Recommending and Implementing Solutions
Day 2 Session 4
Session Objectives

• Learn how to prepare SMART recommendations to address modifiable factors that lead to preventable neonatal deaths and stillbirths

• Learn how to disseminate recommendations from review meetings

• Learn how to implement changes at the health facility level

• Learn factors responsible for success of perinatal death reviews
Introduction

• Perinatal death audits may be a useful tool for reducing stillbirths and neonatal deaths in facilities.

• Can improve QoC, as long as the audit loop can be closed.

• When successful, audits can result in a 30% reduction in perinatal deaths.
Recommending Solutions

• As data and trends are examined- patterns of problems become evident

• Moving from problems to solutions is key

• Solutions are dependent on:
  • Individuals responsible for the investigation
  • Breadth of stakeholder involvement
  • Level of development and local resources

• Committees need the authority to determine what mixture of relevant and effective strategies

• What are evidence based strategies required to address the main gaps in care that have been identified in the review process?

• What went well and what could have been done better?
Recommending Solutions

• Solutions should always be SMART

• Assigning a designated person is

• A formal platform where review findings are presented should be created, if such a platform does not exist

• Meeting minutes - essential and follow up on action items

• Possible solutions include interventions at the level of health worker, health facility, wider health sector, at the level of families or communities.

• Facility based QI approaches are needed to bring about changes in clinical practice or modification of services at the level of systems for e.g.: how to provide the necessary drugs or coverage of trained personnel or establishment of clinical guidelines
Recommending Solutions

• Use findings to create a list of possible actions (during the review meeting)

• Prioritize problems on the basis of the significance of their effect on prognosis, and on the feasibility of the actions necessary to solve them

• Recommendations:
  • Health care provider (improved clinical practices)
  • Health system (improved availability of drugs and commodities)
  • Clinical governance (strengthen clinical guidelines)
Dissemination of Review Findings

• Important at multiple levels

• Audience: Anyone that can implement recommendations or make a difference towards improving quality of care

• Periodic reports – clear, easy to follow language, standard sections such as data audit trends covering births and deaths, causes and modifiable factors, recommendations and solutions enacted

• No blame and no link to individuals involved in care provision

• Context specific: Newsletters, email listserv, whatsapp groups

• Positive vignettes may also be useful for e.g.: cases of a near miss that were prevented because of an action developed by the audit committee.
Implementing Change - 1

• Taking action and implementing change is the entire reason for implementing the audit cycle

• Develop SMART recommendations
  • Immediate term: provider related - improving staffing ratios
  • Medium term: improved logistics supply, establish clinical guidelines.
  • Longer term: patient education, improved infrastructure or transport

• Who is responsible for implementing and monitoring change- maybe more than one person
Implementing Change - 2

- Start with things that are easily achievable
- Use audit meetings as advocacy tools to prompt administration to further action
- Modifiable factors within the control of health workers (detailed history taking, partograph use)
- Modifiable factors within the control of managers (ambulance availability, lack of equipment or supplies)
- Follow up on implementation of recommendations and monitor changes over time
- Celebrate success and identify successful changes whenever they occur
Keep Learning from Excellence

- Analyzing cases from pre-conception to bereavement care will identify areas of good practice
- Important to highlight and recognize these areas amongst staff and across wider hospital teams
- Formal process to share stories of excellent care are useful
- Compendium of successful stories
- Use successful stories for advocacy
Factors for Success

- Proactive institutional ethos that promotes learning as a crucial part of improving QoC
- Supportive political and policy environment at the national or the local level
- Individual responsibility and a sense of ownership
- Leadership at all levels
- A skilled, independent and respected chairperson who is a champion for the process
- Task oriented meeting minutes: recommendations, suggested actions and focal person
- Starting with things under health worker control
- Following up on items that have not been completed
- Staff stability
- Good communication between departments
- Celebrating progress as and when it occurs