

# Supporting facilities for conducting MDR

## Background

Jan Swasthya Sahyog (JSS) is working on quality improvement of maternal and newborn health care services in the 6 district hospitals and 11 CHCs of the six selected districts (Anuppur, Dindori, Mandla, Sidhi, Umaria and Shahdol) of Madhya Pradesh 2016. Improvement in maternal health services can be ensured through many ways and maternal death reviews are one of them. This is a helpful process as it helps to explore, learn and act upon the findings that came out from the review process of maternal death to improve the service delivery and minimise the structural gaps and delays at different levels.

Through the mentoring for the nursing staff, we aim to improve nursing care and nurse-led evidence based practices 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 in 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 is 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 the patient was 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 and fault finding exercise rather than discussion on the cases with a focus on improvements and learnings.

## Reason for the approach:

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 has 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.

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 backtracking with the objective being, after initial understanding of the process it will be easier to guide the district and later on handing over the responsibility to the district.
2. 2018: We started involving the Deputy Director of Maternal Health in the state in these review sessions. She used to join district level MDRs using online platforms i.e. zoom, skype etc..The reports of these MDRs were shared with the State Health Administration. We also started advocating for state driven MDRs. State driven MDRs started, where the data used to be collected and reviewed from the state level officials on a monthly basis.
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

## What we have done this last year

- [Facility-based maternal death review in Shahdol](#)
- [Developing the material for the MDR workshop for capacity building of the internal team of JSS.](#)

## Facility-based maternal death review in Shahdol

In the month of August 2020, a maternal death review was conducted in the presence of representatives from JSS and Gynecologists, medical officers and other staff of district hospital as well as Medical College Staff working in the maternity wing of DH Shahdol. Case papers had been sent prior to the meeting and the remarks of specialists at JSS were taken on all the cases.

A total of 6 cases were discussed. In this review, clinical as well as systemic issues were discussed. The ones who attended this MDR were R.MO, gynaecologist, Shahdol medical college doctor, M.O, Matron, Maternity incharge, LR incharge, HDU incharge, DPHNO in-charge, MH Co-ordinator, Pharmacist, Staff Nurse

### Action points:

#### 1. HDU:

- There is a need to have a written protocol; regarding shifting of patients to the HDU. At present, there is a delay in shifting the patients which leads to further deterioration in their condition. The protocol must be communicated to all the staff.
- Also, in HDU there has to be a format for monitoring charts for all the critical patients, which has to be filled up at periodic intervals.
- Delivery beds in HDU should be made functional so that sick patients can be delivered there, rather than in LR with no monitoring and which is at some distance.

Action taken: monitoring charts have been made for monitoring the critical patients in the HDU and filled at regular periodic intervals.

Delivery beds in HDU were made functional for sick patients to be delivered in HDU, but it became a challenge for the staff to conduct deliveries in HDU due to few infrastructural problems.

- #### 2. The tests for CBC, Malaria parasite and sickling should be available in the lab 24 hours. Currently, in CBC, only Hb is done, which has to be looked into. Rapid test kit for malaria, though available in LR, is not used by the staff.

Action taken: tests for malaria, sickling are available 24hrs in the lab and in CBC only blood grouping and Hb is done as they have a shortage of technicians. In the labour room, malaria test kits are available and used by the staff.

- #### 3. Blood storage unit of the CHCs has to be made functional, in order to manage the complications effectively of the patient and that could reduce the number of referrals done.

Action taken: the blood storage unit has been made functional in the first referral unit beohari and CHC jaisinghnagar.

4. Refresher training is required for the management of PPH (both traumatic and due to retained placenta) for medical officers and gynaecologists.

Action taken: we have planned to start training sessions which were termed as Continuing Medical Education for specialists i.e. Gynecologist, physicians, and anesthesiologists. During the last financial year, there were CMEs conducted for specialists and this time we are exploring the training opportunity for the medical officers.

5. Sickle cell disease must be screened for in all pregnant women at the facilities ( PHC, CHC, DH) and diagnostic tests at DH must be available and functional. High prevalence of SCD is suspected more often.

Action taken: Sickle cell screening has been started in DH and the first referral unit and diagnostic tests are available and functional in these facilities.

## Developing the material for the MDR workshop for capacity building of the internal team of JSS

Capacity building of the internal JSS team regarding MDR in order to understand the importance of MDR, various methods of conducting MDR and how it has to be conducted. This would be beneficial to the team to support the district in conducting the MDR seamlessly and the quality of the MDR conducted can be ensured and proper follow up can be done.

Topics covered:

- What is Maternal Death?
- What is MDR? And MDSR?
- Purpose of MDR?
- Where do we usually go wrong?
- Who should be involved? Who Leads?
- Analysis through case studies

## Some key achievements over these years

1. Maternal death reviews brought out the lacunae in clinical management by specialists of the facility. Thus we planned to start training sessions which were termed as Continuing Medical Education for specialists i.e.Gynecologist, physicians, and anesthesiologists. During the last financial year, there were CMEs conducted for specialists and this time we are exploring the training opportunity for the medical officers.
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 where JSS is working. Screening tests for sickle cell for pregnant women became mandatory in all facilities.
3. State-driven MDRs: The maternal health department of Madhya Pradesh started conducting in-depth maternal death reviews with facility teams.