Tool for Assessing Maternal and Perinatal Death Surveillance (MPDSR) Processes in Facilities

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Purpose and Guidance for Completing this Tool[1]

- This tool is designed to help managers, health workers, and partners better understand the structures and activities that support MPDSR, MDSR and PDSR processes in facilities– so that they can collectively target efforts to strengthen MPDSR in facilities.
- This tool should be used in setting that are implementing MPDSR, MDSR or PDSR processes
- The tool should be completed by a person with MPDSR expertise who has been fully oriented to the purpose and instructions for completing the tool
- The tool should be completed on-site during a visit to the facility by a trained assessor
- The tool includes two types of items:
  - Review of facility documents and other evidence related to implementing MPDSR
  - Questions for managers and health workers who support MPDSR, MDSR or PDSR in the facility
  - In facilities with a single MPDSR committee, conduct a group interview with as many available staff who support MPDSR
  - In facilities with distinct MDSR and PDSR committees (e.g. a large hospital), conduct a separate group interview with specific staff who support MDSR or who support PDSR, asking relevant questions
- Check only applicable boxes and write out the answers to probing questions (e.g. "specify", "describe") in as much detail as possible, using the back of the questionnaire form if needed.
- Try to use local MPDSR terminology to help health workers understand specific questions
- Please respect the confidentiality of patients and health workers; never state or record the names of individual patients or health workers in this tool or when asking questions or reviewing facility documents

Please complete the information below:

Date of facility visit: _____

Name of Assessor: _____

Which option best describes the facility health workers who were interviewed to fill in this tool (please check only one box):

☐ The health workers support only MDSR

☐ The health workers support only PDSR

☐ The health workers support MDSR and PDSR (e.g. members of a combined MPDSR committee.)

[1] There is a separate questionnaire that examines regional (provincial/state) and district MPDSR activities in more detail.

Note to assessor:

- *If interviewers support both MDSR and PDSR processes please address all items in the tool*
- *If interviewees support only MDSR, please skip all PDSR-specific items in this tool*
- *If interviewees support only PDSR, please skip all MDSR-specific items in this tool*

Health Care Facility Background Information

Region: _____ District: _____

Name of facility: _____

1. Facility type (please check one option only; if "other", please specify):
   ☐ Secondary or tertiary hospital
   ☐ District or first referral hospital
   ☐ Health centre
   ☐ Health post
   ☐ Other (please specify) _____

2. Average monthly number of births (live and stillbirths) in this facility:
   ☐ 0-30
   ☐ 30-90
   ☐ 90-150
   ☐ > 150

MPDSR Guidelines, Forms, Reporting

3. Are there any *written* policies, guidelines or protocols regarding the practice of MPDSR available on-site in the facility?
   ☐ Yes ☐ No ☐ Unsure
   If yes, describe: _____

   Assessor (document verification): *Please ask to see all available MPDSR guidelines and forms and check which items are available on-site in the facility*
   ☐ National MPDSR guidelines
   ☐ National MDSR guidelines
   ☐ National PDSR guidelines
   ☐ Other (please specify):
   _____

   Assessor Document Review: Please check the boxes in the table below based on your observation of the designated document.

	Maternal	Perinatal
Standardized death certificate	**designated place to note pregnant or postpartum woman* ☐	**designated place to note stillbirth or neonatal death* ☐
Standardized death notification form	**includes maternal death info* ☐	**includes perinatal death info* ☐

	Maternal	Perinatal
Standardized death review form	*includes maternal death info ☐	*includes perinatal death info ☐
Job aid to support cause of death classification (e.g. ICD-MM or ICD-PM job aid)	☐	☐
Other (please specify)		

4. Is there any financial support for facility MPDSR meetings and death reviews (e.g. photocopying forms, transport, refreshments)?
   ☐ Yes
   ☐ No

   If yes, please specify the source of the funding and how the funds are used to support MPDSR processes: _____

   _____

5. Is there any financial support for implementing death review recommendations that require additional financial resources (e.g. buying essential medicines)?

   If yes, please specify the source of the funding and how the funds are used to support MPDSR processes: _____

   _____

6. Does the facility prepare a facility-specific MPDSR report?
   ☐ Yes, regularly
   ☐ Yes, occasionally
   ☐ No

   If yes, does the facility send its MPDSR report to the district or regional MOH office?
   ☐ Yes, regularly
   ☐ Yes, occasionally
   ☐ No

   Assessor Document Review: Please ask to see a copy of a recent facility MPDSR report and check the appropriate box:
   ☐ Report observed (paper form)
   ☐ Report observed (electronic)
   ☐ No report made available

Organization and Implementation of MPDSR in the Facility

7. Please indicate which death review (audit) processes are implemented in your facility?
   ☐ MDSR only
   ☐ PDSR only
   ☐ Combined MPDSR (maternal and perinatal death audits and response)
   ☐ We do not regularly audit maternal or perinatal deaths in this facility

Comments: _____

_____

7-A When did this facility first begin implementing MPDSR?

☐ < 1 year ago
☐ 1-5 years ago
☐ > 5 years ago

7-B When did this facility first begin implementing MDSR?

☐ < 1 year ago
☐ 1-5 years ago
☐ > 5 years ago

7-C When did this facility first begin implementing PDSR?

☐ < 1 year ago
☐ 1-5 years ago
☐ > 5 years ago

8. Is there an MPDSR coordinator (or equivalent) at the facility who oversees and coordinates MPDSR activities in the facility? (Please check all that apply):
   ☐ Combined MPDSR coordinator?
   ☐ Distinct PDSR coordinator?
   ☐ Distinct MDSR coordinator?

9. Does this facility have a committee for MPDSR (please check one option only)?
   ☐ Combined MPDSR committee?
   ☐ MDSR Committee only?
   ☐ PDSR Committee only?

10. Please check which of the following health worker cadres participate on a regular basis in the facility's MPDSR, MDSR or PDSR committee); *Only check the boxes in the column relevant to the type of committee in your specific facility*

MDSR Committee	PDSR Committee	Combined MPDSR Committee
☐ Facility manager	☐ Facility manager	☐ Facility manager
☐ Health information officer	☐ Health information officer	☐ Health information officer
☐ Midwife	☐ Midwife	☐ Midwife
☐ Nurse	☐ Nurse	☐ Nurse
☐ Doctor/Medical Officer (general)	☐ Doctor/Medical Officer (general)	☐ Doctor/Medical Officer (general)
☐Paediatrician ☐ N/A (we do not conduct perinatal death audits in this facility)	☐Paediatrician ☐ N/A (we do not conduct perinatal death audits in this facility)	☐Paediatrician ☐ N/A (we do not conduct perinatal death audits in this facility)

MDSR Committee	PDSR Committee	Combined MPDSR Committee
☐ Neonatologist ☐ N/A (we do not conduct perinatal death audits in this facility)	☐ Neonatologist ☐ N/A (we do not conduct perinatal death audits in this facility)	☐ Neonatologist ☐ N/A (we do not conduct perinatal death audits in this facility)
☐ Obstetrician	☐ Obstetrician	☐ Obstetrician
☐ Anaesthetist	☐ Anaesthetist	☐ Anaesthetist
☐ Laboratory technician	☐ Laboratory technician	☐ Laboratory technician
☐ Pharmacist	☐ Pharmacist	☐ Pharmacist
☐ Community representative	☐ Community representative	☐ Community representative
☐ Other (please specify):	☐ Other (please specify):	☐ Other (please specify):

11. How frequently do **maternal mortality audits** take place?
    ☐ Only after a death
    ☐ Regularly, at least monthly
    ☐ Regularly, at least quarterly
    ☐ Other (please specify):
    _____

12. How frequently do **perinatal mortality audits** (stillbirths and newborns within the first week) take place?
    ☐ Only after a death
    ☐ At least monthly
    ☐ At least quarterly
    ☐ Other (please specify):

13. How often do you hold MPDSR meetings?
    ☐ Only after a death
    ☐ At least monthly
    ☐ At least quarterly
    ☐ Other (please specify):

14. Is attendance in MPDSR committee meetings mandatory for all committee members?
    ☐ Yes ☐ No ☐ Unsure

15. How are members of MPDSR committees selected (check all that apply)?
    ☐ Membership is pre-specified based on national guidelines
    ☐ Membership is pre-specified based on facility guidelines
    ☐ Members are selected by the facility manager
    ☐ Members are selected by the nurse/midwife in charge of the maternity unit
    ☐Members are selected by the obstetrician/doctor in charge of the maternity unit
    ☐ Staff volunteer to participate
    ☐ Other (please specify):

16. What is the title of the most senior staff member or administrator normally present at MPDSR meetings?
    ☐ Facility manager
    ☐ Facility manager
    ☐ Head of OB-Gyn
    ☐ Head of Pediatrics/neonatalogy
    ☐ Midwife/nurse Maternity in-charge
    ☐ Nurse in charge of sick newborn unit (e.g. NICU)
    ☐ Other (please specify) _____

17. Who usually runs the MPDSR meetings?
    ☐ We rotate among committee members
    ☐ Facility manager
    ☐ Head of OB-Gyn
    ☐ Head of Pediatrics/neonatalogy
    ☐ Midwife/nurse in-charge of maternity
    ☐ Nurse in-charge of sick newborn unit (e.g. NICU)
    ☐ Other (please specify) _____

18. What is discussed at the meetings (describe what happens at the meetings)?
    _____

    _____

19. Are meeting minutes completed for every MPDSR, MDSR and PDSR meeting?
    ☐ Yes ☐ No

    Assessor document review: please ask to see the minutes from prior MPDSR meetings and check all that apply:
    ☐ Minutes specify recommended actions from death reviews
    ☐ Minutes include information on the status of recommendations from prior death audits (e.g. implemented, in progress, not started)
    ☐ Minutes do not include names of individual staff (health workers)
    ☐ There are meeting minutes from meetings held over 1 year ago
    ☐ Other (please specify) _____

Building the Skills of Health Workers to Implement MPDSR – Training and Supervision

20. Please answer the following questions about **MPDSR, MDSR, PDSR training activities for health workers in your facility** (*please check all that apply)*

	Yes	No
The facility management regularly organizes training activities to build MPDSR skills of staff in this facility	☐	☐
Regional/District health managers regularly organize training (on-site or off-site) to build MPDSR skills of staff in this facility	☐	☐
On-site combined MPDSR training was held at least once in the past year	☐	☐

	Yes	No
On-site MDSR training was held at least once in the past year	☐	☐
On-site PDSR training was held at least once in the past year	☐	☐
Off-site combined MPDSR training, in which at least 1 staff member participated, was held at least once in the last year (e.g. workshop organized at regional or district level)	☐	☐
Off-site MDSR training, in which at least 1 staff member participated in the last year, was held at least once in the last year? (e.g. workshop organized at regional or district level)	☐	☐
Off-site PDSR training in which at least 1 staff member participated in the last year (e.g. workshop organized at regional or district level)	☐	☐

21. Please answer the following questions about **supervision of MPDSR activities in your facility** (*please check all that apply)*

Supervision visits in our facility usually include (check all that apply):	Yes	No
Review of primary death data (e.g. patient charts, maternity registers, etc.)	☐	☐
Review of MPDSR reports	☐	☐
Review of MPDSR committee meeting minutes	☐	☐
Review of death review follow-up actions	☐	☐
Other (please add):		

MPDSR Cycle: Identifying and Notifying Deaths

22. From which facility information sources are **maternal** deaths identified? (*Let the respondent answer first, then probe for different areas of facility)*
    - ☐ ANC register
    - ☐ Emergency care register
    - ☐ General adult inpatient ward
    - ☐ Labour and delivery register
    - ☐ Outpatient department register
    - ☐ Postnatal register
    - ☐ Other, specify: _____

23. From which facility information sources are **stillbirths** and **neonatal deaths** identified in this facility?
    - ☐ Emergency care register
    - ☐ Labour and delivery register
    - ☐ Routine Postnatal Care register
    - ☐ Labour and delivery register
    - ☐ Routine Postnatal care register
    - ☐ Sick Newborn or Neonatal Intensive Care Unity (NICU) register
    - ☐ Other, specify:

24. Does your facility routinely notify authorities if there is a maternal death? ☐ Yes ☐ No
25. Does your facility routinely notify authorities if there is a stillbirth? ☐ Yes ☐ No
26. Does your facility routinely notify authorities if there is a neonatal death? ☐ Yes ☐ No
27. Are maternal deaths that occur in the community included in the facility's monthly HMIS report?
    ☐ Yes ☐ No

28. Are perinatal deaths that occur in the community included in the facility's monthly HMIS report?
    ☐ Yes ☐ No

MPDSR Cycle: Collecting Information

29. What documents are used to compile information for death review meetings?
    ☐ Patient charts / case notes
    ☐ Registers
    ☐ Death notification form
    ☐ None
    ☐ Other, specify:
    _____

30. In your opinion, do the medical records and registers capture the necessary information for assessment of cause of death and contributing factors for maternal and perinatal deaths?
    ☐ Yes ☐ No

    If yes, why? If no, why not?
    _____

31. Do you have any concerns about the **quality of information on maternal** deaths in the facility?
    ☐ Yes ☐ No

32. Do you have any concerns about the quality of information on **stillbirths** in this facility?
    ☐ Yes ☐ No

33. Do you have any concerns about the quality of information on **neonatal deaths** in this facility?
    ☐ Yes ☐ No

    If yes, why? If no, why not?
    _____

34. How are maternal and perinatal deaths selected for review? (please check all that apply):
    ☐ Every maternal death is reviewed
    ☐ Every perinatal death is reviewed
    ☐ A sample of maternal deaths are reviewed; *please describe selection approach below**
    ☐ A sample of perinatal deaths are reviewed; *please describe selection approach below***
    ☐ Other (please specify):

    How are maternal deaths selected for review? _____

    How are perinatal deaths selected for review (e.g. sample of perinatal deaths)?
    _____

35. Are maternal deaths occurring in the community reviewed by facility staff?
    ☐ Yes, almost always
    ☐ Yes, occasionally
    ☐ No

36. Are perinatal deaths occurring in the community reviewed by facility staff?
    ☐ Yes, almost always
    ☐ Yes, occasionally
    ☐ No

MPDSR Cycle: Analysing Data and Presenting Results

Assessor Document Review:

37. Is there is a standard form for reviewing maternal deaths available in the facility? ☐ Yes ☐ No
    If yes, please ask to see the form and check whether the standard form includes the following information (check all that apply):
    ☐ Cause of death
    ☐ Modifiable factors that contributed to the death
    ☐ Recommended actions (responses)

38. Is there is a standard form for reviewing perinatal deaths available in the facility? ☐ Yes ☐ No
    If yes, please ask to see the form and check whether the standard form includes the following information (check all that apply):
    ☐ Cause of death
    ☐ Modifiable factors that contributed to the death (stillbirth or neonatal)
    ☐ Recommended actions (responses)

39. What, if any classification system, is used to classify and standardize cause of maternal and perinatal deaths in this facility (check all that apply)?
    ☐ ICD-10
    ☐ ICD-MM
    ☐ ICD-PM
    ☐ None
    ☐ Modified ICD-10 (not ICD MM or ICD MM) (please describe below)
    ☐ Other (please specify) _____

40. Does the mortality review ever result in a change to the cause of death, as compared to the cause of death recorded in the facility records (e.g. death notification report, HMIS report, maternity register)? ☐ Yes ☐ No

    Assessor Document Review: Please ask to see the standard mortality audit form(s) used in the facility; check which system is used to classify deaths in the standard form:
    ☐ No classification system
    ☐ ICD-10
    ☐ ICD-MM
    ☐ ICD-PM
    ☐ Modified ICD-10 (not ICD MM or ICD MM) (please specify)
    ☐ Other (please specify):
    _____

41. Which approach is used to analyse and classify modifiable factors that contributed to a **maternal death**?
    - ☐ 3 delays model
    - ☐ Root cause analysis
    - ☐ Patient – Provider – Administrator
    - ☐ None
    - ☐ Other (please specify):

    _____
42. Which approach is used to analyse and classify modifiable factors that contributed to a **perinatal death**?
    - ☐ 3 delays model
    - ☐ Root cause analysis
    - ☐ Patient – Provider – Administrator
    - ☐ None
    - ☐ Other (please specify):

    _____

Assessor observation:

43. Are there data related to MPDSR processes displayed anywhere in the facility (e.g. on a wall)?
    ☐ Yes ☐ No ☐ Unsure

    If yes, what kinds of data are displayed (check all that apply):
    - ☐ Trends in Maternal deaths (e.g. #'s, causes)
    - ☐ Trends in Stillbirths (e.g. #'s, type)
    - ☐ Trends in Neonatal deaths (e.g. #'s, causes)
    - ☐ Proportion of deaths audited
    - ☐ Implementation of recommended changes (after death reviews)
    - ☐ Frequency of death audit meetings
    - ☐ Other (please specify) _____

MPDSR Cycle: Recommending Solutions

44. How does the mortality review team develop recommendations during death reviews?

    _____

    _____

    Assessor Observation: Review 3-5 completed death review forms and check which criteria are met in most of the forms:
    - ☐ Modifiable factors contributing to the deaths are clearly defined
    - ☐ Recommended actions are based on documented preventable modifiable factors
    - ☐ Recommendations are specific and actionable
    - ☐ Individuals are designated to follow up on specific recommended actions
    - ☐ Other (please specify): _____

MPDSR Cycle: Implementing Changes

45. Are individuals assigned to follow up on specific recommendations?
    ☐ Yes ☐ No ☐ Unsure
    If yes, how is this assigned?

    _____

    _____

46. Is there a systematic process for reporting back to the MPDSR committee on the status of recommended actions (e.g. completed, not completed, in process? ☐ Yes ☐ No
47. Is there a written documentation system for tracking the follow-up of specific recommendations?
    ☐ Yes ☐ No ☐ Unsure

48. In your opinion, what are common barriers to implementing recommendations following mortality reviews (please do not prompt the interviewees; write in answers and check any itemized barriers (below) that are spontaneously identified by interviewees)?

    _____

49. Barriers to implementing recommendations spontaneously identified by interviewees (check all that are reported by interviewees):
    ☐ Lack of MOH leadership/support
    ☐ Lack of Facility leadership/support
    ☐ Lack of communication across system levels
    ☐ Weak referral system
    ☐ Non-availability of essential commodities
    ☐ Non-availability of qualified, competent personnel
    ☐ Non-availability of resources/finances to make needed changes
    ☐ Lack of community engagement
    ☐ Harmful local practices

50. Can you describe a change that was made in this facility based on a mortality audit recommendation?
    ☐ Yes ☐ No

If yes, please describe the change: _____

51. Are successfully implemented actions shared with health workers in this facility?
    ☐ Yes ☐ No ☐ Unsure

52. Are the findings and follow up of death reviews shared with community members?
    ☐ Yes, usually ☐ Yes, sometimes ☐ No

Avoiding Blame and Ensuring Confidentiality

53. Is there a formal code of conduct for MPDSR meetings in the facility? ☐ Yes ☐ No

54. If yes, are MPDSR committee members required to sign the meeting code of conduct?
    ☐ Yes ☐ No

Assessor Document Review: Ask to review a printed or electronic version of the code of conduct for MPDSR meetings. Check all that apply:

☐ Specifies that individual staff names will not be included in meeting discussions
☐ Specifies that individual staff must sign the meeting code of conduct
☐ Specifies that individual staff names will not be included in any death audit documents
☐ Other (please specify): _____

Assessor Document Review: Ask to see at least 3 death review (audit) reports. Are the names of individual staff members included in any of the death audit reports? ☐ Yes ☐ No ☐ Unsure

If yes, please describe:

_____

55. As health workers in this facility do you perceive any connection between professional disciplinary action and MPDSR processes in this facility (please check "yes" if at least one interviewee responds yes): ☐ Yes ☐ No ☐ Unsure

    If yes, please describe:

    _____

56. Do you see any risks associated with the M/PDSR process (please check "yes" if at least one interviewee responds yes)? ☐ Yes ☐ No ☐ Unsure

    If yes, please describe:

    _____

Linkages between Quality Improvement and MPDSR in this Facility

57. Is there a strategy for improving quality of maternal and perinatal care for women and neonates in your facility?
    ☐ Yes
    ☐ No
    ☐ I don't know

58. Please "check" which MPDSR structures and staff positions exist at various levels in your facility:

	Yes	No
a. There is a combined QI and MPDSR committee (i.e. a single committee that oversees QI and MPDSR activities)	☐	☐
b. There is a distinct QI committee that oversees QI activities	☐	☐
c. There is a single facility staff position that oversees facility QI and MPDSR activities	☐	☐
d. There is a single facility staff position that oversees facility MPDSR activities (e.g. QI Coordinator)	☐	☐
e. There is a single facility staff position that oversees facility QI activities (e.g. QI Coordinator)	☐	☐

59. If there are separate QI and MPDSR committees at the facility level, do they share any common members?
    ☐ Yes
    ☐ No
    ☐ Not applicable (no distinct QI and MPDSR committee at the facility)

60. In your view, is the MPDSR committee generally aware of QI objectives and activities in your facility?
    ☐ Yes, very aware
    ☐ Yes, somewhat aware
    ☐ No, not aware

61. In your view, is the QI committee generally aware of MPDSR objectives and activities in your facility?
    ☐ Yes, very aware
    ☐ Yes, somewhat aware
    ☐ No, not aware

Final Reflections

62. What factors facilitate MPDSR processes in your facility (e.g. death notification, death reviews, implementing recommended actions, MPDSR meetings, preparation of MPDSR reports, etc.)?

63. What are barriers / obstacles to implementing MPDSR processes in your facility?

64. What changes would help strengthen MPDSR in your facility?

65. In your view how useful is MPDSR for reducing preventable maternal deaths in your facility?
    ☐ Very useful ☐ Somewhat useful ☐ Not useful

    Why? _____

66. In your view how useful is MPDSR for reducing preventable stillbirths and neonatal deaths in your facility?
    ☐ Very useful ☐ Somewhat useful ☐ Not useful

    Why? _____

Thank you very much for taking the time to answer my questions and for assisting with this MPDSR assessment.

67. Is there anything else you would like to share today about MPDSR in your facility?

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