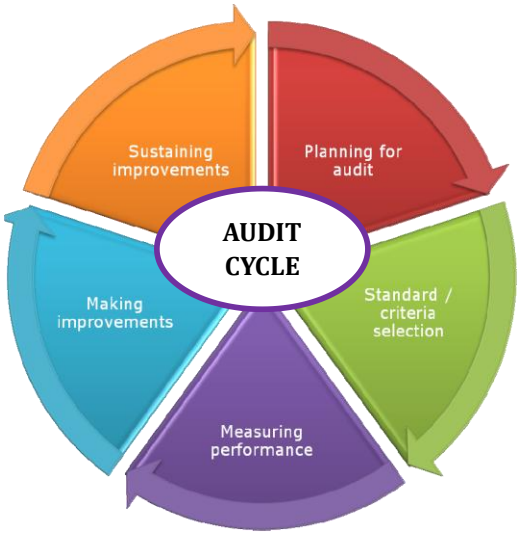
DEDER GENERAL HOSPITAL

GYNECOLOGY AND OBSTETRICS DEPARTMENT



CLINICAL AUDIT TO IMPROVE THE QUALITY OF CLINICAL CARE OF CISERAIAN SECTION

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Advisors:

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Deder, Oromia

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INTRODUCTION

Caesarean section (CS) is a lifesaving procedure when spontaneous or assisted vaginal delivery is not possible. The World Health Organization (WHO) recommends a rate of 5 – 15% for any community and above that is considered unnecessary overuse of the procedure. In Tanzania, the population-based CS-rate in 2010 was 4.5% and in rural areas only 3.2%, indicating general underuse [1, 2]. However, in some health facilities CS-rates are much higher and probably overused.

Although CS in general is a safe operation, the procedure can lead to serious complications. These include endometritis, wound hematomas and infection, venous thromboembolism, anaesthetic complications, infertility and abdominal adhesions which can lead to chronic abdominal and pelvic pain as well as a risk of injury to adjacent organs in future surgeries [3–8]. Furthermore, CS bears consequences for subsequent pregnancies, with higher risks of excessive blood loss, uterine scar rupture, placenta accreta, placenta praevia and abruptio placentae [9–12]. Most of these complications are more serious in resource-limited settings, reinforcing the restraint which should be used in deciding to perform CS.

STATEMENT OF PROBLEM

In addition to these medical complications, CS is associated with considerable costs for patients and hospitals, resulting in a longer hospital stay, whilst the number of available beds in most centers is limited. Therefore, to avoid unnecessary CS, management of women in labour should be appropriate and the decision for CS be made only in situations where no better alternatives are available [13]. Few audits measuring adequacy of decision-making for CS have formally been evaluated in countries such as Tanzania [14–17]. In an attempt to improve health care and reduce maternal and perinatal mortality and morbidity, audit was introduced in Deder General Hospital [18].

OBJECTIVE

General objective

To improve the quality of care provided for women who delivered by CS

Specific objectives

- To ensure women who gave birth by CS are evaluated appropriately
- To ensure women had undergone CS received evidence based intraoperative care
- To ensure women who gave birth by CS received evidence based post operative care

Methods

Study area & period

The clinical audit was conducted in C/S room of Deder General Hospital from **September 22-28, 2017EC**

Study design

Retrospective cross-sectional study

Source population

All patients delivered by C/S and cards are available during the study period.

Inclusion criteria

All women who gave birth by elective CS between **June 21, 2016 to September 20, 2017** was included

Exclusion criteria

Women who delivered by emergency CS

Sampling technique

A total of 19 medical records (client chart) of the last reporting quarter should be sampled for the audit. The individual client charts were withdrawn by systematic random sampling. Clinical audit is not research. It is about evaluating compliance with standards rather than creating new knowledge, therefore sample sizes for data collection are often a compromise between the statistical validity of the results and pragmatic issues around data collection i.e., time, access to data, costs. The sample should be small enough to allow for speedy data collection but large enough to be representative. In some audits the sample will be time driven and in others it will be numerical.

Study Variables

Dependent variables:

Cesarian section

Independent Variables

C/Section, OR,

Data collection method

Data extraction sheet was adapted from National clinical audit tool

Data Processing & analysis

Data from extraction sheets was manually verified and entered into the SPSS version 25 software for analysis. The software checked data types, sizes, classifications, and allowable values. Corrections were made, and the findings were presented in tables and figures.

RESULT

A retrospective clinical audit was conducted on emergency management of poisoning patients. The Overall Performance of management of women delivered by C/S was **88%.** with almost all clients' charts containing appropriate discharge care provided for a mother who delivered by cs and identification of the provider like: name and signature of the care providers **(Table 1).**

Table 1: ACTUAL PERFORMANCE ANDV PERFORMANCE AGAINST TARGET

Sno	**Variables**	**Target**	**Actual Performance**	**Performance against target**
1	Adequate pre-operative preparation is made for a mother who delivered by cs	100%	75	25
2	Standard intraoperative care is provided during c-section for a mother who delivered by cs	100%	93	7
3	Post operative care to be carried out in the post anesthesia care unit and ward clearly communicated for a mother who delivered by cs	100%	75	25
4	Appropriate discharge care is provided for a mother who delivered by cs	100%	100	0
5	Identification of provider is documented for a mother who delivered by cs	100%	75	25
6	Newborn delivered with APGAR score of 7 and above	90%	100	0
7	Woman who delivered by elective cs discharged without complication	100%	100	0

Overall Performance of clinical audit of C/S delivery women

The overall Performance of Management of Women delivered by C/S was 88%.

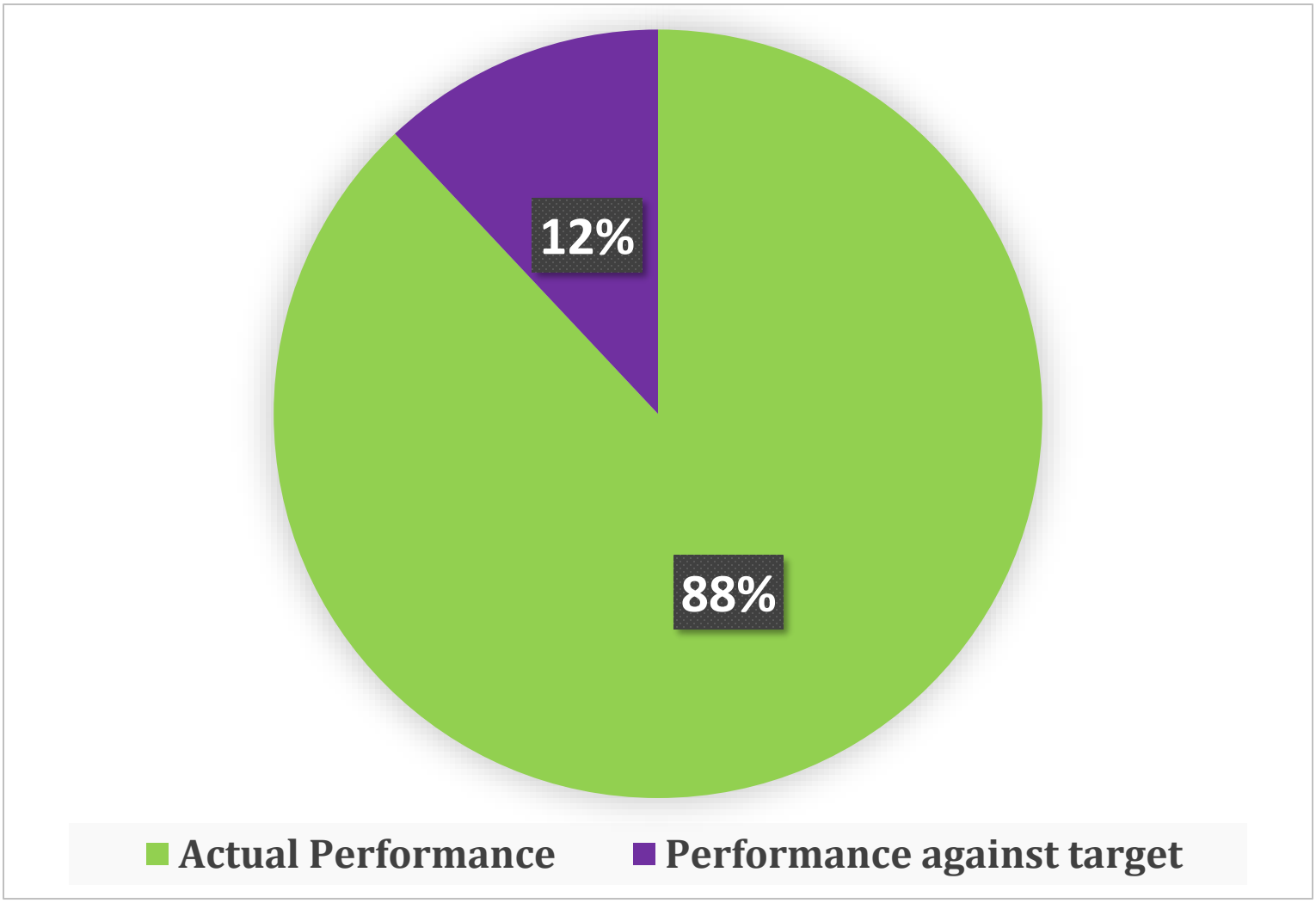

Figure 1: Overall Performance of Management of Women delivered by C/S, September 2017EC

Graph showing score for each criterion/standard for management of Women delivered by C/S, April 2016 E.C.

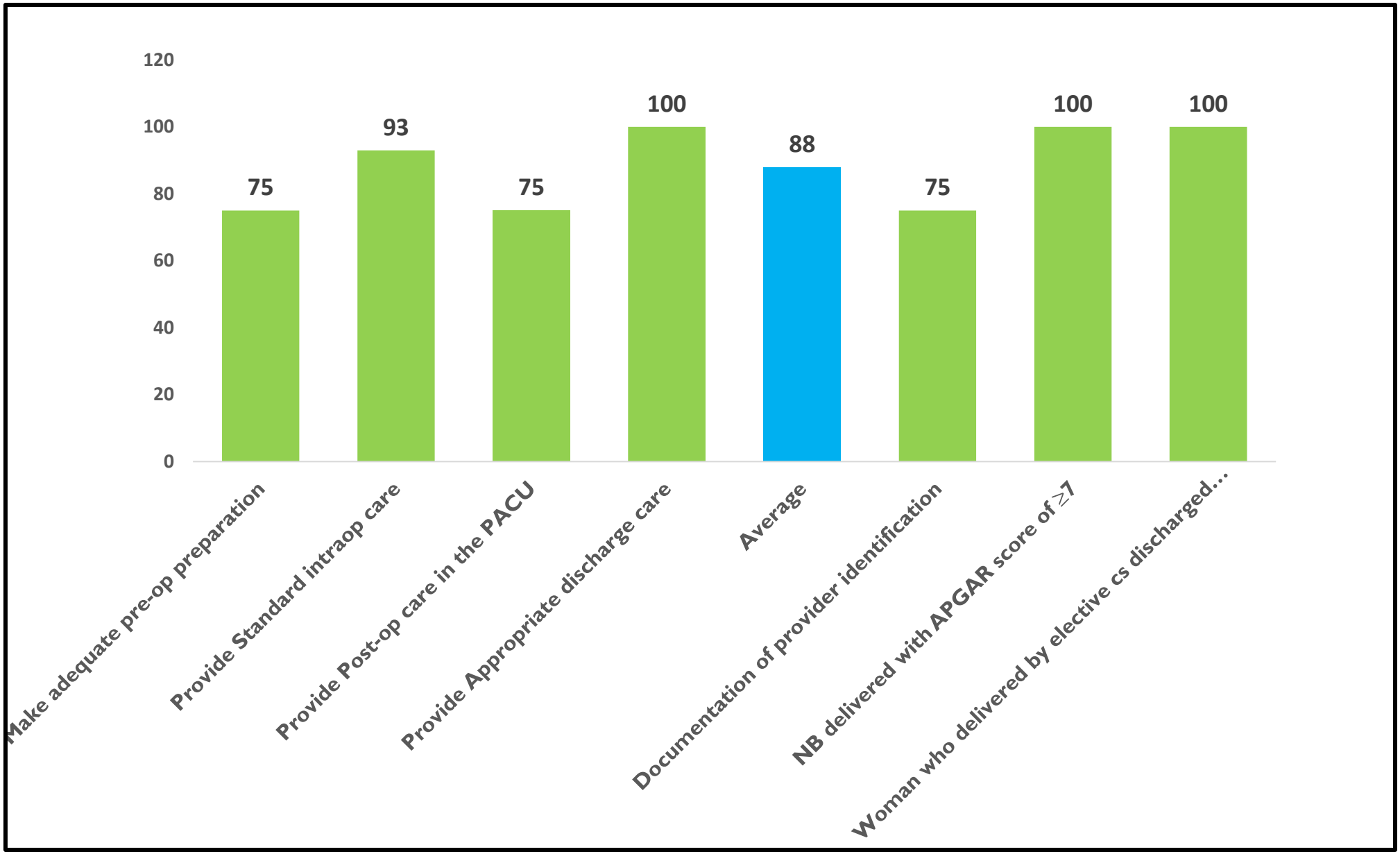

Figure 2: score for each criterion/standard for management of Women delivered by C/S, September 2017EC

Table 2: List of prioritized Problems to be addressed

S.No	Problems List	Status	Rank	Remark
2.	documentation of prophylactic antibiotics administered within 30 min before surgery	0%	2	
3.	Order sheets are not daily revised	0%	3	
4.	Patient progress note is daily followed till discharged	47%	4	
5.	No documentation of maternal V/Ss (BP, PR, RR, SPO2) taken before anesthesia administered	58%	5	

Table 3: Action plan

Summary of problem	Root cause	Change ideas	Responsible body	Time frame
No documentation of prophylactic antibiotics administered within 30 min before surgery	Negligence	To give Feedback for all relevant responsible persons (Anesthesia team, Midwifery team. And ward physicians)	GYN OBS Directory & QU	ASAP
Order sheets are not daily revised	Negligence	To give Feedback for all relevant responsible persons (Anesthesia team, Midwifery team. And ward physicians)	GYN OBS Directory & QU	ASAP
Patient progress note is not daily followed till discharged	Negligence	To give Feedback for all relevant responsible persons (Anesthesia team, Midwifery team. And ward physicians)	GYN OBS Directory & QU	ASAP
No documentation of maternal V/Ss (BP, PR, RR, SPO2) taken before anesthesia administered	Negligence	To give Feedback for all relevant responsible persons (Anesthesia team, Midwifery team. And ward physicians)	GYN OBS Directory & QU	ASAP