JAN SWASTHYA SAHYOG

Maternal Death Reviews

IGUNATMAC PROJECT
2019-2020

Table of Contents

Background

A large part of our effort is to improve the skills of providers. Along with training and mentoring, maternal or neonatal deaths help us identify areas of improvement not only in the skills of providers but also processes and systems of the facility and in local and state-level administrators.

When we mentor the nursing staff, we aim to improve nursing care and nurse-led practice in the facility. However, improvement in the overall quality of care is possible only when the facility staff works as a team. Maternal death review helps us to build accountability of the facility team, especially doctors, allied departments like a blood bank, laboratory, pharmacy, and facility administrators.

Our approach to conducting facility-based MDR

According to the Government of India maternal death and surveillance guidelines, there are two types of maternal death reviews i.e. facility-based and community based maternal death review.

The facility-based maternal death review is expected to be a technical discussion. It should be more focussed on improving clinical care and addressing administrative issues so as to prevent maternal and neonatal deaths. Reviewing case sheets is a way to understand gaps in clinical care.

When we started work on MDRs, our observations were as follows :

- The facility staff was not willing to accept that there is a scope of improvement in the facility. They used to find the gaps in other facilities where she referred from or other delays prior to reaching their facilities.
- The members of allied departments were not interested in labor room related activities.
- MDRs were only a form filling exercise rather than discussion on the cases with a focus on improvement.

To make the facility team realize that there is a scope of improvement in the facility, we chose those cases where the death occurred after 2-3 days were spent by the patient in the facility. If the patient spends more than 2 days in a facility then it is expected that the facility had enough time for diagnosis and management. Still, if the death happened then there are more chances of gaps in the clinical care and hospital management.

We also visited the patient’s home and conducted in-depth interviews with family members, the person who was with the patient throughout the chain of incidents including staff of referral facilities.

During the maternal death reviews, we emphasize the participation of all staff who were involved in service delivery to patients including doctors, specialists, and representatives of allied departments. Moreover, we emphasize the presence of local administrators to make timely decisions. The maternal death review meeting ends with doable solutions with responsibility and timeline.

How our work on MDR have evolved over the last 3 years

1. 2017-2018: We started with facility-level maternal death review with backtracking. This was done by JSS with the facility staff. Action points pertaining to state level were shared with the state.
2. 2018: We started involving the Deputy Director of Maternal Health in the state in these review sessions. She would join via skype. The reports of these MDRs were shared with the State Health Administration. We also started advocating for state driven MDRs.
3. Early 2019: We conducted an MDR workshop at the state level for specialists and district administrators on how to conduct facility level maternal death reviews
4. 2019-2020: We continued to support the state driven MDRs sessions by providing expert opinion and continuous advocacy and also work with facilities to improve the quality of facility-level MDRs

Initially, in 2017-18, We lead the maternal death reviews at the facilities. After a series of MDRs, we advocated with the MP Government in the year 2018, to be involved to review the maternal deaths in detail. The state in response has started to have reviews through video conferencing. They raised the demand for a workshop on maternal death review. In 2019, a workshop was conducted for health officials, specialists, and medical officers from different districts including non-intervention areas on how to run an MDR. Real case-based scenario, presence of a specialist team of the facility i.e. Gynecologists, Physician, Anesthetists, and lady medical officer were asked to come to build a team culture and action plan preparation were the main features of the workshop.

In 2019-20, we handheld the process to conduct maternal death reviews remotely. We provided one technical expert and co-coordinator to strengthen the state's maternal death review at the district level. The process of state-driven maternal death review is explained further.

Some key achievements over the last three years

1. Maternal death reviews brought out the lacunae in clinical management by specialists of the facility. Thus we started training sessions which were termed as Continuing Medical Education for specialists i.e. Gynecologist, physicians, and anesthesiologists.
2. The state started to focus on Sickle cell disease. Sickle cell screening and management program was started in all the tribal districts of MP. Screening tests for sickle cell for pregnant women became mandatory in all facilities.

3. State-driven MDRs: For the first time, the maternal health department of Madhya Pradesh started conducting in-depth maternal death reviews with facility teams.

What we have done this last year

- State-driven MDR: participated in 2 such sessions this year as part of the MDR review committee which was chaired by MD, NHM of Madhya Pradesh
- Involvement of JSS in State Investigation Committee
- Facility-based maternal death review in Umaria
- Quality improvement of maternal death reviews at DH Shahdol

State Driven MDR

We have conducted/facilitated 34 maternal deaths reviews in the last three years. During facility-based maternal death reviews, we played the role of an expert. To sustain this, such reviews should be cultured in the facility itself. In the facility-based maternal death reviews without an external expert, the discussion was towards defending themselves in the team. We did advocacy to the state to play the role of external expert by attending maternal death reviews using video conferencing. We also offered support to conduct state-driven maternal death reviews.

Process for a state-driven maternal death review

Iguntmac team supported two-state driven maternal deaths reviews in which cases of DH Shahdol, DH Anuppur, and Sidhi have been reviewed. We provided a technical expert from JSS and an MDR coordinator. The co-ordinator collects the case sheets of patients especially from our interventional districts. The technical expert makes a summary of his/her findings and sends it to the state.

We tried to ensure that it would be a learning exercise in order to learn from the failed efforts and take corrective actions in the future to save the life of the mother. But if things do not improve and people repeat the same mistakes and give unreasonable excuses, strict actions should be taken against the concerned person(s).

The overall process of state-driven maternal death review includes the following steps:

1. The district shares a list of maternal deaths in districts
2. State-level officials select two cases of maternal death per health division ca
3. State-level officials share list to divisional officers and district officials- Two maternal death cases per division

4. State asks summary in a structured format prior to the actual video conferencing of maternal death review
5. On the day of MDR, CMHO and the Gynecologist has to explain the summary of a death case and the discussion happens

Challenges with state-driven MDR

1. Inclusion of medical college staff in state-driven maternal death reviews and facility-based maternal death review is not regular.
2. Timely reporting and getting a summary of maternal deaths reviews prior to the state-driven maternal death reviews
3. The time slot on video conferencing given for maternal death reviews is very less. The state maternal health team is struggling to increase the time.

Involvement of JSS in State Investigation Committee

Being a part of state driven MDR at District Hospital Anuppur, while having discussion in the meeting there were few points where absolute ignorance from the facility was seen/ observed by the expert who attended the meeting from JSS. To investigate it further the state had formed a committee; an expert (Obstetrician & Gynecologist) from JSS was part of the committee.

Facility-based maternal death review in Umaria

At the beginning of the year, 2019 we conducted a facility-based maternal death review and referral audit in Umaria. The cause of death was PPH, which was preventable. Partograph reflected the misuse of oxytocin resulting in the contraction of the uterus before delivery. It reflects a lack of knowledge or inadequate monitoring by the doctors. Few cases of referral were also reviewed. A state representative had joined the review remotely. In this review, clinical as well as systemic issues were discussed.

Action points:

1. Lack of doctor: Need of a lady medical officer in the maternity wing. Civil surgeon to post at least one lady medical officer in the labor room.
2. Augmentation of labor: It can lead to the PPH. All staff nurses can administer intravenous uterotonics only after order from a doctor.
3. Screening test of Sickle cell disease: It was not happening though the laboratory technician was trained. It has started, after this meeting.
4. The patient was referred without stabilizing: There were no proper records of referral out patients. Maternity wing staffs to maintain a counter register for referrals and proper documentation with reasons for referrals signed by the doctor. Referral slips need to be printed.
5. Blood banks have minimal blood and are always looking for replacement donations. This is the reason for frequent referrals and sometimes maternal deaths in district hospitals. Need to increase blood donation camps.

Quality improvement of maternal death reviews at DH Shahdol

JSS has been working with DH Shahdol for the last two years. The leadership at Shahdol has been more interested in running good quality facility based MDRs compared to other intervention facilities. Maternal death reviews were started with the initiative by the facility itself.

Our work here was to continue to provide support to improve the quality of these reviews. We did this through the maternal health coordinator. The purpose for us to attend the reviews was to providing inputs to the technical discussion. A doctor from the iguntmac team attended 3 maternal death reviews. Case sheets were reviewed by JSS technical experts and then a summary was made.