RESPONDING TO MATERNAL DEATH AT FACILITY LEVEL

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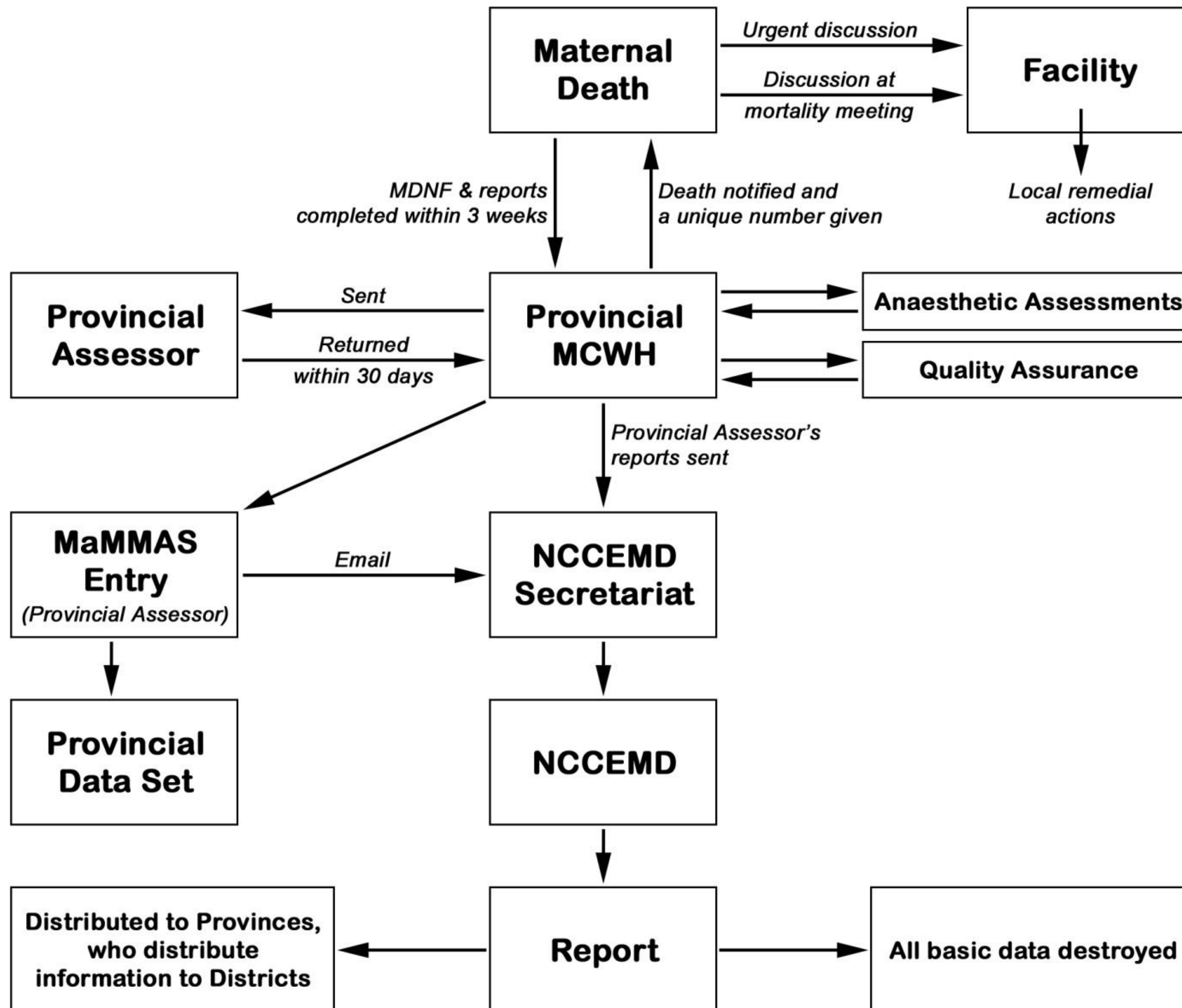
for the NCCEMD

NCCEMD PROCESS



AN AUDIT THAT GOES *"BEYOND THE NUMBERS"*

- Identify maternal deaths
- Analyse each death in detail to establish cause, underlying factors, problems in clinical management , and problems in the functioning of the health system.
- Use the information to identify major problems ('avoidable' or 'modifiable' factors) and recommend solutions.

Data collection is currently predominantly facility based so does not comprehensively explore community based factors

MDNF CHECKLIST

Actions after a maternal death in facility		
	Time framework (since death)	Date
Inform senior clinical manager in facility*	immediately	
Inform next of kin and arrange for supportive counselling	immediately	
Preliminary discussion of death by all those involved	within 3 days	
Notify provincial maternal death coordinator	within 3 days	
Inform district specialist team	within 3 days	
Discussion of death at facility M&M meeting	within 4 weeks	
Completion of MDNF	within 4 weeks	
Final submission of MDNF and copies of all relevant documents	within 4 weeks	

**Discuss need for postmortem; forensic or medical interest*

MORTALITY MEETINGS AT LOCAL INSTITUTION

- It is very important that the maternal death is discussed at the institution where it occurred.
- This allows for team discussion, joint assessment of avoidable factors and plans for remedial action where necessary.
- Doctors, midwives, and administrative staff should attend, and where relevant anaesthetists
.

MDNF: information to be provided by facility

- Demographic details of deceased
- Antenatal care and labour details
- HIV status
- Interventions for critical event
- Case summary
- Facility assessment of cause of death and avoidable factors

Case Summary

- This is very important
- It is the story of the sequence of events leading up to the maternal death.
- Time sequence of events very useful.
- Indicate cadre of staff involved.
- If available include information from relatives concerning events before admitted.
- NB! This all confidential information and will not be divulged for legal or disciplinary matters.

MDNF checklist (cont)

Final submission			
Item	Included	Not available	Not relevant
Completed MDNF signed by health worker and countersigned by senior clinical manager		xxxxxxxxx	Xxxxxxx
Copy of medical notes (must include all records from other facilities visited before facility where died			Xxxxxxxx
Copy of nursing notes			Xxxxxxxx
Copy of maternity case records			
Copy of all theatre records			
Copy of anaesthetic records			
Copy of post-mortem report (or verbal report)			

LOCAL REMEDIAL ACTIONS

- A Maternal death in an institution is a very distressing and traumatic event – for family, but also for staff involved.
- Family and staff require supportive counselling.
- However, it is important to use the M+M meeting to discuss what lessons can be learnt and suggest what may be necessary to prevent a similar kind of death from recurring.

FACILITY and NATIONAL RESPONSES

Facility

- Discussion of maternal death at the facility with ***all*** relevant personnel.
- Identification and implementation of local remediable action.

National

- Consultative meetings to identify key recommendations and dissemination of reports nationally, regionally and at district level

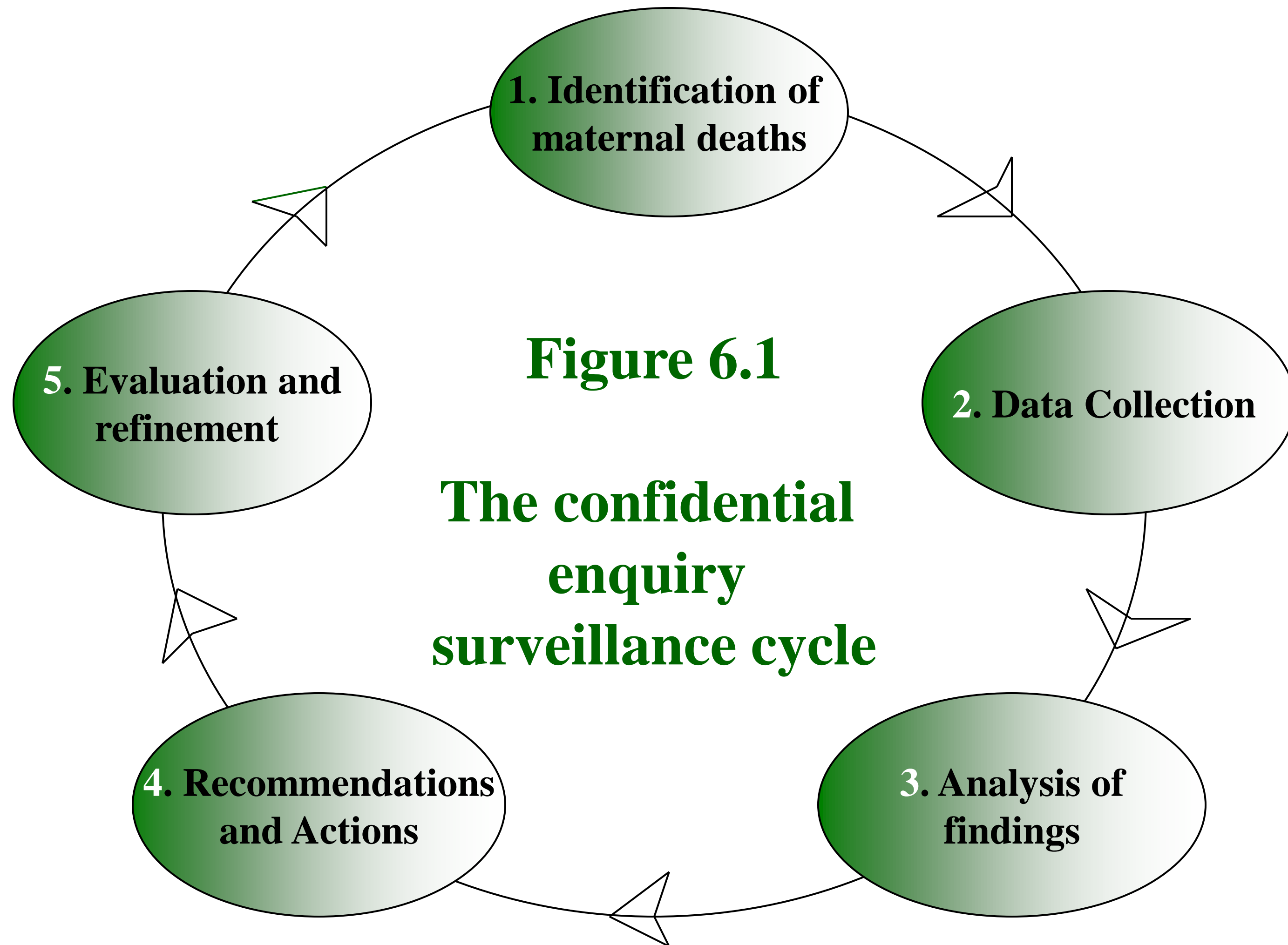


Figure 6.1

The confidential enquiry surveillance cycle

Thank you