IMPROVING NURSING KNOWLEDGE AND SKILLS ASSOCIATED WITH ANTENATAL CARE AND MANAGEMENT OF PREGNANT WOMEN INTRAPATURM AT LUMAKANDA COUNTY HOSPITAL

BACKGROUND &PROBLEM IDENTIFICATION

Approximately three quarters of all neonatal deaths occur during the first week of life with a million babies dying on the day they are born.The low proportion of intrapartum still births in the high-income countries suggests that they are primarily preventables with quality intrapartum care.*Lawn JE,Blencowe H,Oza S,You D ,Lee AC,Waiswa P,et al.*

As a work improvement Team(WIT),we undertook to analyze our own performance data for the previous five months on perinatal mortality commencing January to May ,2024.This was meant to determine our baseline information, the extend of the problem and brainstorm on the possible causes of high perinatal mortality and their countermeasures that could aid in reverting the trend.

The outcome of our analysis was as demonstrated in the table below

Month	Total Deliveries	Macerated still births (MSBs)	Fresh Still Births (FSBs)	Neonatal deaths(0-7days)	Total perinatal deaths	Perinatal deaths as a % of Total Deliveries
Jan,2024	120	00	01	02	03	2.50
Feb,2024	136	00	00	06	06	4.41
Mar,2024	63	00	02	00	02	3.17
April,2024	43	00	00	00	00	0.00
May,2024	144	03	00	05	08	5.56
Average Percentage						**3.75**

PROBLEM STATEMENT.A significantly high rate of perinatal mortality averaging 3.75%(of total skilled deliveries) monthly from January to May 2024

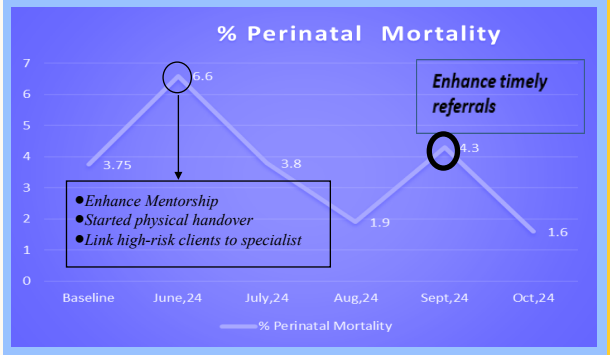
AIM STATEMENT:

To reduce perinatal mortality from the current monthly average of 3.75%(of total skilled deliveries to less than 2% by 31st October ,2024

MEASUREMENT OF PROGRESS

Perinatal mortality against the total number of skilled deliveries monthly

	BASELINE (JAN-MAY,2024	JUNE 2024	JULY 2024	AUG 2024	SEPT 2024	OCT 2024
Total skilled deliveries	506	105	130	103	138	123
Total perinatal deaths	19	7	5	2	6	2
% perinatal deaths	3.75	6.6	3.8	1.9	4.3	1.6



CHANGES MADE

- There was high mortality rate at the inception of the project in June standing at 6.6%of the total deliveries
- After through deliberations and brainstorming ,there was a concensus amongst the team members that these were the root causes of the high mortality
- Knowledge and skills gap on monitoring of labor,newborn resuscitation and management of other obstetric emergencies amongst the midwives providing direct care to clients
- Inadequate monitoring of pregnant women at high risk during antenatal period
- Lack of physical handing over of clients during change of shift intrapartum
- Delays in referrals from the nearby private and peripheral facilities

Quite a number of interventions/Changes were executed with the aim of reversing the upward trajectory of mortality. They included.

- Leverage on three trained Emergency Obstetric and Neonatal Care(EMONC)mentors to continuously offer mentorship specifically on monitoring labour,newborn resuscitation and management of a myriad of other obstetric emergencies.
- Screen,identify the high risk clients and link them to the specialist clinic for close monitoring
- Physically hand over clients during intrapartum period including physically auscultating the Fetal Heart Rate (FHR)
- The above changes were of paramount importance because they reverted the upward surge of mortalities to a downward trajectory .It was therefore imperative that these measures be incorporated in daily standards.
- Notably,there was a slight surge in mortality in September. Upon thorough brainstorming and analysis of our performance data, it was unearthed that the late referrals from peripheral facilities and a nearby private facility were the major contributors t the surge. An explicit communication was made to these facilities on the urgent need to execute timely referrals and their representatives were requested to participate in our perinatal death reviews. This led to a reduction in mortality in October hence enabling us to realize our aim of lowering the mortality rate to below 2%

PDSA-Change Ideas Test

GOAL :Reduce the number of perinatal deaths

PREDICTION :Reduced rate of perinatal mortality

PLAN

Mentees attached to mentors for continuous on job training on monitoring of labor, newborn resuscitation and management of other obstetric emergencies intapartum

DO

Identify mentors to offer on job training to mentees

Attach mentees with knowledge gap to mentors

STUDY

Track the number of deliveries and resuscitations done on their outcomes

ACT

Track the number of perinatal deaths against total deliveries monthly to monitor progress.

SUSTAINABILITY OF THE INTERVENTIONS

The project should continue beyond the earlier stated timelines and if this positive impact is sustained, the changes made should be incorporated in the standard operating procedures at the hospital and even beyond. The project will be easily sustained because the resources utilized are within our control. For instance, the mentors are staff working in the hospital hence can continue with the mentorship sessions seamlessly.

KEY INSIGHTS

Leadership Insight

- Exemplary leadership practices were paramount importance in the success of the project
- Through collaborative team leadership style, a shared vision of having a low perinatal mortality by the end of October ,2024 was developed and explicitly communicated.
- The process of service provision was deeply discussed and possible gaps and their countermeasures brainstormed in a free, open environment where each member gave their opinion
- Through mentorship ,those who had knowledge and skills gaps were capacitated and would perform procedures more confidently
- The team leader was at the forefront in executing the countermeasures hence creating enthusiasm among the other staff.
- Small successes were celebrated through words of affirmation and affordable gifts such as candies and appreciation cards. This ignited the passion to perform. With exemplary leadership, organization's vision can easily be realized.

Contact Details: SILAS WAKOLI MAKOKHA
Job Role : Team Leader and Nursing Officer In Charge
Email :silaswakoli@gmail.com
Phone No: +254710945185

LEADING CHANGE