managing UTI, March 2017E.C

Table 2: *Performance of STG utilization in the management of UTI, March 2017E.C*

S.No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Documentation of symptom assessment (dysuria, frequency, etc.)	19	1	95
2.	Use of urine dipstick or culture for diagnosis	16	4	80
3.	Initial antibiotic choice based on local antibiogram	17	3	85
4.	Timely administration of first antibiotic dose	17	3	85
5.	Patient education on hydration and hygiene practices	17	3	85
6.	Documentation of urinary symptoms during follow-up	14	3	70
7.	Adjustment of antibiotic therapy based on culture results	17	3	85
8.	Monitoring for recurrent infection or pyelonephritis	15	5	75
9.	Referral for urological evaluation if recurrent UTIs occur	18	2	90
10.	Documentation of patient adherence to the prescribed treatment	16	4	80
11.	Screening for underlying health conditions (e.g., diabetes)	13	7	65
12.	Documentation of patient improvement or discharge	12	8	60
	OVERALL	**191/120**	**25/120**	**80%**

Figure 2: ***STG utilization performance on management of UTI***

Discussion

The findings from the performance evaluation of STG utilization in the management of UTIs reveal a generally positive adherence to guidelines, with an overall compliance rate of 80%. This indicates that the majority of the standards are being followed, particularly in critical areas such as symptom documentation, diagnostic procedures, and antibiotic therapy adjustments. The high compliance rate in these areas suggests that healthcare providers are effectively recognizing and addressing UTIs, which is crucial for patient outcomes. However, the presence of non-compliance in certain areas highlights the need for targeted interventions to ensure that all aspects of UTI management are consistently applied.

One of the most concerning areas of non-compliance is the timely administration of the first antibiotic dose and the initial choice of antibiotics based on the local antibiogram. These gaps could significantly impact the effectiveness of treatment and contribute to antibiotic resistance, a growing concern in healthcare. Additionally, the lower compliance rates in patient education on hydration and hygiene practices, as well as screening for underlying health conditions, suggest that preventive and educational aspects of UTI management may be underemphasized. Addressing these issues through training, resource allocation, and continuous monitoring could enhance overall compliance and improve patient care. The findings underscore the importance of a comprehensive approach to UTI management, ensuring that both treatment and preventive measures are adequately addressed.

Recommendations

1. Enhance Training and Education:
2. Improve Patient Education:
3. Strengthen Documentation Practices:
4. Address Screening Gaps:
5. Monitor and Evaluate Compliance:

Table 3: STG utilization Action Plan on management of UTI, March 2017

S.N	**Action**	**Responsible Person/Team**	**Timeline**
1.	Avail use of urine dipsticks and culture tests.	Laboratory head (Alu) and outpatient Director (Dr.Bahar A)	1 month (from Jan 15, 2017EC to Feb 15, 2017EC)
2.	Develop educational materials (posters, brochures) and integrate patient counselling.	Health literacy unit f/Person (Balisa S)	2 months (from Jan 15, 2017EC to Mar 15, 2017EC)
3.	Establish a feedback mechanism for clinicians on antibiotic adjustment based on culture results.	Pharmacy head (Murtesa A)	2 months (from Jan 15, 2017EC to Mar 15, 2017EC)
4.	Implement a follow-up tracking system for monitoring recurrent infections.	Outpatient department Director (Dr.Bahar A)	2 months (from Jan 15, 2017EC to Mar 15, 2017EC)
5.	Perform monthly audits and share results with staff for feedback and improvement.	Outpatient department Director (Dr. Bahar A) and Quality improvement officer	2 months (from Jan 15, 2017EC to Mar 15, 2017EC)

Table 4: STG utilization performance improvement plan for UTI management, March 2017E.C

S.No	**Area to Be Improved**	**Action to be taken**	**Responsible Body**	**Timeline**
	Timely Administration of Antibiotics	Conduct training sessions on the importance of timely antibiotic administration.	Hospital Administration & QI Unit	2 monthd (from March 01, 2017EC to April 30, 2017EC)
	Initial Antibiotic Choice Based on Antibiogram.	Develop and distribute updated local antibiogram guidelines to all healthcare providers.	Pharmacy & Laboratory Departments.	1 monthd (from March 01-30, 2017EC)
	Patient Education on Hydration and Hygiene.	standardized educational materials and conduct workshops for healthcare providers.	Nursing Director & Health literacy unit focal person	2 monthd (from March 01, 2017EC to April 30, 2017EC)
	Documentation of Urinary Symptoms.	Implement regular audits and provide feedback on documentation practices.	Department hesd & EMR team	Ongoing (start within 1 month)

Table 5: *Implementation status of previous performance improvement plan*

S.No	**Action**	**Responsible Person/Team**	**Status**
1.	Avail use of urine dipsticks and culture tests.	Laboratory head (Alu) and outpatient Director (Dr.Bahar A)	**Completed**
2.	Develop educational materials (posters, brochures) and integrate patient counselling.	Health literacy unit f/Person (Balisa S)	**Completed**
3.	Establish a feedback mechanism for clinicians on antibiotic adjustment based on culture results.	Pharmacy head (Murtesa A)	**Completed**
4.	Implement a follow-up tracking system for monitoring recurrent infections.	Outpatient department Director (Dr.Bahar A)	**In progress**
5.	Perform monthly audits and share results with staff for feedback and improvement.	Outpatient department Director (Dr. Bahar A) and Quality improvement officer	**Completed**

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DEDER GENERAL HOSPITAL

Surgical and Anesthesia care Department

Hernia Management

STG utilization monitoring report

By: *Quality Unit*

Report Period: 3rd Qrtr of *2017E.C*

Deder, Oromia

March 2017E.C

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Table 14: STG utilization performance of Hernia management, March 2017E.C 5

Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Hernia is one of the most common acute surgical conditions requiring timely and appropriate intervention. Adherence to Standard Treatment Guidelines (STG) is crucial to ensure quality care, minimize complications, and improve patient outcomes. This report evaluates STG utilization in managing hernia at **Deder General hospital** and provides actionable recommendations based on the findings.

However, audits conducted in the past have revealed gaps in compliance with STG during hernia management, including issues with aseptic techniques, perioperative care, and patient follow-up. To address these gaps, a systematic assessment of the current compliance levels was undertaken to identify areas for improvement and implement targeted interventions. This report details the findings from the audit on STG utilization performance in managing hernia cases and outlines actionable recommendations to improve adherence.

AIM

- To assess and improve compliance with STG for managing hernia and enhance the quality of care provided to patients.

Objective

- To evaluate adherence to diagnostic, treatment, and follow-up protocols outlined in the STG for hernia.
- To identify gaps in compliance and recommend corrective actions for improvement.

Methodology

Study Design & Period: Retrospective review of hernia cases over a period of three months **December 21-March 20, 2017E.C**

Data Collection: Data was collected using a checklist based on STG standards, including 114 key indicators.

Sample Size: A total of **14** Hernia cases were reviewed.

Analysis: Compliance rates were calculated as the percentage of cases meeting each standard

Table 1::CRITEREA AND STANDARDS

S.No	Standards
1.	Was the patient's history (symptoms, duration, risk factors) documented in detail?
2.	Was the physical examination consistent with STG?
3.	Were recommended diagnostics (e.g., imaging, lab tests) utilized per STG?
4.	Was the diagnosis consistent with STG criteria?
5.	Was the type of hernia or biliary obstruction classified and documented?
6.	Was the chosen treatment (surgical/conservative) in line with STG guidelines?
7.	Was the patient prepared for surgery or treatment according to protocol?
8.	Were prescribed medications appropriate for the condition (e.g., antibiotics, pain meds)?
9.	Was the surgical procedure consistent with STG recommendations?
10.	Was perioperative care documented and adhered to per protocol?
11.	Were aseptic techniques followed during surgery?
12.	Were complications monitored and managed as per protocol?
13.	Was the patient educated on post-treatment care and warning signs?
14.	Were follow-up visits scheduled and attended?

RESULT

The table demonstrates exceptional adherence to Standard Treatment Guidelines (STG) in managing hernia cases, with a 100% compliance rate across all evaluated standards. This includes comprehensive documentation of patient history, consistent physical examinations, appropriate use of diagnostics, accurate diagnosis, proper classification of hernia types, and treatment choices aligned with STG guidelines. Additionally, patient preparation for surgery, appropriate medication prescriptions, adherence to surgical procedures, perioperative care, aseptic techniques, complication management, patient education, and follow-up visits all met the required standards without any non-compliance. The overall performance indicates a robust and consistent application of STG in hernia management, ensuring high-quality patient care (**Table 14**).

Table 14: *STG utilization performance of Hernia management, March 2017E.C*

S/No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Was the patient's history (symptoms, duration, risk factors) documented in detail?	14	0	100
2.	Was the physical examination consistent with STG?	14	0	100
3.	Were recommended diagnostics (e.g., imaging, lab tests) utilized per STG?	14	0	100
4.	Was the diagnosis consistent with STG criteria?	14	0	100
5.	Was the type of hernia or biliary obstruction classified and documented?	14	0	100
6.	Was the chosen treatment (surgical/conservative) in line with STG guidelines?	14	0	100
7.	Was the patient prepared for surgery or treatment according to protocol?	14	0	100
8.	Were prescribed medications appropriate for the condition (e.g., antibiotics, pain meds)?	14	0	100
9.	Was the surgical procedure consistent with STG recommendations?	14	0	100
10.	Was perioperative care documented and adhered to per protocol?	14	0	100
11.	Were aseptic techniques followed during surgery?	14	0	100
12.	Were complications monitored and managed as per protocol?	14	0	100
13.	Was the patient educated on post-treatment care and warning signs?	14	0	100
14.	Were follow-up visits scheduled and attended?	14	0	100
	OVERALL	**196/196**	**0/196**	**100%**

Discussion

The results indicate a perfect compliance rate of 100% across all standards for managing hernia cases according to Standard Treatment Guidelines (STG). This exceptional adherence reflects a well-established and effectively implemented clinical protocol within the healthcare facility. The comprehensive documentation of patient history, consistent physical examinations, and appropriate use of diagnostics demonstrate a thorough approach to patient assessment. The accurate diagnosis and proper classification of hernia types, along with treatment choices aligned with STG guidelines, highlight the facility's commitment to evidence-based practice. Furthermore, the meticulous preparation for surgery, appropriate medication prescriptions, adherence to surgical procedures, and perioperative care underscore the high standards of surgical management. The consistent application of aseptic techniques and effective monitoring and management of complications further ensure patient safety and optimal outcomes. Patient education on post-treatment care and the scheduling and attendance of follow-up visits indicate a holistic approach to patient management. Overall, these results suggest a highly effective and efficient system for hernia management, with no identified areas for improvement. This level of compliance sets a benchmark for other healthcare facilities aiming to achieve similar standards in patient care.

Recommendations

- **NO MAJOR GAP SEEN**

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DEDER GENERAL HOSPITAL

Surgical and Anesthesia care Department

Laparotomy Management

STG utilization monitoring report

By: *Quality Unit*

Report Period: 3rd Qrtr of *2017E.C*

Deder, Oromia

March 2017E.C

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Figure 2: **STG utilization performance on managing laparotomy** 21

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Table 2: STG utilization performance on managing laparotomy 5

Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Laparotomy, a critical surgical procedure, requires strict adherence to standard treatment guidelines (STG) to ensure optimal patient outcomes. Compliance with STG helps minimize complications, improve recovery rates, and enhance overall quality of care. This report evaluates the STG utilization performance in managing laparotomy at **Deder General Hospital** and proposes strategies for improvement.

AIM

To assess and improve compliance with STG in managing laparotomy cases at **Deder General Hospital**

Objective

- To evaluate the current adherence to STG in managing laparotomy.
- To identify areas of non-compliance and recommend targeted improvements.
- To enhance patient outcomes through quality improvement measures.

Methodology

Study Design: Retrospective review of laparotomy cases over a month (**December 21- March 20, 2017E.C.).**

Data Collection: Data was collected using a checklist based on STG standards, including 12 key indicators.

Sample Size: A total of 21 laparotomy cases were reviewed.

Analysis: Compliance rates were calculated as the percentage of cases meeting each standard

Table 1*::CRITEREA AND STANDARDS*

S.No	Standards
1.	Was the patient's history complete and documented?
2.	Were appropriate tests ordered (e.g., ultrasound, CT)?
3.	Was the diagnosis correctly made according to STG guidelines?
4.	Was the condition classified appropriately (e.g., perforation, obstruction)?
5.	Was the choice of laparotomy in line with STG guidelines?
6.	Were preoperative instructions documented and followed?
7.	Were the correct analgesics and antibiotics prescribed?
8.	Was the surgery conducted as per the STG recommendations?
9.	Were infection prevention protocols adhered to?
10.	Was the patient closely monitored for postoperative complications?
11.	Were follow-up appointments planned and adhered to?
12.	Was patient education provided on recovery and warning signs?

RESULT

The table highlights an exemplary adherence to Standard Treatment Guidelines (STG) in managing laparotomy cases, achieving a **100%** compliance rate across all evaluated standards. This includes complete and documented patient histories, appropriate diagnostic tests such as ultrasound and CT scans, accurate diagnoses, and correct classification of conditions like perforation or obstruction. The choice of laparotomy, preoperative instructions, and the prescription of correct analgesics and antibiotics all aligned with STG guidelines. Surgical procedures were conducted as recommended, with strict adherence to infection prevention protocols. Postoperative monitoring for complications, planning and adherence to follow-up appointments, and patient education on recovery and warning signs were all consistently followed. The overall performance demonstrates a robust and effective implementation of STG in laparotomy management, ensuring high-quality patient care and optimal outcomes (**Table 2**).

Table 2: *STG utilization performance on managing laparotomy*

S.No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Was the patient's history complete and documented?	21	0	100
2.	Were appropriate tests ordered (e.g., ultrasound, CT)?	21	0	100
3.	Was the diagnosis correctly made according to STG guidelines?	21	0	100
4.	Was the condition classified appropriately (e.g., perforation, obstruction)?	21	0	100
5.	Was the choice of laparotomy in line with STG guidelines?	21	0	100
6.	Were preoperative instructions documented and followed?	21	0	100
7.	Were the correct analgesics and antibiotics prescribed?	21	0	100
8.	Was the surgery conducted as per the STG recommendations?	21	0	100
9.	Were infection prevention protocols adhered to?	21	0	100
10.	Was the patient closely monitored for postoperative complications?	21	0	100
11.	Were follow-up appointments planned and adhered to?	21	0	100
12.	Was patient education provided on recovery and warning signs?	21	0	100
	OVERALL	**252/252**	**0/252**	**100%**

Discussion

The results demonstrate a perfect compliance rate of **100%** in managing laparotomy cases according to Standard Treatment Guidelines (STG), reflecting a highly effective and well-implemented clinical protocol. The comprehensive documentation of patient histories and appropriate use of diagnostic tests indicate a thorough and systematic approach to patient assessment. Accurate diagnosis and proper classification of conditions, such as perforation or obstruction, highlight the facility's commitment to precise and evidence-based practice. The alignment of laparotomy choices, preoperative instructions, and medication prescriptions with STG guidelines underscores the adherence to standardized care protocols. The consistent application of infection prevention measures and adherence to surgical recommendations ensure patient safety and reduce the risk of complications. Effective postoperative monitoring and the planning of follow-up appointments demonstrate a proactive approach to patient recovery and long-term care. Additionally, providing patient education on recovery and warning signs reflects a holistic approach to patient management. Overall, these results indicate a highly efficient and reliable system for laparotomy management, with no identified areas for improvement. This level of compliance sets a high standard for other healthcare facilities aiming to achieve similar excellence in surgical care.

Recommendations

- **NO MAJOR GAP SEEN**

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Surgical and Anesthesia care Department

Appendicitis Management

STG utilization monitoring report

By: *Quality Unit*

Report Period: 3rd Qrtr of *2017E.C*

Deder, Oromia

March 2017E.C

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Purpose

Since EBC was launched in 2014 it was mentioned that monitoring Utilization to STG was necessitated as mentioned in EBC document to make sure that clients was treated as per the protocol and there is uniformity of the care provided for the all clients. Deder General Hospital has also followed this and conducting the Monitoring of STG adherence.

Introduction

Appendicitis is one of the most common acute surgical conditions requiring timely and appropriate intervention. Adherence to Standard Treatment Guidelines (STG) is crucial to ensure quality care, minimize complications, and improve patient outcomes. This report evaluates STG utilization in managing appendicitis at **Deder General Hospital** and provides actionable recommendations based on the findings.

AIM

- To assess and improve compliance with STG for managing appendicitis and enhance the quality of care provided to patients.

Objective

- To evaluate adherence to diagnostic, treatment, and follow-up protocols outlined in the STG for appendicitis.
- To identify gaps in compliance and recommend corrective actions for improvement.

Methodology

Study Design & Period: Retrospective review of Appendicitis cases over a period of three months **December 21-March 20, 2017E.C**.

Data Collection: Data was collected using a checklist based on STG standards, including 12 key indicators.

Sample Size: A total of 15 Appendicitis cases were reviewed.

Analysis: Compliance rates were calculated as the percentage of cases meeting each standard

***Table 1**: CRITEREA AND STANDARDS*

S.No	Standards
1.	Was the history comprehensive and documented?
2.	Were appropriate diagnostic tests ordered (e.g., CBC, abdominal ultrasound)?
3.	Was a differential diagnosis included?
4.	Was the diagnosis documented in line with STG criteria for appendicitis?
5.	Were relevant diagnostic tools (e.g., CT scan, ultrasound) used appropriately to confirm diagnosis?
6.	Was the treatment choice in accordance with STG?
7.	Were preoperative antibiotics prescribed and fasting guidelines followed?
8.	Was the correct surgical procedure performed (open vs. laparoscopic appendectomy)?
9.	Were perioperative care protocols followed (e.g., antibiotic prophylaxis)?
10.	Was the patient monitored for infection or any postoperative complications (e.g., wound dehiscence)?
11.	Was pain managed according to guidelines?
12.	Were follow-up visits scheduled within the STG recommended time frame?

RESULT

The performance of STG utilization in managing appendicitis, showing a high overall compliance rate of **99%** (**Table 2**). All standards, including comprehensive history documentation, appropriate diagnostic tests, differential diagnosis, diagnosis alignment with STG criteria, correct use of diagnostic tools, treatment choice, preoperative care, surgical procedures, perioperative care, and postoperative monitoring, achieved a 100% compliance rate. However, pain management and scheduling follow-up visits within the recommended time frame had lower compliance rates of 93%, with one non-compliant case each. Overall, out of 158 evaluated criteria, 178 were compliant, and 2 were non-compliant, indicating strong adherence to STG guidelines with minor areas for improvement (**Table 2**).

Table 2: *STG utilization performance of Appendicitis management, March 2017E.C*

S.No	Standards	Compliant (YES)	Non-Compliant (NO)	Compliance Rate (%)
1.	Was the history comprehensive and documented?	15	0	100
2.	Were appropriate diagnostic tests ordered (e.g., CBC, abdominal ultrasound)?	15	0	100
3.	Was a differential diagnosis included?	15	0	100
4.	Was the diagnosis documented in line with STG criteria for appendicitis?	15	0	100
5.	Were relevant diagnostic tools (e.g., CT scan, ultrasound) used appropriately to confirm diagnosis?	15	0	100
6.	Was the treatment choice in accordance with STG?	15	0	100
7.	Were preoperative antibiotics prescribed and fasting guidelines followed?	15	0	100
8.	Was the correct surgical procedure performed (open vs. laparoscopic appendectomy)?	15	0	100
9.	Were perioperative care protocols followed (e.g., antibiotic prophylaxis)?	15	0	100
10.	Was the patient monitored for infection or any postoperative complications (e.g., wound dehiscence)?	15	0	100
11.	Was pain managed according to guidelines?	14	1	93
12.	Were follow-up visits scheduled within the STG recommended time frame?	14	1	93
	OVERALL	178/180	2/180	**99%**

Discussion

The results indicate a high level of adherence to Standard Treatment Guidelines (STG) in managing appendicitis, with an overall compliance rate of 96%. The consistent 100% compliance across most standards, such as history documentation, diagnostic testing, surgical procedures, and perioperative care, reflects effective implementation of clinical protocols. However, the lower compliance rates in pain management (715%) and scheduling follow-up visits (715%) highlight areas needing improvement. These gaps suggest potential variability in post-operative care and patient follow-up, which could impact patient outcomes. Addressing these specific areas through targeted training and protocol reinforcement could further enhance the quality of care and ensure comprehensive adherence to STG recommendations.

RECOMMENDATIONS

- **Conduct Regular M&E**

IMPROVEMENT PLAN

- **No major gap seen**

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