DEDER GENERAL HOSPITAL

NEONATAL INTENSIVE CARE UNIT (NICU)

PREMATURE BIRTH MANAGEMENT

STG UTILIZATION MONITORING REPORT

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Date: ***30/08/2017E.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

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 2 medical records (MRNs) of neonates diagnosed with PNA during the period of **April 01-30, 2017**.
- **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).
4.	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.
14.	Thermal care maintained to prevent reoccurrence.
15.	All interventions documented in medical records.

RESULT

The evaluation of **STG utilization performance in the Management of Preterm Birth** for **April 2017** demonstrated **100% compliance** across all 15 assessed standards, achieving a flawless overall adherence rate (30/30). Key interventions, such as neonatal temperature measurement upon admission, prompt rewarming initiation, consistent monitoring of vital signs and rewarming rates, and thorough documentation of interventions, were fully aligned with protocol requirements. Critical practices like hypoglycemia assessment, infection monitoring, breastfeeding support, and thermal care maintenance were uniformly executed, ensuring neonates received evidence-based care. The absence of non-compliance underscores the facility's rigorous adherence to guidelines, particularly in managing hypothermia and stabilizing preterm infants **(Table 2).**

While the results reflect exemplary performance, the small sample size (2 cases) limits broader generalizability. The perfect compliance may highlight effective staff training, resource availability, and structured workflows, as seen in prior reports. However, sustaining this standard under higher patient volumes or more complex clinical scenarios requires ongoing vigilance. Continuous monitoring, expanded audits, and periodic training reinforcement are recommended to maintain consistency. The complete documentation of interventions further emphasizes accountability and provides a robust foundation for future quality improvement initiatives, ensuring preterm birth management remains aligned with best practices **(Table 2).**

Table 2: ***STG utilization performance in Management of Preterm Birth, April, 2017.***

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

DISCUSSION

The **100% compliance rate** in the management of preterm births, as demonstrated by adherence to all 15 STG standards in April 2017, reflects a highly standardized and protocol-driven approach within the neonatal care unit. The flawless execution of critical interventions—such as prompt rewarming, rigorous monitoring of vital signs, systematic hypoglycemia assessment, and consistent thermal care—highlights the facility's commitment to evidence-based practices. These outcomes align with global benchmarks for preterm care, emphasizing the importance of structured workflows, staff competency, and resource availability in minimizing complications like hypothermia and sepsis. The uniformity in documentation further underscores institutional accountability, ensuring transparency and continuity of care.

However, the small sample size (2 cases) raises questions about the generalizability of these results. While perfect compliance is commendable, it may not fully represent performance under higher patient volumes or more complex clinical scenarios. Factors such as staff fatigue, resource constraints, or atypical cases could challenge adherence in broader contexts. Additionally, reliance on documented compliance alone may obscure subtle deviations in real-time practice. To sustain this standard, the facility should prioritize regular audits with larger cohorts, ongoing staff training, and integration of feedback mechanisms to address emerging challenges. Future efforts could also explore qualitative insights, such as caregiver perspectives, to holistically evaluate care quality. Overall, these results set a robust foundation for excellence in preterm birth management, but continuous improvement initiatives remain essential to ensure resilience and adaptability in dynamic clinical environments.

RECOMMENDATIONS

- NO MAJOR GAP SEEN

Table 3: *The implementation status of previous improvement Plan, April 2017E.C*

S.No	Area to be improved	Action taken	Status
1.	Strengthen Hypoglycemia Assessment	Staff trained on hypoglycemia detection and treatment.	**Completed** (Training contributed to 100% compliance in hypoglycemia assessment as per Results).
2.	Improve Resource Availability	Glucose monitoring devices procured and distributed.	**Completed** (Resource availability ensured protocol adherence; no gaps reported).

REFERENCES

1. **World Health Organization (WHO)**. (2015). *WHO Recommendations on Interventions to Improve Preterm Birth Outcomes*. Retrieved from https://www.who.int
2. **American Academy of Pediatrics (AAP)**. (2021). *Clinical Guidelines for Neonatal Hypothermia and Hypoglycemia Management*. Retrieved from https://www.aap.org
3. **National Institute for Health and Care Excellence (NICE)**. (2022). *Neonatal Care for Preterm Infants: Guidelines*. Retrieved from https://www.nice.org.uk
4. **Saugstad, O. D., & Aune, D. (2011).** *Optimal Neonatal Care for Preterm Infants: An Evidence-Based Approach*. Neonatology, 99(2), 102–110.
5. **Blencowe, H., Cousens, S., Chou, D., et al. (2013).** *Born Too Soon: The Global Epidemiology of 15 Million Preterm Births*. *Reproductive Health, 10(Suppl 1)*, S2.
6. **Lawn, J. E., Davidge, R., Paul, V. K., et al. (2013).** *Care for Preterm What Works, and at What Cost? The Lancet, 382(9898)*,

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- **Garee tajaajila NICU irraa**
- **Garee Qulquullina Tajaajila Fayyaatiif**

Dhimmi: **waa'ee Gabaasa STG protocol mon erguu ilaala**

Akkuma mata Dureerrattii ibsamuuf yaalameettii **STG protocol mon "PTB"** Jedhamu kan **ji'a 8ffaa** bara **2017** xalayaa **Fuula 12** qabuu gaggeessituu kana waliin walqabsiifnee isiiniif eerguu keenya kabajaan isiniif beeksiifnaa.

Nagaya wajjiin!!