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## Hospital care for children: quality assessment and improvement tool

A systematic standard based  
participatory approach



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# **Hospital care for children: quality assessment and improvement tool**

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approach**

*Second Edition (2015)*

## **ABSTRACT**

This tool allows for a systematic, participatory assessment of the quality of care provided to children at hospital level, and for developing a plan of action to improve quality of care. The primary use of the tool falls within the scope of a quality improvement approach at national level. When used within country-wide programmes the tool produces recommendations for national health authorities on how to improve the health system performance across its main functions, (i.e. governance, financing, human resources, essential medical products and technologies, health information systems, and service delivery). The tool can also be used in a single facility for internal audit purposes. Additional important functions of the tool include developing local capacities (through a peer to peer model) and promoting the adoption of evidenced based guidelines.

This second edition of the tool has been updated according to the new evidence and recommendations, previous experiences and lessons learned, and current emphasis given to patients' rights and equity.

## Keywords

CHILDREN  
CHILDREN, HOSPITALIZED  
HEALTH POLICY  
HOSPITALS  
QUALITY ASSESSMENT, HEALTH CARE

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## **Acknowledgments**

This is an updated edition of the tool for assessing quality of paediatric care at hospital level based on the generic paediatric assessment tool developed by WHO Headquarters in 2001 and adapted for use in the European region in November 2009. The previous versions of the tool, as well as this technical update were developed by the WHO Collaborating Centre for Maternal and Child Health at the Institute for Maternal and Child Health IRCCS Burlo Garofolo Trieste, Italy. The primary authors of this updated version are Marzia Lazzerini and Giorgio Tamburlini.

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# Preface

## **Rationale of the tool**

Quality of care (QoC) has been recognized by the international community as a key aspect of the unfinished mother, newborn and child health agenda (1). This is true globally both in developed and developing countries. Besides hampering the achievement of desired health outcomes, low QoC prevents the fulfilment of the right to health of women and children and may cause inefficiency and unjustified direct and indirect costs for both the health systems and individual households. To achieve a substantial reduction in maternal and child mortality, improvements are needed both in coverage and in QoC. As highlighted in several studies and country experiences, programs that have improved coverage alone have failed to achieve the expected reduction of maternal and child mortality and morbidity (2, 3). Various approaches to quality assessment and quality improvement have been proposed over time (4, 5). Systematic reviews on quality improvement approaches and an analysis of facilitators and barriers to QoC in maternal, newborn and child health have been recently published (6,7). However, the evidence-base on the effectiveness and efficiency of different quality improvement approaches and tools at hospital level in low and middle income countries is still relatively weak (6,7). Some of these approaches, and particularly those used in Western Europe, North America and Australia for accreditation to excellence, require considerable financial and human resource investments and cannot be afforded by the majority of low-resource health systems. Approaches focusing on single or few aspects of care have been used as a way to introduce the concept of quality improvement but have lacked a systematic evaluation of the whole continuum of care particularly across different services. Many approaches focus on the availability of the essential infrastructure, equipment, commodities, and/or on the existence of written procedures and protocols, but fail to assess the actual case management. Evidence shows that even when all the necessary structural components are available the QoC may still be poor, since what ultimately matters is the appropriate use of the available infrastructure, staff and commodities to ensure effective case management (3, 8). Finally, quality assessment alone cannot guarantee that any change will take place; use of the information gathered during the assessment to develop an action plan is a necessary step in every quality improvement process.

## **Previous experience with the tool and lessons learnt**

The first version of this paediatric hospital quality assessment tool was developed by WHO in 2001 (8). The tool was adapted for use in the European region and revised in content in 2009. A tool with similar structure, evaluating quality of hospital care provided to mothers and newborns was also developed in 2009 (9). Overall the paediatric quality assessment tool has been used in several countries in Europe, Central Asia, Africa, and South East Asia by a variety of international agencies, donors and NGOs, within country-wide programs as well as in single facilities, after adaptation for use in different epidemiological and health system contexts (3, 10-19). The WHO maternal and newborn tool (9) has also been widely used across different regions (20-26).

A systematic, participatory, action-oriented approach to quality improvement can be an important agent of change through a variety of mechanisms. These mechanisms include improved knowledge of international guidelines and recommendations, peer review of hospital practices through a multi-professional and supportive approach, and detailed action plans developed with clear time-lines and responsibilities at facility level. When used within country-wide programs these tools produced recommendations for health authorities at national level to improve the health system performance across its main functions, (i.e. governance, financing, human resources, essential medical products and technologies, health information systems, and service delivery) (3,8,11). Most importantly, when a second assessment could be organized to evaluate the effects of the quality improvement process, sustained improvement in QoC was documented (8,11,25). Since this tool was first developed there have been changes in evidence-based practice, and more emphasis has been given to patients' rights and equity (6,27,28). The revised version of the tool has also taken into account previous experiences and lessons learned on how to best use it. The guiding principles on which the tool is based are summarized in Box 1.



## Box 1. Guiding principles of the tool

1. Coverage needs to be complemented by Quality of Care (QoC) to achieve the desired health outcome.  
▶ *The tool is aimed at assessing and improving QoC.*
2. Checking availability of basic equipment and supplies is necessary but not sufficient to evaluate QoC; appropriate use of resources and case management also need to be assessed.  
▶ *The tool is divided into sections, evaluating availability and appropriate use of resources, case management, and key hospital policies.*
3. Focusing on single key interventions is not enough; quality child care requires systematic attention to all the main components that can guarantee continuum of care.  
▶ *The tool evaluates several different aspects of health care, at different times points (from access, to case management in hospital, monitoring, case referral, discharge and follow up) and across different services.*
4. Effective clinical management alone is not enough to ensure QoC; holistic and culturally appropriate care is necessary. A health system should ensure that all patients' rights are met, not only the right to effective clinical management.  
▶ *Users' views, together with health staff views, are collected by the tool through structured interviews. A chapter is dedicated to the assessment of meeting the rights of women and children.*
5. All children have the right to equitable, effective, safe, timely, efficient and child friendly care  
▶ *Assessment of children's rights include the assessment of equity, effectiveness safety and continuity of care and cannot be separated from the children's and their caretakers' rights to respectful, culturally appropriate and holistic care.*
6. A participatory approach is needed for raising awareness of problems and for building commitment.  
▶ *The tool is based on a problem-solving, participatory approach with full involvement of hospital managers, health professionals, caretakers and older children and adolescents.*
7. A blaming attitude and punitive approach causes denial and /or hiding of problems, decreased work satisfaction and motivation, and increased barriers to quality improvement.  
▶ *The focus of the tool is on the system, and not on the individual, with a non-blaming, supportive approach.*
8. Assessment is the first step to trigger a quality improvement cycle and, in order to be effective, it should be combined with planning for action.  
▶ *The assessment is undertaken in an action-oriented way that facilitates identification and prioritisation of problems and the development of a plan for action. Matrixes for planning are included in the tool.*
9. Both capacities and commitment are needed to improve QoC.  
▶ *The assessment is also a training and motivating activity; international standards and best practices are presented during the assessment through a peer-to-peer approach to serve as models for improvement. Local capacity is developed as a result of the process at both facility, sub-national, and national level.*
10. Health system factors need to be considered when planning quality improvement intervention  
▶ *When applied over a representative sample of health facilities, the assessment indicates gaps in key health system functions that need to be addressed at national level.*

## Technical update for the 2015 edition

This tool was technically updated by the WHO Collaborating Centre in Mother and Child Health, Trieste, Italy, which also contributed to the previous versions of the tool, including the first generic tool developed in 2001 for WHO Headquarters and the 2009 version adapted for use in the European Region. The updating process included:

1. review of main lessons learnt in the use of the previous versions of the tool;
2. definition of guiding principles;
3. review of the clinical standards, mainly based on the 2<sup>nd</sup> edition of the WHO Pocket Book (29);
4. development of the draft revised version;
5. external review by a panel of international experts;
6. tool finalization.

Substantial changes were made in this second edition of the tool, compared to its previous version, published in 2009. First, the structure of the tool was modified to conform with the WHO tool "Hospital care for mothers and newborns: quality assessment and improvement tool", also developed by the WHO Collaborating Centre for Maternal and Child Health Trieste Italy, and published by WHO Regional Office for Europe in March 2014 (28). Both tools are now divided in five sections to provide a better framework for analysis, as well as additional instruments for planning. Second, the contents of the tool were updated, in order to incorporate the last WHO guidelines and recommendations as well as other international standards. Content revision was also based on previous experience in the use of the tool, and on epidemiology of diseases in WHO European Region. More specifically, Chapter 1,2 and 10-13 were completely restructured. Chapter 7 on chronic conditions was completely revised, adding new sections to evaluate QoC for common chronic diseases (such as asthma, diabetes, cystic fibrosis, celiac disease). Chapter 13 on child rights has also been reviewed and expanded. This chapter is now entitled "Child rights to accessible (equitable) respectful and child friendly care" reflecting that the most important child right is the right to accessible effective and safe care (while it would be useless, for example, to look at pain relief and play therapy in situations when children are admitted without indication and unnecessary painful diagnostic or therapeutic procedures are already applied- note that this example is particularly relevant for the CEE/CIS Region-). Several key items were also revised in each chapter. A series of annexes and checklists has been added in this new version of the tool, to further standardised the assessment.

In selecting reference standards , priority was given to WHO guidelines and recommendations, and particularly to the WHO Guidelines for Hospital care for Children, 2<sup>nd</sup> Edition (29). If no guideline or recommendation from WHO was available, other references were evaluated using the following pre-defined order of importance: other high quality guidelines or recommendations based on evidence; systematic reviews; primary studies. When no scientific evidence was available, position papers or other official recommendations from international societies or agencies were used. In a very few instances expert opinion was adopted when none of the previous evidence was available. Overall, several new references were added to this updated edition of the tool, in line with the WHO tool "Hospital care for mothers and newborns: quality assessment and improvement tool (28).

Several annexes were also added to the tool, with the aim of standardising the assessment as much as possible. This revised version of the tool also includes a list of quantitative indicators to evaluate adherence to WHO Guidelines (Annex 3.1). The indicators have been field tested and used for quality assessment in several countries (Kyrgyzstan, Ukraine, Moldova and Kosovo Region).

The evaluation of the quality of newborn care is not included in this tool, while it is comprehensively treated in the WHO Maternal and newborn quality assessment and improvement tool (28).

The structure and contents of this second edition of the tool are explained in details in the following section.

## **Structure and content of the tool**

The structure of the tool has been made as consistent as possible with the WHO tool for assessing and improving mothers' and newborn care, developed by the WHO CC in Trieste for the WHO European Office in 2014 (28). The tool is organized in five main sections as follows

### **1) *Support services***

This section guides the assessment of the physical infrastructure, staff, availability of medicines, equipment and supplies.

### **2) *Case management***

This section includes eight chapters assessing essential case management practices for children at hospital level, plus a chapter dedicated to clinical monitoring. Overall, more than 50% of the total items of the tool relate to case management. The focus on case management is crucial to promote the idea that case management is the most important dimension of quality and that in many cases substantial improvement in case management is possible with existing resources, without major external input.

### **3) *Policies***

This section includes four chapters assessing the existence, contents and implementation of hospital policies. Policies to ensure infection prevention, guidelines development and dissemination, staff training, audit systems, access to hospital and continuity of care, and children's rights are assessed in this section. In agreement with the principle that children's first right is to safe and effective care, the section on children's rights to respectful and holistic care is seen as a complement of the sections on quality of case management and availability of essential drugs, equipment and basic facilities.

### **4) *Interviews with the staff and interviews with mothers***

This section collects information on case management, organisational aspects of care, children's rights, and overall services from the perspective of health professionals, mothers and other caretakers, children and adolescents. The questionnaires have been modified taking into account previous experiences and the need to maintain consistency with the contents of the other sections of the tool.

### **5) *Feedback on findings and plan for action***

The importance of well planned feedback meetings, at both facility level - with the hospital managers and staff - and at national level - with Ministry of Health and other partners - is emphasized in this new version of the tool. These feedbacks represent key steps in moving forward along the Quality Improvement cycle by proposing and planning actions. Compared to the first edition of the tool, this section has been expanded to include new instruments to guide the conception of action plans at both facility and national level.

For each chapter and subchapter, a set of key items is evaluated, based on standards. References on the standards used to design the assessment are listed at the end of each section.

# How to use the tool

## Purpose of the tool

### ***Country assessment and single hospital assessments***

- The primary use of the tool falls within the scope of a quality improvement approach at a national level (30). The tool is meant to aid Ministries of Health (MoHs), key partners and stakeholders to carry out an evaluation of the QoC provided at hospital level, to identify key areas that need to be improved, and to develop specific action plans. When the tool is used for country-wide assessments, an adequate sample of hospitals should be assessed to represent all levels of care, regional differences and management characteristics (public, private-no-profit and private-for-profit). Such sample will provide results that can be generalized to the whole network and/or to specific subgroups of health facilities.
- The tool can also be used in a single facility for internal audit purposes.

### ***Additional functions***

The assessment tool is also useful to:

- ◆ introduce the concept and the contents of international guidelines and evidence-based health care and to promote the implementation of WHO recommendations and of other international standards in clinical practice;
- ◆ introduce the concepts of quality improvement, supportive supervision, participatory assessment, peer review and professional case reviews, and to promote respectful care;
- ◆ build capacity among national experts and local staff in leading a process of quality improvement;
- ◆ provide information for certification and accreditation schemes and performance-based incentives for health facilities or specific departments and units.

The tool was originally developed to assess the quality of generic paediatric care for the most common paediatric conditions. While the tool is not suitable for assessing specialised care, it includes the assessment of basic care that should be provided for all the most common child conditions, including growth failure, anaemia, and now major chronic diseases, as well as acute conditions. Other tools should be used to evaluate very specialised care. For example, a tool for assessing the QoC of paediatric haematology and oncology was developed in 2013, piloted in Albania and is available upon request<sup>1</sup>.

## Using the tool in practice

### ***Step 1. Preliminary arrangements and selection of the assessment team***

- This tool has mainly been used in collaboration projects involving WHO Regional and Country offices and Ministries of Health for country evaluations. Other international agencies, such as UNICEF, institutions and NGOs have also used it. Possible partners to support the activity should be identified, contacted and involved at an early stage. General timelines for the activity and the number of facilities to be assessed are discussed at this stage.
- At least in the initial phase of a country-wide assessment, it is recommended that an international team of experts works together with a national team, to provide guidance and

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<sup>1</sup> Enkeleida Thartori, Giulio Zanazzo and Giorgio Tamburlini. Doctoral thesis. University of Trieste, Italy. Assessment tool for the QoC in paediatric haematology and oncology, 2013.

coaching and to build the capacity for quality assessment. The presence in each team of at least one international assessor with previous experience in the use of the tool is crucial in order to ensure that standard methods are used, to provide an example of appropriate supportive supervision and peer review attitude and to ensure that an independent point of view, which national assessors may find difficulty to express, is represented.

- The team of assessors should be composed by senior paediatricians. The participation of paediatric nurses should be encouraged to promote nursing staff role and capacity. Professionals with adequate training and experience in interviewing (ideally a psychologist or sociologist) should also be part of the team; ability to speak local language may be crucial for this team member.
- The team of assessors is usually composed by one international paediatrician, (appointed as a team leader) and a variable number of national assessors, usually from a minimum of 2 to a maximum of 8, to ensure that a pool of national experts will be available for subsequent activities.
- National assessors need to be experienced and well recognised professionals. They should not be staff members or have management responsibility in the hospitals that they are to assess.
- It is essential that the members of the assessment team know the international standards very well and particularly the WHO Guidelines for hospital Care for Children (the “Pocket Book”). National assessors should have good clinical experience in paediatric care, be familiar with the principles of evidence based health care, and be able to access WHO recommendations and other international standards.
- It is also essential that the members of the assessment team have the capacity to maintain a supportive, peer-to-peer attitude during the assessment, as well as a good capacity to manage time efficiently, to collect information from multiple sources and to analyse them consistently and according to the instructions.
- If the assessment is organized by WHO Country Office it is recommended that a representative from the office takes part in at least one assessment to provide support and fully understand the approach and its implications. Similarly, if the evaluation is organized by other agencies, the participation of a representative will ensure that the process and the importance of adequate follow-up of the actions to be implemented, are fully understood.

### ***Step 2. Local adaptation***

- The tool was developed as a generic framework to be adapted to the epidemiology and health system structure at country/local level. The tool has been developed to assess general paediatric care and as such can be used in hospitals of different levels, from small district hospitals to tertiary care centres, provided that the assessment is limited to the common diseases that have been included.
- If a translation of the tool into the local language is required for the national assessors or for the purposes of the interviews, the translation should either be carried out by a professional translator and reviewed by an expert in the field of paediatric health, or directly entrusted to a health professional with good knowledge of English.

### ***Step 3. Preparing for the assessment visit***

- Preliminary information on the objectives and methods of the assessment must be communicated to the local health authorities before making arrangements with hospital managers and key staff.
- The criteria for selecting the hospitals to be assessed should be explicitly discussed and agreed upon. Selection of facilities may follow different criteria, depending also on the objective of the assessment. When the assessment is performed with the objective of obtaining a description of the quality of the hospitals services for children in a country, efforts should be made to ensure that a representative sample is identified, avoiding show-case hospitals. Different criteria may be applied if the assessment focuses on specific issues, such as

availability/quality of facilities in hard to reach areas, or in facilities that had been left out in previous interventions.

- A detailed timetable of the assessment visit must be drawn up by local authorities in collaboration with the assessment team leader.
- Adequate time for the assessment must be ensured. The time needed to evaluate one facility is, on average, one full day, with variations based on hospital size. When developing the timetable, travel time should be considered as well as local working hours and holidays. The assessment is quite an intensive activity and arrangements should take into account that also assessors need adequate time to rest when several assessments are concentrated in a short period of time.
- Prior to the visit, written information should be sent to all hospitals that will be assessed and should include: a) the purpose of the assessment; b) its supportive, action-oriented approach; c) the list of services that will be visited; d) a proposed timetable; e) any information or document that will be needed for the assessment (e.g. hospital statistics). Providing adequate information prior to the visit will avoid spending additional time during the visit.
- The first chapter of the tool should be sent to the hospital management before the visit with a request to provide the relevant information. This will help raise awareness regarding the assessment but cannot be a substitute for external assessment, as the information provided prior to the visit will need to be checked directly by the assessors so that any discrepancy can be discussed.
- An adequate number of copies of the tool (at least one copy for each hospital and for each assessor, plus one for the hospital managers) should be printed, as well as an adequate number of interview forms.
- A one-day workshop is required to train the national assessors. The scope of this workshop is to ensure that every assessor understands the tool structure and use. If needed, clarifications should be provided on the evidence underpinning the reference standards. A common understanding of the scoring system should be established by carrying forward some practical exercise. Interviewers should attend the workshop and principles and methods for interviewing mothers and hospital staff (confidentiality and anonymity) should be discussed. How to incorporate the findings from the interviews in the overall assessment should also be clearly discussed. Adequate time should be given to discussion among national and international assessment team members before starting the assessment, so that any doubts about the methods are clarified.
- New team members will need to be supervised during the assessment by experienced assessors until they are fully acquainted with the tool and have acquired the appropriate principles, skills, practice and attitude of confidential and supportive peer-to-peer assessment.
- If one or more interpreters are needed, ensure that they receive a copy of the tool in both languages prior to the beginning of the assessment and that they have adequate familiarity with medical terms.

#### ***Step 4. Presenting the aim, objectives and methods of the assessment at hospital level***

- The visit starts with an introductory briefing to staff and managers on objectives and methods of the assessment.
- The presentation should start by putting the assessment of the facility in the context of ongoing quality improvement programs at national level.
- It should be explained that both hospital staff and mothers/other caretaker (service users) will be interviewed on hospital routines and practices, that the assessor(s) will need to observe clinical practice directly, and examine medical records and logbooks.
- During the presentation, the participatory, non-blaming (neither for the individuals nor for the teams), supportive and confidential approach needs to be emphasized. Implications need to be discussed and fears of punishment in case of unsatisfactory results need to be discussed with managers and MoH prior to the visit and again when introducing the assessment to the hospital

staff. It should be stressed that results will be reported to the MoH in an anonymous way, without quoting names of the hospitals, or of single individuals.

- The importance of participation of both managerial (hospital director and/or deputy, heads of departments and head nurse/midwife) and clinical staff (doctors, nurses and allied health professionals) in the assessment should be emphasised, because it is important for directors to be fully aware of skills and knowledge of the staff. However, in some cases the presence of the manager/s may interfere with routine practices and bias the assessment. Decision on how to best involve the manager in each single facility should be made by the team leader in dialogue with the national team.
- The assessment team will make every possible effort to minimize any disturbance created by the assessment. Any concern regarding the assessors' presence during clinical care should be addressed.
- If the assessors plan to take photos, permission from the hospital director should be obtained, as well as from every single individual in accordance with the general rules on privacy.
- The timing for the final debriefing meeting, as well as other logistic arrangements (e.g. lunches), should be decided at the beginning of the assessment.
- After the presentation of the purposes and methods of the assessment, and introduction of the assessors, the visit can start.

#### **Step 5. Assessment visit**

- The assessment visit should include all relevant services: admission, paediatric ward/s, intensive care units (if existing), pharmacy, laboratory, blood bank.
- The assessment includes different sources of information: hospital statistics, medical records, direct observation of cases and interviews. Through a combination of different sources, the tool allows a comprehensive assessment of QoC and the identification of gaps in QoC.
- It is not necessary to follow the sequence of the chapters. The sequence of the assessment will depend on convenience, organizational needs, and on the occurrence of real cases which allow for direct observation of case management. The ideal sequence would be: a) Director office (Hospital Director together with heads of Departments, to assess statistics and organisational issues, existing policies); b) emergency department; c) Paediatric ward/s; d) other services.
- The assessors should establish, based on direct observation, whether clinical protocols exist and are implemented and whether medicines, equipment and supplies are available and appropriately used. It is suggested to spend as much time as possible on the ward to gain first hand information on the real routine of work.
- Case observation should not be intrusive. Permission to observe cases and make interviews should be sought from the mother or from other caretakers of the child.
- Assessors should always be respectful, seek permission from staff, try to make themselves unobtrusive, avoid making comments and engaging in dialogues/discussions with staff and managers during the observation of clinical practice. They should observe situations and actions, check the timing (e.g. time required to deal with an emergency, to transport the child to other services etc...), write main notes in real time, and finalize the assessment of each section (including scores and comments) before the next observation.
- Capacity building and peer-to-peer approach are key features of the assessment process. During the observation of clinical practices the local staff may raise issues/questions and assessors should be prepared to discuss them in a supportive way. Discussions should not occur in front of caretakers or older children.
- If direct observation of case management is not possible- for example for the assessment of emergency situations- a variety of techniques, such as practical exercises, role-plays, and scenarios (e.g. what would you do if..., let's imagine a child is brought to the hospital with...), mannequin-based simulations may provide the necessary information.

- An adequate number of clinical records, as specified in the tool chapters, need to be evaluated to assess how a specific condition is usually managed.
- The availability of a hard copy of the WHO Pocket Book (2<sup>nd</sup> Edition, 2013) or its national adaptation during the assessment is mandatory, particularly when dealing with the evaluation of antibiotic prescriptions and dosages.
- A number of confidential interviews with mothers/other care-takers of the child should be made. A sample of health care providers (doctors, midwives and nurses, chief doctors and heads of departments) will also be interviewed. The questionnaires and related Information on how to conduct the interviews are detailed in ANNEX 4.1 and 4.2.
- The assessment usually identifies key staff members who may represent driving forces for the internal process of quality improvement.

### **Step 6. Assessment and scoring by each team member**

- Each assessor will take note of strengths and weaknesses on each subchapter and attribute a score to each item he/she is assessing using the information gathered from different sources.
- At the end of each subchapter and chapter, the overall score for the section will be recorded as well as the main strengths and weaknesses, which provide inputs for the feedback session.
- Each key practice/item is scored using 4 categories:  
*3 = care corresponding to international standards* (no need for improvement or need for minor improvements only);  
*2 = substandard care but no significant hazard to health or violation of human rights* (need for some improvement to reach standard care);  
*1 = inadequate care with consequent serious health hazards or violation of children's rights,* (e.g. omission of evidence based interventions or information with consequent risk for health or violation of human rights (need for substantial improvement to reach standard care)  
*0 = very poor care with consequent systematic and severe hazards to the health of children.*
- The score for each subchapter and chapter is calculated as the arithmetical mean of the scores of each key practice on the summary tables provided in the tool. Therefore, overall scores for subchapters and chapters are likely to include decimals.
- Parts of the tool or specific items may be “not applicable” to the context, and should therefore not be scored.
- At the end of the assessment, the assessors will meet to discuss findings and agree on the scoring, and on identified strengths and weaknesses for each chapter.
- Each assessor will identify strengths and weaknesses, make comments and indicate options and possible solutions to be discussed in the feedback session. Annex 5.1 can be used for this purpose.
- The team will jointly prepare the feedback to be given to the hospital staff, which will focus on main strengths and weaknesses. The time needed for the final team scoring (by chapter) and discussion within the team is, in the hands of experts, usually no more than one hour.
- The international team leader will coordinate the delivery of feedback to the hospital staff, deciding to involve other members of the team as more appropriate.

### **Step 8. Providing feedback at facility level**

- It is crucial that a feedback meeting is held in each facility at the end of the assessment. Managers and staff members should all be invited, giving priority to personnel in charge of the various units, both doctors and nurses. The time and place for this meeting should be agreed in advance to ensure staff participation.
- Providing feedback is a sensitive process, which needs to be handled with an appropriate attitude. Assessors should always remember that the ultimate aim is to motivate to change and show that improvement is possible. The general attitude should be supportive, stressing what



is being done correctly and the potential for improvement, and emphasizing that the identification of individual responsibilities is not the objective of the assessment.

- Hospital staff and managers should be reminded that the assessment looks at their single facility in the context of other ongoing quality assessment programs (e.g. at country or regional level) and that the assessment is part of an initiative to support hospitals in improving the QoC. A confidential report will be sent to higher authorities describing the assessment findings without linking specific findings to specific hospitals. The report will suggest health system changes and indicate specific support needed from local and national authorities.
- Plans for follow up and/or for supportive supervision should be agreed upon, if follow up is included in the program.
- The feedback should be provided by main areas (i.e. support services, case management, policies, interviews) and include the relevant views of mothers/caretakers and health staff who have been interviewed. National assessors may be asked to present the results with the support of the international assessors.
- The feedback should be provided in a concise way focusing on priorities with details of findings used to illustrate key points.
- Local managers and staff should be allowed to express their views on the findings. A variety of reasons can be brought up to justify this or that specific gap, and views of service users may not always be welcome or valued by the staff. Assessors should accept explanations and at the same time encourage staff members to take into account the users' view. It may be helpful to provide examples from other countries and facilities, showing the evolution of health services in more developed countries.
- If needed, clarifications, explanations and appropriate references in existing guidelines and scientific literature should be provided by the assessors, on controversial issues identified during the visit.

#### ***Step 9. Developing an action plan at facility level***

- In the second part of the feedback session, the managers and staff are invited to develop, based on the findings, a list of priority issues to be addressed at facility level.
- The tool provides a template (Annex 5.2) that can be used to develop a draft plan for action. Adequate time (2 to 4 weeks) should be allowed to finalize and present it to relevant authorities.
- The development of the action plan should be facilitated by helping the local staff identify and prioritize: a) what can be done based on existing resources, and b) what will need additional resources (e.g. equipment, supplies, training) and the involvement of higher authorities.
- The action plan should include the identification of staff members in charge of specific actions, a timeline, and the commitment of hospital managers to provide support and the necessary authorizations.
- Shortly after the assessment visit, a written report should be given to hospital managers including main findings: scores, strengths, weaknesses, comments, and the draft action plan. It is advisable to also provide a copy of the assessment tool with all the comments by the various assessors, ideally in a digital copy of the tool. These documents represent the basis for implementation of changes and should be used to further develop the plan of action, for follow up and supervision, and as a comparison for subsequent assessments. Hospital managers should be encouraged to further discuss the assessment findings with the staff, in order to ensure common understanding and commitment in implementing the necessary actions.

#### ***Step 10. Providing feedback to regional/national level and developing a national action plan***

- A one-day meeting of all assessors should be held at end of all the assessment visits to discuss the findings, identify common strengths and weaknesses, prepare the presentations for the final meeting with MoH and other partners, and finalize the reports to be given to each hospital.

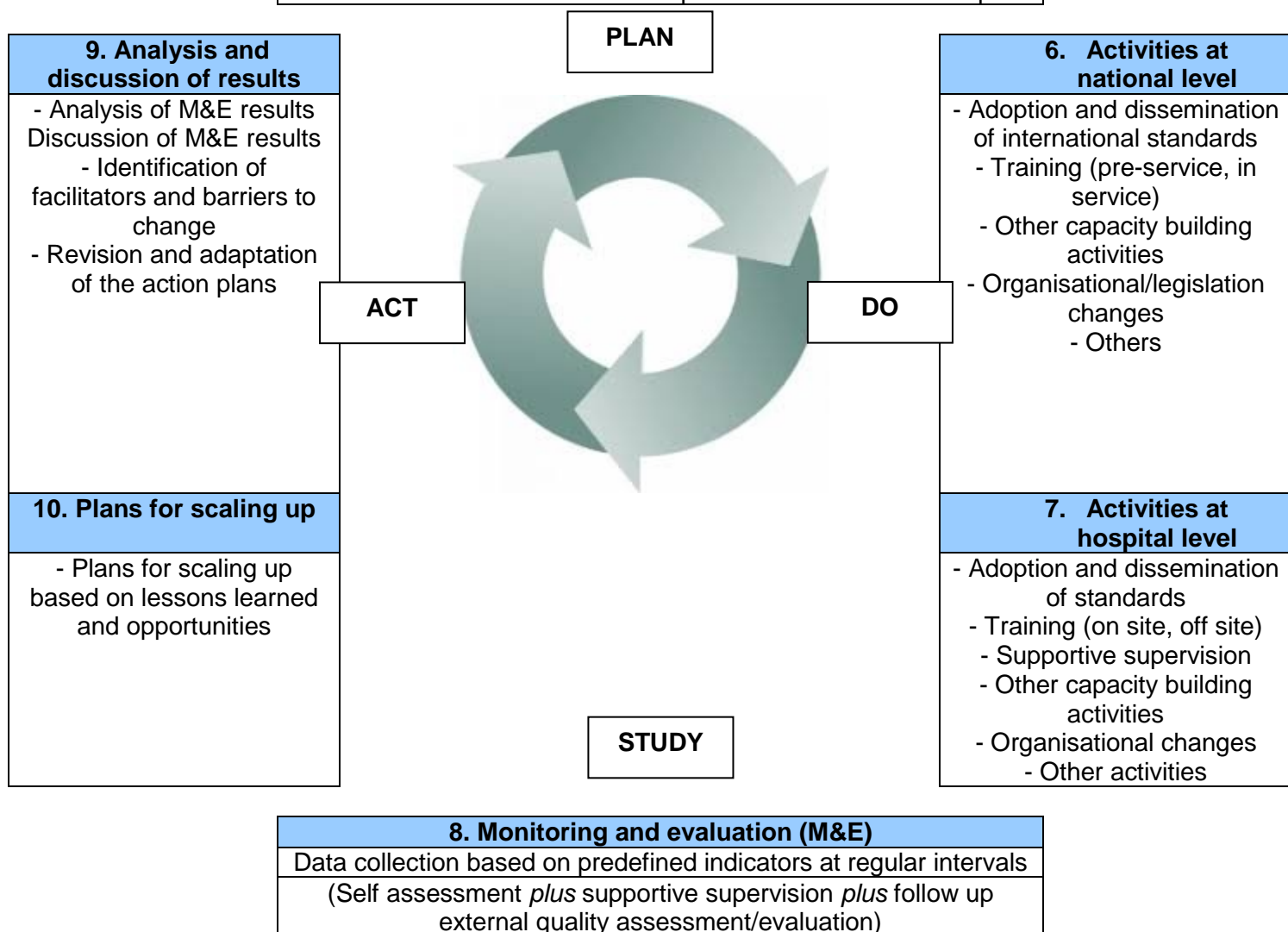
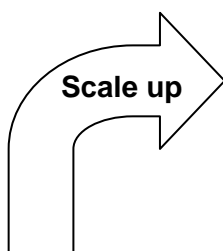
- A one-day official meeting should be organized to present and discuss the overall results of the assessment with all the parties involved. Participants to the meeting should include Ministry of Health representatives, health authorities, hospital managers, all relevant national and international partners, members of academic, scientific and professional societies, other key stakeholders, and of course all the assessors. Representatives of patients' associations should be invited, if existing.
- The meeting starts with a presentation of the findings of the assessments. It is recommended to present results in a confidential way without linking the names of the facilities with specific scores and emphasizing that the main purpose is to identify systemic issues that need to be addressed. Tables and figures may be used to summarize the findings of the assessment and a number or a letter may indicate the various hospitals. It is recommended to include the findings from the interviews with mothers/other caretakers and hospital staff.
- In the second part of the meeting the team of assessors will facilitate the identification of the necessary actions using the WHO health system framework (governance, financing, human resources, essential medical products and technologies, health information systems, and service delivery modes) (31). This tool provides a template for this purpose (Section 5; Annex 5.3).
- Timelines and responsibilities should be identified as well as future steps (which may include, for example, a workshop to develop further the national plan of action) and the role of partners. Reference can be made to the European policy for health and well-being (32), if appropriate.
- The meeting may include the definition of a follow-up plan and a discussion on mechanisms that could be developed (or improved if already existing) to ensure sustainability (e.g. supportive supervision and follow up, link with accreditation systems) and to maintain and expand the national capacity in quality assessment and improvement.
- After the end of the country assessment task the team leader will coordinate the preparation of a report including all the recommendations to be presented to Ministry of Health (or local) authorities and other relevant partners. The final report should include a summary of the findings in all the main areas, the scores for each hospital in each main area (in a confidential way), overall strengths and weaknesses, and the actions recommended for improving the QoC. The WHO health system framework may be used to present these recommendations.

### **Follow up activities**

- The tool is primarily used as a standard-base participatory system to carry forward an analysis of the QoC at hospital level, and to develop a plan of action. After the PLAN phase, the other phases of the Quality improvement cycle should follow (Figure1): DO (i.e. implement actions, such as adoption and diffusion of standards, training etc); CHECK (i.e. monitoring and evaluation of results, etc); ACT (i.e. critical analysis of the results of monitoring and evaluation, possible modifications of the action plans based on the lessons learned, and plans for scale up). As such, the tool should be included in *continuous quality improvement* programs.
- Monitoring and evaluation is a crucial phase of the quality improvement cycle and should be planned and implemented with careful attention. It is recommended that both process indicators, such as those proposed as Annex 3.1 "Indicators for monitoring adherence to WHO Pocket Book" or elsewhere (33,34), and health outcome indicators are selected for use. Supportive supervision (i.e. periodic visits to the facility to provide both technical support and collect indicators for monitoring) has proven to be an effective method to improve adherence to WHO Guidelines in the European Region (35) and is recommended for both checking progresses (based on the monitoring indicators) and providing advice.
- After a period of implementation (one to two years), it is advisable to carry out a second full assessment, using the same tool and team of assessors as the first assessment. This assessment should aim at evaluating progresses, identifying remaining problems, and proposing further actions for quality improvement.
- Achievements should be critically analysed, in order to take stock of lessons learned. Any plan for further scale up should be based on a robust analysis of previous experiences.

**Figure 1. Use of the Quality Assessment Tool within a National Quality Improvement Framework**

<b>1. Country orientation</b>
Identification of leadership and stakeholders
Orientation of stakeholders
<b>2. Situation analysis</b>
Review of previous assessments/interventions/M&E data
Identification of priority areas/facilities
<b>3. Preparatory activities</b>
Adaptation of international standards to the local context
Adaptation and translation of the assessment tool
Definition of a national team
<b>4. Quality assessment</b>
Hospitals assessment in a representative sample of hospitals
Feedback on findings
Identifications of problems and solutions at local level
Identifications of problems and solutions at national level
<b>5. Definition of the action plan</b>
Prioritisation of actions and development of a local action plan
Prioritisation of actions and development of a national action plan



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## IDENTIFICATION

Members of the assessment team:

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Date: \_\_\_\_\_ Country: \_\_\_\_\_

City: \_\_\_\_\_

District: \_\_\_\_\_ Region: \_\_\_\_\_

Facility name: \_\_\_\_\_

Name of Director/Manager of the Hospital: \_\_\_\_\_

Name of the Head of Paediatric Department \*: \_\_\_\_\_

### TYPE OF HOSPITAL

- Public Hospital
- Private (church, NGO others)
- Mixed (describe)

Describe type of funding for the hospital:

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## REGIONAL AND COUNTRY DATA

Collect information on the population and health system context to better understand the role of the facility within the health system.

### CATCHMENT AREA

#### Population

- Total population in the hospital catchment area \_\_\_\_\_
- Children under 5 years in the hospital catchment area \_\_\_\_\_
- Children under 18 years in the hospital catchment area \_\_\_\_\_

#### Health facilities providing paediatric care

- Only outpatient \_\_\_\_\_
- Inpatient care \_\_\_\_\_
- Describe whether other health facilities are private or public, and if there are any restrictions on access to care

**Any external event** e.g. conflict, environmental disaster or infectious outbreak, with impact on access to hospital care and/or to QoC due to lack of commodities, staff etc.

### COUNTRY INDICATORS

Discuss with the health facility staff how the indicators in their health facility relate to the global maternal and child health indicators (data on country statistics are usually available on the WHO/UNICEF websites – indicate sources of data and reference year \_\_\_\_\_)

	Country Indicator
1. Under-five child mortality rate	
2. Infant (children under 1) mortality rate	
3. Perinatal (0-18 days) mortality rate	
4. Exclusive breastfeeding <6 months (%)	
5. Underweight (%), moderate & severe	
6. Stunting (%), moderate and severe	
7. Immunisation coverage (DTP, Measles, Polio, BCG and others)	
8. Pneumonia (%), Care seeking for suspected pneumonia	
9. Antibiotic treatment for suspected pneumonia	
10. Diarrhoea (%) 2008-2012*, Treatment with oral rehydration salts	



**SECTION 1**  
**HOSPITAL SUPPORT SERVICES**

## 1.1 Physical structures, staffing, and basic services

**Objective:** To evaluate the appropriateness of the physical structures, staffing levels and basic services

**Source of data and instructions:**

- ◆ Documents and records such as staff rosters, log book for basic service breakdowns
- ◆ Observation of facility layout and functioning of services
- ◆ Interviews with manager of facility, basic services manager, unit clinical managers

Some information can be collected before the visit (in the form of a questionnaire) to be available for reference to aid evaluation and discussed during the hospital assessment.

1.1.1 Standards on physical structures and staffing are followed	Score	Comments
<ul style="list-style-type: none"> <li>□ If there are national standards on physical infrastructures, these standards are implemented in the hospital</li> <li>□ If there are national standards on staffing, these standards are implemented in the hospital</li> </ul>		
<b>1.1.2 Existing physical and human resources are adequate according to the volume of work</b>		
<ul style="list-style-type: none"> <li>□ Use ANNEX 1.1.1 to evaluate existing facilities</li> <li>□ Use ANNEX 1.1.2 to review number and type of staff</li> <li>□ Use ANNEX 1.1.3 to review number and type of staff on shifts</li> <li>□ Adequate policies and procedures are in place to check presence of staff in hospital during working hours</li> </ul>		
<b>1.1.3 Basic services (power, water, heating, cooling) are available</b>		
<ul style="list-style-type: none"> <li>□ Use ANNEX 1.1.4 to check availability of basic services</li> <li>□ Adequate systems are in place for the technical maintenance of basic services</li> </ul>		

## ANNEX 1.1.1 Evaluate existing facilities for child care

<b>Outpatient department</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	Separate for children yes <input type="checkbox"/> no <input type="checkbox"/>
Working hours	_____	Number of visits /year_____
<b>Admission department*</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	Separate for children yes <input type="checkbox"/> no <input type="checkbox"/>
Working hours	_____	Number of visits /year_____
<b>Intensive Care Unit</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	Separate for children yes <input type="checkbox"/> no <input type="checkbox"/>
Number of beds	_____	Number of admissions /year_____
<i>If no, where are children in need of intensive care transferred? _____</i>		
<b>Main Paediatric Department</b>		
Number of beds	_____	Number of admissions /year_____
Are newborns < 1 month admitted in the same dept? yes <input type="checkbox"/> no <input type="checkbox"/>		
<i>If no, where are newborns transferred? _____</i>		
<b>Isolation unit for infective diseases</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	Separate for children yes <input type="checkbox"/> no <input type="checkbox"/>
Number of beds	_____	Number of admissions /year_____
<i>If no, where are these cases transferred? _____</i>		
List other departments and wards admitting children		
_____		
_____		
<b>Laboratory services</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	Working hours _____
<b>Blood bank</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	Working hours _____
<b>Internal pharmacy</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	Working hours _____

\* This is intended as the unit providing first care; it is not a purely administrative unit.

### ANNEX 1.1.2 Review number and type of staff

Staff type	Total Number	Division by departments/units
Paediatricians		
Other Doctors		
Paediatric Nurses		
General Nurses		
Other clinical Staff (specify): Type _____		
Pharmacy staff (specify) Qualified/Other		
Laboratory staff (specify) Qualified/Other		

### ANNEX 1.1.3 Review number and type of staff on shifts

Are paediatricians present in the hospital at evenings/nights and during weekend - in the first admission department    yes <input type="checkbox"/> no <input type="checkbox"/> if yes how many _____ - in the paediatric ward                            yes <input type="checkbox"/> no <input type="checkbox"/> if yes how many _____ If no, how are they called? _____			
Paediatrician to beds ratio	morning ____	night ____	week-end ____
Nurses to beds ratio	morning ____	night ____	week-end ____

#### Additional points and notes

Systems to check staff presence:  Roles and responsibilities of staff:  Others (e.g. staff turnover, etc):
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### ANNEX 1.1.4 Check availability of basic services

Describe the system in place, including existing back-up systems	Any problems in availability of service during the last year?		If any problem, describe
	Main Paediatric ward	Other wards relevant to children	
Power	Yes: ___ No: ___	Yes: ___ No: ___	
Water	Yes: ___ No: ___	Yes: ___ No: ___	
Heating	Yes: ___ No: ___	Yes: ___ No: ___	
Cooling (if relevant)	Yes: ___ No: ___	Yes: ___ No: ___	

### SCORE FOR 1.1. PHYSICAL STRUCTURE, STAFFING, BASIC SERVICES

KEY PRACTICES/ITEMS	Score
1.1.1 Standards are followed	
1.1.2 Physical and human resources are adequate	
1.1.3 Basic services are available	
<b>SUBCHAPTER SCORE</b>	

## 1.2 Statistics, health management information systems and medical records

**Objective:** To evaluate the quality of the health management information systems. Review of hospital statistics will also provide useful information to evaluate case management.

**Source of data and instructions:**

- ◆ Documents and records: statistics, medical records (at least 30), reports
- ◆ Observation of equipment and processes, and of their use
- ◆ Interview with service providers and users

The information relevant to this chapter can be collected before the visit (e.g. sending a questionnaire to the hospital) and results can be made available for reference during the visit. However, all items need also to be evaluated directly during the assessment, to get sure information on routine practices.

1.2.1 Relevant statistics and information are available and accurate	Score	Comments
<ul style="list-style-type: none"> <li>□ Use ANNEX 1.2.1 to 1.2.3 to collect information</li> <li>□ Use ANNEX 1.2.2 to evaluate information on reasons for admission</li> <li>□ There are effective systems recording accurate information on patient flow (admissions, outpatients, etc.)               <ul style="list-style-type: none"> <li>○ paper based</li> <li>○ computer based</li> </ul> </li> <li>□ There are no errors or inconsistencies in statistical data</li> <li>□ Diseases are grouped according to a standard classification, such as ICDR</li> <li>□ Indicators of QoC are used (e.g. case fatality rate, length of hospitalisation, proportion of caesarean sections, etc )</li> <li>□ The medical record officer or other staff member responsible for coding has accurately coded the main diagnoses</li> </ul>		
1.2.2 Use of statistics is appropriate	Score	Comments
<ul style="list-style-type: none"> <li>□ There is a periodical review and evaluation of statistics and indicators of care               <ul style="list-style-type: none"> <li>○ at each department level</li> <li>○ by the relevant professional teams, including doctors and nurses</li> </ul> </li> <li>□ Data is used to identify and plan actions to improve QoC</li> <li>□ Senior staff are aware of how the hospital statistics and indicators relate to regional and national indicators</li> </ul>		

<b>1.2.3</b>	<b>Quality of medical records is adequate</b>	<b>Score</b>	<b>Comments</b>
	<input type="checkbox"/> Use ANNEX 1.2.4 to evaluate quality of medical records		
<b>1.2.4</b>	<b>Information flow is effective</b>	<b>Score</b>	<b>Comments</b>
	<input type="checkbox"/> Referral notes are available <input type="checkbox"/> Information from previous admissions are available <input type="checkbox"/> Information on care provided in other services, either at PHC level or in the hospital, is available <input type="checkbox"/> A discharge letter is attached to the medical chart for each child discharged		
<b>1.2.5</b>	<b>Access to records is suitable</b>	<b>Score</b>	<b>Comments</b>
	<input type="checkbox"/> The mother/other caretakers can have access to the medical record of the child upon request <input type="checkbox"/> Records are stored in a way that keeps information confidential		

## ANNEX 1.2.1 Patient flow and other indicators

Use the following tables to evaluate health facility statistics related to children. Ask the management to show you the statistical reports.

Indicate the number of paediatric medical outpatient visits, admission visits and hospitalisations per year, as a total, and by age groups. All data refer to children only (not to adult).

Year:<sup>a</sup> \_\_\_\_\_

	Outpatient visits <sup>b</sup>	Admission department <sup>c</sup>	Hospital Admissions <sup>d</sup>	Children referred to other facilities <sup>e</sup>
0 – 28 days?				
1 up to 12 months?				
1 up to 5 years ?				
≥ 5 years?				
Total, all age groups?				

Calculate **Hospitalisation Rate**: \_\_\_\_\_

Calculate **Referral rate**: \_\_\_\_\_

**Average duration of stay** in hospital in children 0-5 \_\_\_\_\_

Number of **re-admitted** children \_\_\_\_\_

Add here notes and comments:

\_\_\_\_\_

Notes:

- Record the hospital figures for the last available year. If data are available for a different period, please specify time period
- This field need to be filled in the case that the hospital includes services for outpatient visits (such as the so called “polyclinic”
- This is intended as the unit providing first care; it is not a purely administrative unit.
- Total admission (not just emergency admissions)
- This is the total number of children referred



## ANNEX 1.2.2 Causes of hospital visits

List the five most important (in terms of absolute numbers) medical reasons (diagnoses) for outpatient visits, first admission department visits, and hospital admissions in children. Record the hospital figures for the last available year. If data are available for a different period, please specify time period

Year: \_\_\_\_\_

	Outpatient visits	First Admission department	Hospital Admissions
1.			
2.			
3.			
4.			
5.			

**Notes and comments:**

### ANNEX 1.2.3 Mortality review

Use the hospital figures for the last available year. If data are available for a different period, please specify time period **Year** \_\_\_\_\_

*Request mortality audits documents to complete this evaluation. Link this evaluation to the evaluation of mortality audit systems*

<b>Hospital indicators</b>	<b>Comments</b>
<p><u>Total</u> number of deaths in hospitalised children (age 0-5 years) per year</p> <p>For each case specify : cause of death, age, and department, if death occurred early after arrival (mortality within 24 or 48 hours)</p>	
<b>Recorded cases of death in the district /region</b>	<b>Comments</b>
<p>For each case specify: cause of death, age, setting , timing (e.g. if death occurred before or after 48 hours from hospitalisation)</p> <ul style="list-style-type: none"> <li>- At home deaths</li> <li>- At hospital deaths</li> </ul> <p>Additional notes (e.g quality of mortality audits etc):</p>	

## ANNEX 1.2.4 Quality of medical records

Evaluate at least 20 medical charts. Synthesise the finding in the table below

Total charts evaluated= ___ specify)	Number of charts Adequate for each criteria (% of total chart)
1. Patient identification details are detailed and clearly legible	
2. The date is recorded	
3. The admission and discharge diagnoses are explicit	
4. Diagnostic examinations are clearly reported	
5. Medicines are clearly prescribed (dose, duration, route of administration, timing)	
6. Intravenous fluids are clearly prescribed (dose, duration, route of infusion, timing)	
7. Treatment administration is explicitly recorded	
8. Referral or follow-up needs are clearly recorded	
9. The anaesthetic form (if any), has been completed and signed	
10. The operation form (if any) has been completed and signed	

### SCORE FOR 1.2. STATISTICS, HEALTH MANAGEMENT INFORMATION SYSTEMS AND MEDICAL RECORDS

KEY PRACTICES/ITEMS	Score
1.2.1 Relevant statistics and information	
1.2.2. Use of statistics	
1.2.3 Quality of medical records	
1.2.4 Information flow	
1.2.5 Access to records	
<b>SUB-CHAPTER SCORE</b>	

## 1.3 Pharmacy management and medicine availability

**Objective:** To evaluate the health facility policy and procedures related to selection, procurement, distribution, purchasing and stock management for medications and pharmaceutical supplies.

**Sources of data and instructions:**

- ◆ Review of documents: pharmacy records, ward records, patient files
- ◆ Observation of organisation, practices and procedures
- ◆ Talk to staff as complementary source of information
- ◆ Check also availability of guidelines using ANNEX 11.1

<b>1.3.1 An essential medicine list exists and is used</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ WHO list of essential medicines</li> <li>□ National list of essential medicines or other list (check if the list includes all medicines for the management of common conditions)</li> </ul>		
<b>1.3.2 Medication storage areas are tidy, clean and secure and with proper system</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ General medication storage is at room temperature unless there is a specific requirement for a particular medicine</li> <li>□ Direct sunlight is avoided, there is sufficient light to read labels</li> <li>□ Storage of medicines in high humidity rooms is avoided</li> <li>□ Cupboards and containers are available for storage</li> <li>□ Medications are not stored on the floor or touching walls to protect from dampness and insects and rodents</li> <li>□ Ventilation in/outlet is covered with nets</li> <li>□ Internal use and injectable medications are separated from disinfectants or toxic medications</li> <li>□ Medications are properly secured from theft: no free access, door with lock</li> <li>□ Narcotics are kept in a separate locked cupboard</li> <li>□ Medications remain in original package or are adequately labelled</li> <li>□ Medications are stored with a proper criteria               <ul style="list-style-type: none"> <li>○ In alphabetical order</li> <li>○ By International Common Denomination (ICD)</li> <li>○ By Groups (classes or administration)</li> </ul> </li> </ul>		
<b>1.3.3 Cold chain is maintained for specific medications</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Medication refrigerator temperature are maintained within acceptable limits</li> <li>□ There are working thermometers in all refrigerators</li> <li>□ Storage temperature is recorded in a log at least daily</li> <li>□ There is a backup power supply</li> </ul>		
<b>1.3.4 Pharmacy has current and accurate records of medicine storage and usage</b>	<b>Score</b>	<b>Comments</b>

<ul style="list-style-type: none"> <li><input type="checkbox"/> There are clear and well maintained records of supplies received and dispensed</li> <li><input type="checkbox"/> There are written purchase procedures</li> <li><input type="checkbox"/> Donation are recorded separately from purchases</li> <li><input type="checkbox"/> There are clear and well maintained in-out records of narcotics</li> <li><input type="checkbox"/> There are no stock-outs (no stocks of an essential medicine)</li> <li><input type="checkbox"/> There are no overstocks</li> <li><input type="checkbox"/> There are no expired products</li> <li><input type="checkbox"/> There are procedures to dispose of expired or damage pharmaceutical products</li> <li><input type="checkbox"/> There are written procedures on how the wards are supplied (check if supply is per named patient, or with standard ward stocking, or by other systems)</li> </ul>		
<b>1.3.5 A system is in place to track adverse medicine reactions and medication errors</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Written procedures exist</li> <li><input type="checkbox"/> Written procedures are followed</li> </ul>		
<b>1.3.6 Suitable medicines are available in the hospital pharmacy</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Check ANNEX 1.3.1 to asses availability of medicines</li> </ul>		
<b>1.3.7 Suitable medicines are available in the clinical areas in which they are likely to be needed</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Check ANNEX 1 3.1 to asses medicines availability</li> </ul>		

## ANNEX 1.3.1 Medicine availability checklist

### Sources of data and instructions:

This information should ideally be collected before the visit (questionnaire filled in by health facility), and be available for reference during the visit. Check for the presence of medicines and enquire with staff if medicines are regularly available.

If not collected in advance, collect this information early on in the visit, from the emergency area, the wards and the pharmacy.

Availability of medicines varies considerably in different regions. Please indicate available medicines (*mark as yes or no*)

Note in comment column if:

- ◆ Local adaptations of the medicine are used
- ◆ Medicines are only available for sale and not freely available for patients
- ◆ Medicines are within their expiry dates. Check if medicines with the earliest expiry date are used first (e.g. they are in the front-row).

<b>I.V. Solutions</b>	<b><u>First admission/ Emergency department</u></b>	<b><u>Paediatric ward</u></b>	<b><u>Internal Pharmacy</u></b>	<b><u>Comments</u></b>
Glucose 30-50% IV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Glucose 10 % IV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Glucose 5 % IV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Normal saline IV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Ringer's lactate IV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Other.....	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
<b>Drugs for emergencies</b>				
Epinephrine (Adrenaline) s.c.	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Dopamine/Dobutamine	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Corticosteroids IV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Salbutamole nebuliser or inhaler	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Salbutamole IV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Furosemide IM/IV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	

Diazepam (IM/ IV/per rectum)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Phenobarbital IM/ IV	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Paracetamol	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Ibuprofen	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Morphine	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Ketamine	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Insulin				
<b>Antibiotics, and other drugs</b>				
Ampicillin	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Amoxicillin	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Amoxy-clavulanic	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Benzyl penicillin	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Antistaphylococcal penicillin (e.g. Flucloxacillin)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Ceftriaxone	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Other 3 <sup>rd</sup> generation Cephalosporins (.....)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Chloramfenicol	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Ciprofloxacin	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Gentamycin	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Other aminoglicosyd Netylmicin, Gentamycin	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Cotrimoxazole	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Erythromycin	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
All anti-Tb drugs needed according to the national Tb control programme	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
All anti HIV drugs needed according to the national HIV control programme	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	

Other:..... .....	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Mebendazole	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Fluconazole/ Ketoconazole	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Acyclovir	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
<b>Vitamins</b>				
Iron (specify type)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Iron tablets, ____ mg	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Vitamin-mineral mix	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Vitamin A oral	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
ORS low osmolarity	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Anti-tetanus immunoglobulin	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	

### SCORE FOR 1.3 PHARMACY MANAGEMENT AND MEDICINE AVAILABILITY

KEY PRACTICES/ITEMS	Score
1.3.1 An essential medicine list exists and is used	
1.3.2 Medication storage areas are tidy, clean and secure and with proper system	
1.3.3 The cold chain is maintained for specific medications	
1.3.4 The pharmacy has current and accurate records	
1.3.5 A system is in place to track adverse medicine reactions and medication errors	
1.3.6 Suitable medicines are available in the hospital pharmacy	
1.3.7 Suitable medicines are available in the clinical areas in which they are likely to be needed	
<b>SUB-CHAPTER SCORE</b>	



## 1.4 Equipment and supplies

**Objective:** To evaluate if the equipment and supplies for child clinical care are available and well maintained and the staff has adequate knowledge on how to use them properly and safely.

**Source of data and instructions:**

Use multiple sources of information:

- ◆ Documents and records: purchase records, reports
- ◆ Observation of equipment and supplies and of their use
- ◆ Talking with service providers and users
- ◆ Check procedures and processes for procurement and maintenance
- ◆ Check also availability of guidelines using ANNEX 11.1

All the following aspects need to be assessed:

- **Availability:** check the number of devices / supplies present in the hospital (evaluate if the hospital is under-equipped or over-equipped)
- **Maintenance:** check if devices/ supplies are properly functioning and the quality of the maintenance processes
- **Correct use:** evaluate staff capacity to use the equipment adequately and safely, according to their technical instructions
- *Note that use according to **appropriate indications is further evaluated in SECTION 2.***

<b>1.4.1 Equipment and supplies are available</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Use ANNEX 1.4.1 to assess equipment availability		
<b>1.4.2 Equipment is well maintained</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Use ANNEX 1.4.1 to assess equipment maintenance		
<b>1.4.3 There is adequate knowledge on how to use the equipment</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Use ANNEX 1.4 to assess correct use		

## ANNEX 1.4.1 Equipment for children

		<u>Availability</u>	<u>Maintenance</u>	<u>Correct use</u>	<u>Comments</u>
Resuscitation table / couch		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Scales - for children - for infants		Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	
Measuring board to measure length and height - for children - for infants		Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	
Stethoscopes		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Thermometers		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Heat source		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Suction equipment		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Oxygen Source Specify _____		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Flow-meters for oxygen		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Equipment for the administration of oxygen		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Indicate which equipment you use: (please tick)	nasal prongs	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
	catheters	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
	masks	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Oxygen saturimeter		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Self inflating bags for respiratory support		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Masks	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Nebulisers (specify type)		Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	

Spacers with masks for administration of salbutamol	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
IV-giving sets with chambers for paediatric use	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Paediatric size butterflies and/or cannulae	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Paediatric size NG-tubes	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Torch	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Otoscope	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Functional X-ray *	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Ultrasound equipment *	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Other relevant equipment	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	

\* For correct use of X-Ray and ultrasound, if possible assess the quality of the images (on an adequate sample of images)

#### SCORE FOR 1.4 EQUIPMENT AND SUPPLIES

Type of equipment	Score
1.4.1 Equipment is available	
1.4.2 Equipment is well maintained	
1.4.3 There is adequate knowledge on how to use the equipment	
<b>SUB-CHAPTER SCORE</b>	

## 1.5 Diagnostic services: laboratory

**Objective:** To evaluate if the availability and use of diagnostic services is adequate

**Source of data and instructions:**

- ◆ Discuss with doctors, and chief laboratory technicians
- ◆ Observe patient's charts and real cases
- ◆ Check also availability of guideline using ANNEX 11.1

<b>1.5.1 Availability of priority tests for managing emergency conditions in adequate time</b>		<b>Score</b>
	<b>Average time</b>	<b>Comments</b>
<input type="checkbox"/> Blood glucose		
<input type="checkbox"/> Haemoglobin		
<input type="checkbox"/> Hematocrit (PCV)		
<input type="checkbox"/> Full blood count		
<input type="checkbox"/> Leukocytes count		
<input type="checkbox"/> Blood grouping and cross-match		
<input type="checkbox"/> Serum creatinine		
<input type="checkbox"/> Blood gases analysis		
<input type="checkbox"/> Electrolytes		
<input type="checkbox"/> Urine stick		
<input type="checkbox"/> Liquor microscopy or biochemistry		
<input type="checkbox"/> Malaria rapid test or blood smear (if appropriate)		
<input type="checkbox"/> HIV rapid test (if appropriate)		
<b>1.5.2 Availability of other lab tests</b>		<b>Score</b>
	<b>Average time</b>	<b>Comments</b>
<input type="checkbox"/> Liver function tests and bilirubin		
<input type="checkbox"/> Renal function tests		
<input type="checkbox"/> Protein C reactive		
<input type="checkbox"/> Erythrocyte sedimentation rate		
<input type="checkbox"/> Urine biochemistry		
<input type="checkbox"/> Urine microscopy		
<input type="checkbox"/> Liquor microscopy		
<input type="checkbox"/> Urine culture		
<input type="checkbox"/> Blood culture		
<input type="checkbox"/> Liquor culture		
<input type="checkbox"/> Sputum smear for TBC		
<input type="checkbox"/> Other tests for TBC		
<input type="checkbox"/> HIV test		
<input type="checkbox"/> Antibodies for HBV		
<input type="checkbox"/> Antibodies for HCV		
<input type="checkbox"/> Other serological tests		

<input type="checkbox"/> List other test available		
<b>1.5.3 Availability of blood</b>		<b>Score</b>
<input type="checkbox"/> Blood is available at hospital level in case blood transfusion is needed <input type="checkbox"/> Blood is adequately screened before transfusion (HIV, HBV, HCV, etc)		Comments
<b>1.5.4 Quality Control</b>		<b>Score</b>
<input type="checkbox"/> There are systems of quality control <input type="checkbox"/> Such systems are adequately used		Comments
<b>1.5.5 Use of tests in clinical practice</b>		<b>Score</b>
<input type="checkbox"/> Staff is able to interpret laboratory tests and the results of the tests and this is taken into account for clinical management (both diagnosis and treatment)		Comments
<b>1.5.6 Access and cost</b>		<b>Score</b>
<input type="checkbox"/> At least emergency laboratory tests are free of charge <input type="checkbox"/> If tests are free of charge by law, no unofficial payment is due		Comments

**SCORE FOR 1.5 LABORATORY SUPPORT**

<b>KEY PRACTICES/ITEMS</b>	<b>Score</b>
1.5.1 Availability of priority tests	
1.5.2 Availability of other lab tests	
1.5.3 Availability of blood	
1.5.4 Quality Control	
1.5.5 Use of tests in clinical practice	
1.5.6 Access and cost	
<b>SUB-CHAPTER SCORE</b>	

## 1.6 Ward infrastructure

**Objective:** To evaluate the infrastructures and the organization of the areas dedicated to child care. The paediatric ward is usually evaluated. It is also important to evaluate the room/s used for emergency treatment, both the admission department and in the paediatric ward

**Source of data and instructions:**

- ◆ Observation of organisation, practices and procedures
- ◆ Interview with mothers
- ◆ Talk to staff as complementary source of information

1.6.1 Overall appearance	Score	Comments
<ul style="list-style-type: none"> <li>□ Environment is child friendly               <ul style="list-style-type: none"> <li>- There are child friendly posters or images</li> <li>- There is enough natural light</li> </ul> </li> <li>□ There are posters on the walls providing information for families (e.g. health promotion)</li> </ul>		
1.6.2 Area for emergency treatment	Score	Comments
<ul style="list-style-type: none"> <li>□ In the admission department ward the room/s for emergency treatment is well designed and equipped:               <ul style="list-style-type: none"> <li>- there are no physical barriers</li> <li>- there is enough light</li> <li>- there are enough plugs for devices requiring power supply</li> <li>- there are posters and other job aids on emergency care</li> <li>- equipment and supplies are ordered and ready</li> <li>- Physical distance from the intensive care unit permit adequate care during transport</li> </ul> </li> <li>□ In the pediatric ward the room/s for emergency treatment is well designed and equipped:               <ul style="list-style-type: none"> <li>- there are no physical barriers</li> <li>- there is enough light</li> <li>- there are enough plugs for devices requiring power supply</li> <li>- there are posters and other job aids on emergency care</li> <li>- equipment and supplies are ordered and ready</li> <li>- physical distance from the intensive care unit permit adequate care during transport</li> </ul> </li> </ul>		
1.6.3 Effective use of available space	Score	Comments
<ul style="list-style-type: none"> <li>□ Overall the space is adequate</li> <li>□ Available rooms are used appropriately</li> <li>□ Cases requiring close monitoring are close to</li> </ul>		

<p>the nurse station</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> There are isolation rooms for infectious cases requiring isolation, and these rooms are use appropriately</li> </ul>		
<b>1.6.4 Overall hygienic conditions</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Ward is clean with no visible soiling</li> <li><input type="checkbox"/> Waste is properly collected</li> <li><input type="checkbox"/> Cupboards, shelves and trolleys are clean and orderly</li> <li><input type="checkbox"/> Equipment for cleaning is appropriately stored</li> </ul>		
<b>1.6.5 Rooms for patients are adequately equipped</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Each child has her/his own bed</li> <li><input type="checkbox"/> Adequate space is provided also for the mother/other members of the family</li> <li><input type="checkbox"/> Beds are safe, clean and well maintained</li> <li><input type="checkbox"/> Bed linen and blankets are provided by the hospital, and they are clean</li> <li><input type="checkbox"/> A cupboard is available for each family, to store their personal belongings</li> <li><input type="checkbox"/> Facilities to wash hands are available in each room</li> <li><input type="checkbox"/> There is enough privacy (no overcrowding)</li> <li><input type="checkbox"/> Room temperature is adequate both in winter and in summer</li> <li><input type="checkbox"/> Room lightening is adequate both during day time and nigh time</li> <li><input type="checkbox"/> Each room is clearly identified</li> <li><input type="checkbox"/> Patients are clearly identified</li> <li><input type="checkbox"/> Air ventilation is adequate</li> </ul>		
<b>1.6.6 Toilets and showers are adequate</b>		
<ul style="list-style-type: none"> <li><input type="checkbox"/> Facilities are easily accessible and clearly identified</li> <li><input type="checkbox"/> Adequate number and type of toilets</li> <li><input type="checkbox"/> Adequate number and type of showers</li> <li><input type="checkbox"/> Safe surface for baby changing and washing</li> <li><input type="checkbox"/> Hot water available continuously</li> <li><input type="checkbox"/> Temperature is adequate both in winter and in summer</li> <li><input type="checkbox"/> Privacy is respected</li> <li><input type="checkbox"/> Toilets are dedicate services, not used for other purposes (eg. for storing material)</li> <li><input type="checkbox"/> Toilets and showers are clean</li> </ul>		
<b>1.6.7 Facilities to prepare and administer food are adequate</b>		
<ul style="list-style-type: none"> <li><input type="checkbox"/> A clean area dedicated to storing, preparing and administering food is available</li> </ul>		
<b>1.6.8 A play room exists and is adequately</b>		

<b>equipped- Educational needs are supported</b>		
<ul style="list-style-type: none"> <li><input type="checkbox"/> A room is appropriately equipped as a play room (washable age-appropriate toys) and is accessible to children without inappropriate restrictions</li> <li><input type="checkbox"/> Educational needs of children are generally taken into consideration (e.g. efforts are made to minimise absence from school, or to maximise access to education even in hospital, for what is feasible)</li> <li><input type="checkbox"/> An educational support is provided for long-stay children (e.g. access to teachers, books)</li> </ul>		
<b>1.6.9 Room for procedures that requires privacy</b>		
<ul style="list-style-type: none"> <li><input type="checkbox"/> There is an dedicated room in which to perform procedures that require privacy</li> <li><input type="checkbox"/> A space exists for staff to talk to mother/family in private, if needed</li> </ul>		
<b>1.6.10 Space for doctors and nurses</b>		
<ul style="list-style-type: none"> <li><input type="checkbox"/> There is an adequate space in which doctors can perform their duties and hold clinical meetings</li> <li><input type="checkbox"/> There is an adequate space in which nurses can perform their duties and hold clinical meetings</li> </ul> <p>Toilets for staff are also adequate (number, hot water availability)</p>		

### SCORE FOR 1.6: WARD INFRASTRUCTURE

KEY PRACTICES/ITEMS	Score
1.6.1 Overall appearance	
1.6.2 Area for emergency treatment	
1.6.3 Effective use of available space	
1.6.4 Overall hygienic conditions	
1.6.5 Rooms for patients are adequately equipped	
1.6.6 Toilets and showers are adequate	
1.6.7 Facilities to prepare and administer foods are adequate	
1.6.8 A Play room exists and is adequately equipped- Educational needs are supported	
1.6.9 Room for procedures that require privacy	
1.6.10 Space for doctors and nurses	
<b>SUB-CHAPTER SCORE</b>	



## SCORE FOR 1 HOSPITAL SUPPORT SERVICES

SUBCHAPTERS	Score
1.1 Physical structures, staffing and basic services	
1.2 Statistics, health management information systems (HMIS) and medical records	
1.3 Pharmacy management and medicine availability	
1.4 Equipment and supplies	
1.5 Laboratory support	
1.6 Ward infrastructure	
<b>CHAPTER 1 SCORE</b>	

## CHAPTER 1 SUMMARY

<b>MAIN STRENGTHS:</b> 1. 2. 3. 4. 5.
<b>MAIN WEAKNESSES:</b> 1. 2. 3. 4. 5.
<b>COMMENTS:</b> 1. 2. 3. 4. 5.

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# **SECTION 2**

## **CASE MANAGEMENT**

- 2. Emergency triage and treatment**
- 3. Case management of respiratory diseases**
- 4. Case management of diarrhoea**
- 5. Case management of other conditions presenting with fever**
- 6. Case management of anaemia and growth failure**
- 7. Case management of main chronic conditions**
- 8. Supportive care**

## 2. Emergency triage and treatment

**Objective:** to evaluate triage and case management of emergency conditions

**Sources of data:**

- ◆ Documents and records:
  - ◆ Written guidelines and protocols (use also ANNEX 11.1)
    - Clinical logs: characteristics of hospitalised children– notice if there are patterns/stereotypes which can indicate low QoC (e.g frequent hospitalisation of children without indications)
    - Medical records: review a randomly chosen sample of records from the last 1-3 months
- ◆ Observation of real cases
- ◆ Case scenarios (see ANNEX 2.1)
- ◆ Interviews with staff
- ◆ Structured interviews with mothers and other members of the family (see SECTION 4)

<b>2.1 A system of triage is in place</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ All emergency department staff is trained in emergency triage and treatment of children</li> <li>□ Children are routinely triaged according to standard criteria</li> <li>□ The triage system utilises a systematic method for evaluating children, such as an ABC approach or similar</li> <li>□ There is an effective plan for activating expert care in a timely manner in emergency cases when this is needed</li> </ul>		
<b>2.2. Appropriate management of airways</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Children are correctly assessed for presence of obstructed airways</li> <li>□ Manoeuvres for managing obstructed airways are correctly performed</li> </ul>		
<b>2.3 Appropriate management of breathing difficulties</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Children are correctly assessed for presence of breathing difficulties</li> <li>□ Administration of oxygen (timing, quantity, delivery methods, monitoring) is correct</li> </ul>		
<b>2.4 Appropriate management of shock</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Children are correctly assessed for presence of shock</li> <li>□ Administration of fluids (timing, quantity, delivery methods, monitoring) is correct</li> <li>□ Other emergency measures to assist children with shock are correctly performed (e.g stop any bleeding, thermal control)</li> </ul>		
<b>2.5 Appropriate management of convulsions</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Children with convulsions are immediately treated in emergency room with appropriate dosage of intra rectal diazepam</li> <li>□ The child is correctly positioned</li> </ul>		

<ul style="list-style-type: none"> <li>□ There is a plan to manage status epilepticus (2<sup>nd</sup> and 3<sup>rd</sup> line drugs)</li> <li>□ In case of high fever, an antipyretic is administered by a suitable route</li> </ul>		
<b>2.6 Management of severe trauma and injuries</b>		
<ul style="list-style-type: none"> <li>□ A primary survey is performed to identify life-treating injuries, in a systematic manner</li> <li>□ Emergency care is provided accordingly (management of airways, provision of oxygen, stopping haemorrhage, as needed)</li> <li>□ A secondary survey is performed when the patient is stable</li> </ul>		
<b>2.7 Timely treatment</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Emergency treatment is provided without delay (eg. without waiting for administrative procedures)</li> </ul>		
<b>2.8 Admission criteria</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Children accessing the hospital through the emergency department are hospitalised only if criteria for hospitalisation are present</li> </ul>		

### SCORE FOR 2. EMERGENCY TRIAGE AND TREATMENT

KEY PRACTICES/ITEMS	SCORE
<b>2.1 A system of triage is in place</b>	
<b>2.2 Management of airways</b>	
<b>2.3 Management of breathing difficulties</b>	
<b>2.4 Management of shock</b>	
<b>2.5 Management of convulsions</b>	
<b>2.6 Management of severe trauma and injuries</b>	
<b>2.7 Timely treatment</b>	
<b>2.8 Admission criteria</b>	
<b>CHAPTER 2 SCORE</b>	

### SUMMARY

<p><b>MAIN STRENGTHS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
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**MAIN WEAKNESSES:**

- 1.
- 2.
- 3.
- 4.
- 5.

**COMMENTS:**

- 1.
- 2.
- 3.
- 4.
- 5.

## ANNEX 2.1 Case scenarios for emergency triage and treatment

The following case scenario can be used to assess knowledge of staff, their skills, and team work

### **Case Scenario 1**

- A little girl aged 6 months. She was playing with some small nuts, and suddenly she presented with cough and difficult breathing. When she is brought to the hospital she has severe respiratory distress. She is conscious. Ask the staff to show how they would triage and manage her.
- Repeat the same case scenario with the following variation: boy aged 4 years

Answer: these are cases of suspect foreign body (nut, plastic toy) in the airways. Staff needs to show how they will manage the airways according to Chart 3 of the Pocket Book

### **Case Scenario 2**

- A boy aged 2 years has been coughing for 2 days. When he is brought to the hospital he is agitated, the respiratory rate is 65 breath/min, he has severe respiratory distress and he is pale. When he breaths he makes a wheezing sound. He has also runny nose. Peak temperature at home was 37.3 C axillary. The older brother also has cough and runny nose. Ask the staff to show how they would triage and manage him.

Answer: this is a case of wheezing with severe broncho-obstruction, and possible hypoxemia. Appropriate emergency treatment includes the use of pulse-oximetry to measure oxygen saturation rate, provision of oxygen with nasal prongs (after having cleaned the nose), and inhalation with salbutamol. Response to emergency treatment should be monitored by measuring respiratory rate, heart rate, and oxygen saturation. The child should be re-evaluated after salbutamol for a differential diagnosis between wheezing due to viral infection (suggested by the low temperature), and pneumonia. The mothers should be instructed on how to use salbutamol.

### **Case Scenario 3**

- An infant aged 3 months, born at term but never breast-feed has been passing liquid stools for the last 2 days. In the last day he has not been able to feed. He appears weak, lethargic, with sunken eyes, and with a depressed fontanella. He was weighted only at birth (2700 grams), and now weights 4.300 gr. Pulse is valid, heart rate is 140 beat/minute. Ask the staff to show how they would further assess the infant and manage him.

Answer: this is a case of severe dehydration. Staff needs to rule out the presence of shock by checking heart rate, pulse (and blood pressure). Emergency treatment should include thermal control and rehydration according to Plan C for infants. Staff should mention that they will check glycaemia.

### **Case Scenario 4**

- A boy aged 5 years is taken to the emergency department unconscious after a car accident. There are signs of abdominal trauma. Heart rate is 175 beat/minute, respiratory rate is 35. The child is pale. Ask the staff to show how they would triage and manage him.

Answer: this is a case of possible haemorrhagic shock due to trauma. Emergency management should include: thermal control, oxygen, urgent investigation for haemoglobin blood level and blood group, and immediate treatment with fluids. Monitoring should include frequent measurement of heart rate and respiratory rate (or cardio-respiratory monitor if available).



**Case Scenario 5**

- A girl aged 1 year presents to the emergency department with convulsions. Temperature is 39 C°. She was relatively well just before convulsion appeared. Ask the staff to show how they would triage and manage her.

Answer: this is a case of probable febrile convulsion. Staff should mention management of the airways (check for obstructed breathing due to secretions), provision of oxygen, appropriate treatment with diazepam, and other drugs if the convulsion does not stop; paracetamol to reduce temperature after having managed the convulsion (i.e. not orally during the convulsion). Investigations should include differential diagnosis of the cause of fever. Reassurance of parents and education on how to manage further episodes of convulsions should also be mentioned.

### 3. Case management of respiratory diseases

**Objective:** to evaluate case management for the most common respiratory diseases

**Sources of data:**

- ◆ Documents and records:
  - Written guidelines and protocols (use also ANNEX 11.1)
  - Clinical logs: characteristics of hospitalised children – notice if there are patterns/stereotypes which can indicate low QoC (e.g frequent hospitalisation of children without indications)
  - Medical records: review a minimum of 35 files randomly chosen from the last 1-3 months (see ANNEX 3.1)
- ◆ Observation of real cases
- ◆ Case scenarios
- ◆ Interviews with staff
- ◆ Structured interviews with mothers and other members of the family (see SECTION 4)

<b>3.1 Admission criteria</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Children with respiratory diseases are hospitalised only if criteria for hospitalisation are present (e.g. severe pneumonia, chronic cough)		
<b>3.2 Clinical assessment of suspected pneumonia</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> For each child presenting with cough, a differential diagnosis between pneumonia and other conditions is made based on history, examination, and investigations <input type="checkbox"/> Health workers correctly diagnose pneumonia and classify/recognize severity <input type="checkbox"/> Signs such as chest-indrawing, respiratory rate, presence of cyanosis are correctly evaluated		
<b>3.3 Investigations for suspected pneumonia</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Pulse oximetry is used to detect hypoxia and as a guide to when to start or stop oxygen therapy <input type="checkbox"/> Chest X-ray is performed only in children with: <ul style="list-style-type: none"> <li>- severe pneumonia, or</li> <li>- pneumonia that does not respond to treatment, or</li> <li>- Suspected complications, or</li> <li>- unclear diagnosis, or</li> <li>- associated HIV</li> </ul>		
<b>3.4. Administration of appropriate antibiotics for pneumonia</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Antibiotics are not routinely recommended for children aged 2–59 months with non-severe pneumonia (i.e. fast breathing with no chest indrawing or danger sign), with a wheeze but no fever (< temperature 38 °C), as the cause is most likely to be viral. <input type="checkbox"/> Children aged 2–59 months with <i>pneumonia</i> are treated with oral amoxicillin at least 40mg/kg/dose twice daily for 5 days at home		

<p>(first dose in hospital).</p> <ul style="list-style-type: none"> <li>□ Children aged 2–59 months with <i>severe pneumonia</i> are treated with parenteral ampicillin (or penicillin) and gentamicin as a first line treatment: <ul style="list-style-type: none"> <li>— Ampicillin: 50 mg/kg, or Benzyl penicillin: 50,000 units per kg IM/IV every 6 hours for at least 5 days</li> <li>— Gentamicin: 7.5 mg/kg IM/IV once a day for at least 5 days</li> </ul> </li> <li>□ Ceftriaxone is used as a second line treatment in children with severe pneumonia with failure of first line treatment.</li> </ul>		
<b>3.5 Oxygen therapy</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Oxygen is administered to all children who need it, based on oxygen saturation. If oximetry is not available then the following clinical signs can be used to guide the need for oxygen therapy: central cyanosis, nasal flaring, inability to drink or feed, grunting with every breath.</li> <li>□ Oxygen is administered correctly (nasal prongs, correct flow, no interruptions).</li> <li>□ Children living at <math>\leq 2500</math> m above the sea level should receive oxygen therapy if their saturation <math>\leq 90\%</math> as measured by pulse oxymeter.</li> <li>□ Children living at <math>&gt; 2500</math> m above the sea level should receive oxygen therapy if their saturation <math>\leq 87\%</math> as measured by pulse oxymeter.</li> <li>□ Children with hypoxemia are closely monitored using pulse oximetry</li> </ul>		
<b>3.6 Complications of pneumonia</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Possible complications of pneumonia, such as pleural effusions, are correctly suspected based on history, examination and radiological findings</li> </ul>		
<b>3.7 Management of children with bronco-obstruction</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Children with bronco-obstruction are correctly identified.</li> <li>□ Children with bronchoconstriction are treated with inhaled salbutamol using a metered dose inhaler (MDI) with spacer devices to relieve bronchoconstriction.</li> <li>□ Oral salbutamol is not used for treatment of acute or persistent wheeze except where inhaled salbutamol is not available.</li> <li>□ Inhaled bronchodilators are correctly administered (way, dose and frequency)</li> </ul>		
<b>3.8 Management of children with laryngeal-obstruction</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Children with laryngeal-obstruction are correctly identified.</li> <li>□ Drugs for laryngeal obstructions (adrenalin,</li> </ul>		

steroids) are correctly administered (way, dose and frequency).		
<b>3.9 Management of children with long lasting cough</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> A differential diagnosis between different conditions causing long lasting cough (e.g tuberculosis, pertussis, foreign body, asthma, etc), is made, based on the child history, examination and investigations. <input type="checkbox"/> Children with TB are treated according to WHO recommendations. <input type="checkbox"/> Children with suspected pertussis are treated with oral erithromicin or azytromicin.		
<b>3.10 Discharge</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Children are hospitalised only for the time which is strictly required. <input type="checkbox"/> Adequate information is provided before discharge (eg, how to treat recurrent wheezing). <input type="checkbox"/> Follow up is planned as needed.		

### SCORE FOR 3. CASE MANAGEMENT OF RESPIRATORY DISEASES

KEY PRACTICES/ITEMS	SCORE
<b>3.1 Admission criteria</b>	
<b>3.2 Clinical assessment for suspected pneumonia</b>	
<b>3.3 Investigations for suspected pneumonia</b>	
<b>3.4. Administration of appropriate antibiotics for pneumonia</b>	
<b>3.5 Oxygen therapy</b>	
<b>3.6 Complications of pneumonia</b>	
<b>3.7 Management of children with bronco-obstruction</b>	
<b>3.8 Management of children with laryngeal-obstruction</b>	
<b>3.9 Management of children with long lasting cough</b>	
<b>3.10 Discharge</b>	
<b>CHAPTER 3 SCORE</b>	

### SUMMARY

<b>MAIN STRENGTHS:</b>  1.  2.
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- 3.
- 4.
- 5.

**MAIN WEAKNESSES:**

- 1.
- 2.
- 3.
- 4.
- 5.

**COMMENTS:**

- 1.
- 2.
- 3.
- 4.
- 5.

## ANNEX 3.1. Indicators of adherence to WHO Guidelines

Review a minimum of **35 cases randomly chosen** among children 6 months-5 years admitted in the last 1-3 months with acute respiratory infections, diarrhoea or fever. Use the following tables for case definition and data extraction. Use the WHO Pocket Book as a reference standard.

### 3.1.1 Case definition

1) Hospitalisation - <i>Unnecessary</i>	Definition: failure to comply with the WHO Pocket Book recommendations on hospitalisation. Examples: - According to WHO criteria the child has "cough or cold" but is hospitalised - According to WHO criteria the child has "mild dehydration" but is hospitalised
2) Diagnosis - <i>Incorrect</i>	Definition: failure to comply with the WHO Pocket Book recommendations for diagnosis. Examples: - According to WHO criteria the child has "cough or cold" but is diagnosed with "pneumonia" - According to WHO criteria the child has "mild dehydration" but is diagnosed with "severe dehydration"
3) Treatment – <i>Incorrect</i>	Definition: failure to comply with the WHO Pocket Book recommendations for treatment. Examples: - According to WHO criteria the child should receive treatment for "cough or cold" but received treatment for "pneumonia" , or should receive treatment for "pneumonia" but received treatment for "severe pneumonia" - According to WHO criteria the child has "mild dehydration" but is treated for "severe dehydration"
4) Diagnosis and treatment – <i>Inconsistent</i>	Definition: there is no consistency between the diagnosis made according to WHO criteria and the treatment prescribed, or the diagnosis is not made explicit in the chart. Examples: - According to WHO criteria the child has "cough or cold" but received treatment for "pneumonia" - According to WHO criteria the child has "mild dehydration" but received treatment for "severe dehydration"
5) Iatrogenic risk - <i>Increased</i>	Definition: unnecessary drugs -defined as the use of 2 or more drugs not in compliance with the WHO Pocket Book recommendations on case management- because of not proven efficacy /risk of adverse effects. Examples: - Any unnecessary use of drugs, such as steroids or antibiotics in diarrhoea, sedative drugs for children with fever; cardiotoxic drugs in children without a clear indication for a cardiotoxic.
6) Pain - <i>Unnecessary</i>	Definition: unnecessary invasive procedures (such as intramuscular/intravenous injection or other invasive procedures) that don't comply with the WHO Pocket Book recommendations. Examples: - Intramuscular/intravenous antibiotic injections in a child who, according to WHO criteria, should be treated with an oral antibiotic - Intravenous fluid in a child who according to WHO criteria could be rehydrated orally
7) Monitoring - <i>Inadequate</i>	Definition: inadequate monitoring in respect to the clinical diagnosis of the child, as for WHO criteria Additional disease-specific definitions: - If the child has a respiratory infection: respiratory rate is not monitored at least twice a day - If the child has diarrhoea: weight is not monitored at least twice a day - If the child has meningitis: the neurological status is not monitored at least twice a day
8) Nutritional status - <i>Not assessed</i>	Definition: growth of the child is not adequately assessed according to WHO criteria (measuring both weight on age and height on age according to WHO standards 2006); and/or a child with acute or chronic malnutrition according to WHO criteria is not identified
9) Use of IV fluids- <i>Incorrect</i>	Definition: when compared with the WHO PB recommendations, fluids are not used correctly either in type, quantity or frequency.

Examples:

- Intravenous fluids are prescribed when they are not needed, such as when the child is able to drink
- The wrong type of fluids (such as an hypotonic solution), or a wrong quantity (either too much or too little), is given.

### 3.1.2 Patients chart review: Data extraction form

Use the WHO Pocket Book and the "Case definition below" as references and just put a cross in the Table

Name of assessor.....

		Case												
		1	2	3	4	5	6	7	8	9	10	11	12	TOTAL
1.Hospitalisation	<i>Unnecessary</i>													
	<i>Necessary</i>													
2.Diagnosis	<i>Incorrect</i>													
	<i>Correct</i>													
3.Treatment	<i>Incorrect</i>													
	<i>Correct</i>													
4.Explicit diagnosis	<i>Lacking</i>													
	<i>Present</i>													
5.Iatrogenic risk	<i>Increased</i>													
	<i>Not increased</i>													
6.Pain	<i>Unnecessary</i>													
	<i>Necessary</i>													
7.Monitoring	<i>Inadequate</i>													
	<i>Adequate</i>													
8.Nutritional status	<i>Not assessed</i>													
	<i>Assessed</i>													
9.Use of IV fluids	<i>Incorrect</i>													
	<i>Correct</i>													



## 4. Case management of diarrhoea

**Objective:** to evaluate case management for diarrhoea

**Sources of data:**

- ◆ Documents and records:
  - Written guidelines and protocols (use also ANNEX 11.1)
  - Clinical logs: characteristics of hospitalised children – notice if there are patterns/stereotypes which can indicate low QoC (e.g. frequent hospitalisation of children without indications)
  - Medical records: review a minimum of 35 files randomly chosen from the last 1-3 months (see ANNEX 3.1)
- ◆ Observation of real cases
- ◆ Case scenarios
- ◆ Interviews with staff
- ◆ Structured interviews with mothers and other members of family (see SECTION 4)

<b>4.1 Admission criteria</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Children with diarrhoea are hospitalised only if criteria for hospitalisations are present (e.g. severe dehydration, continuous vomiting, dysentery, or other conditions requiring further investigation or treatment)		
<b>4.2 Assessment of dehydration</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> The degree of dehydration is correctly assessed in all patients with diarrhoea <input type="checkbox"/> The degree of dehydration is correctly classified		
<b>4.3. Rehydration plan</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> The correct rehydration plan is chosen based on the assessment of dehydration (Plan A, Plan B, Plan C) <input type="checkbox"/> Children with severe dehydration are rehydrated using isotonic intravenous solutions such as sodium chloride or ringer lactate <input type="checkbox"/> The amount of fluids for rehydration and the duration of the infusion are correctly calculated and reported in the medical chart <input type="checkbox"/> Total fluids intake is monitored, and adjusted as necessary <input type="checkbox"/> Signs of dehydration are monitored, according to the severity of the disease		
<b>4.4 Use of antibiotics and other drugs</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Antibiotics are given only to children with bloody diarrhoea, salmonella fever or suspected cholera <input type="checkbox"/> Children with diarrhoea and blood in stool (i.e. dysentery) are treated with ciprofloxacin as a first line treatment. Ceftriaxone is given as a second line treatment in severely ill children where local antimicrobial sensitivity		

is not known. <input type="checkbox"/> Antidiarrhoeal drugs or other drugs of unproven efficacy are not prescribed		
<b>4.5 Feeding</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Breastfeeding mothers are advised to continue breastfeeding <input type="checkbox"/> If the child is not able to suck, alternative methods of giving breast milk are considered ( cup, spoon, nasogastric tube) <input type="checkbox"/> If the child is not normally breastfed, the possibility of re-lactation is considered <input type="checkbox"/> For children over 6 months of age, solid foods are reintroduced early (approximately 4 hours after rehydration) <input type="checkbox"/> The child is encouraged to eat, and foods are offered frequently (6 times a day) <input type="checkbox"/> Zinc supplementation is prescribed for 2 weeks		
<b>4.6 Discharge</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Children are hospitalised only for the time which is strictly required <input type="checkbox"/> Adequate information is provided before discharge <input type="checkbox"/> Follow up is planned as needed		

**SCORE FOR 4. CASE MANAGEMENT OF DIARRHOEA**

KEY PRACTICES/ITEMS	SCORE
<b>4.1 Admission criteria</b>	
<b>4.2 Assessment of dehydration</b>	
<b>4.3 Rehydration plan</b>	
<b>4.4 Use of antibiotics and other drugs</b>	
<b>4.5 Feeding</b>	
<b>4.6 Discharge</b>	
<b>CHAPTER 4 SCORE</b>	

**SUMMARY**

<p><b>MAIN STRENGTHS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>
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5.

**MAIN WEAKNESSES:**

- 1.
- 2.
- 3.
- 4.
- 5.

**COMMENTS:**

- 1.
- 2.
- 3.
- 4.
- 5.

## 5. Case management of other conditions presenting with fever

**Objective:** to evaluate case management for conditions presenting with fever other than respiratory conditions and diarrhoea

**Sources of data:**

- ◆ Documents and records:
  - Written guidelines and protocols (use also ANNEX 11.1)
  - Clinical logs characteristics of hospitalised children – notice if there are patterns/ stereotypes which can indicate low QoC (e.g frequent hospitalisation of children without indications)
  - Medical records: review a minimum of 35 files randomly chosen from the last 1-3 months (see ANNEX 3.1)
- ◆ Observation of real cases
- ◆ Case scenarios
- ◆ Interviews with staff
- ◆ Structured interviews with mothers and other care-takers (see SECTION 4)

<b>5.1 Admission</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Fever alone (axillary temperature > 38C°), without other criteria of severity (clinical criteria of severity, age below 6 months, fever more than 5 days, laboratory abnormalities) is not a reason for hospitalisation.		
<b>5.2 Differential diagnosis and investigations</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> An appropriate assessment is undertaken for all children with febrile conditions <ul style="list-style-type: none"> <li>- History</li> <li>- Examination</li> <li>- Laboratory and other exams if needed</li> </ul> <input type="checkbox"/> Children with fever admitted for further investigations have a clearly made investigation plan in the medical chart		
<b>5.3. Diagnosis and management of meningitis</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Lumbar puncture is performed without delay when meningitis is suspected <input type="checkbox"/> Findings of lumbar puncture are correctly interpreted <input type="checkbox"/> Children with acute bacterial meningitis are treated empirically with 3rd generation cephalosporins <ul style="list-style-type: none"> <li>— Ceftriaxone: 50mg/kg per dose IV every 12 hours or 100 mg/kg once daily, or</li> <li>— Cefotaxime: 50mg/kg per dose every 6 hours for 10–14 days.</li> </ul> <input type="checkbox"/> Complications of meningitis (e.g. convulsions) are diagnosed and treated appropriately <input type="checkbox"/> Appropriate patient monitoring is performed and recorded (state of consciousness, respiratory rate, pupil size)		
<b>5.4 Diagnosis and management of urinary tract infection (UTI)</b>	<b>Score</b>	<b>Comments</b>

<ul style="list-style-type: none"> <li>□ UTI diagnosis is made on a urine sample appropriately collected (mid stream or sterile bag when mid stream is difficult to obtain) and immediately examined or conserved at 4-8 °C</li> <li>□ UTI diagnosis is made through correct interpretation of direct urine examination (microscopy or dip sticks for leucocytes and nitrates) plus urine culture</li> <li>□ If urgent microscopy is not available antibiotic treatment is started if leucocytes and nitrites are found in dip stick</li> <li>□ Appropriate antibiotic treatment is given (timing, dosage, choice of antibiotic in relation to likely pathogenic bacteria and age, duration)</li> <li>□ Associated conditions (e.g urinary tract congenital anomaly) are correctly diagnosed and managed</li> <li>□ Appropriate advice on follow-up and in case of subsequent febrile episodes is given to patient</li> </ul>		
<b>5.5 Diagnosis and management of acute otitis media</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Otoscopy is part of the physical examination of all children</li> <li>□ Differential diagnosis between external otitis, acute otitis media and mastoiditis is made</li> <li>□ Adequate dosage of anti-inflammatory drugs (eg. paracetamol) are administered</li> <li>□ Children with acute otitis media are treated with oral amoxicillin at 40 mg/ kg twice per for 7–10 days.</li> </ul>		
<b>5.6 Assessment and management of other severe febrile conditions</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Appropriate assessment and differential diagnosis of fever is performed (typhoid, septic arthritis, osteomyelitis, empyema, etc)</li> <li>□ Correct treatment is given</li> </ul>		
<b>5.7 Rheumatic Fever</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Diagnosis is based on clear criteria, such as the WHO criteria (revised Jones criteria)</li> <li>□ Treatment is according to the guidelines</li> </ul>		
<b>5.8 Fever lasting longer than 7 days</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ An appropriate assessment is undertaken for all children with long lasting fever to evaluate possible differential diagnosis (e.g salmonellosis, TB, endocarditis), including history, examination, investigations</li> <li>□ Appropriate treatment is prescribed based on the diagnosis</li> </ul>		

**SCORE FOR 5. CASE MANAGEMENT OF OTHER CONDITIONS PRESENTING WITH FEVER**

<b>KEY PRACTICES/ITEMS</b>	<b>SCORE</b>
5.1 Admission	
5.2 Differential diagnosis and investigations	
5.3 Diagnosis and management of meningitis	
5.4. Diagnosis and management of urinary tract infection (UTI)	
5.5 Diagnosis and management of acute otitis media	
5.6 Assessment and management of other severe febrile conditions	
5.7 Rheumatic Fever	
5.8 Fever lasting longer than 7 days	
<b>CHAPTER 5 SCORE</b>	

**SUMMARY**

<p><b>MAIN STRENGTHS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>MAIN WEAKNESSES:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>COMMENTS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>

## 6. Case management of anaemia and growth failure

**Objective:** to evaluate case management for anaemia and growth failure

**Sources of data:**

- ◆ Documents and records:
  - Written guidelines and protocols (use also ANNEX 11.1)
  - Clinical logs: characteristics of hospitalised children – notice if there are patterns/ stereotypes which can indicate low QoC (e.g. frequent hospitalisation of children without indications)
  - Medical records: review a minimum of 35 files randomly chosen from the last 1-3 months (see ANNEX 3.1)
- ◆ Observation of real cases
- ◆ Case scenarios
- ◆ Interviews with staff
- ◆ Structured interviews with mothers and other care-takers (see SECTION 4)

6.1 Differential diagnosis and investigations for anaemia	Score	Comments
<input type="checkbox"/> An appropriate diagnostic approach is undertaken to make a differential diagnosis of anaemia, based on: <ul style="list-style-type: none"> <li>- History (e.g. nutrition, other symptoms, etc)</li> <li>- Examination (e.g. vital signs, growth failure, spleen enlargement etc)</li> <li>- Investigations: total blood cell count, serum iron storage and ferritin, reticulocytes, LDH, bilirubin)</li> </ul>		
6.2 Management of anaemia	Score	Comments
<input type="checkbox"/> When iron-deficient anaemia is suspected the case is managed with: <ul style="list-style-type: none"> <li>- appropriate type and dosage of iron</li> <li>- appropriate nutritional advice</li> <li>- adequate follow up plan</li> <li>- in countries at high risk of intestinal parasite infections, or if such an infection is suspected, if the child is over 1 year and has not received mebendazole, a dose of mebendazole is given</li> </ul> <input type="checkbox"/> When either the history, the examination or the investigations suggest a diagnosis different from nutritional anaemia, the case is further investigated, referred if needed, and treated accordingly		
6.3 Identification of children with growth failure (acute or chronic malnutrition) and differential diagnosis	Score	Comments
<input type="checkbox"/> All children are appropriately assessed with the use of growth charts, based on weight on height and on height on age tables and charts <input type="checkbox"/> Children with acute malnutrition are correctly		

<p>identified based on weight-for-height</p> <ul style="list-style-type: none"> <li>□ Children with chronic malnutrition are correctly identified, based on height-for-age</li> <li>□ An appropriate diagnostic approach is undertaken to make a differential diagnosis between the causes of acute or chronic malnutrition (e.g. inadequate nutritional intake, infections, celiac disease, cystic fibrosis, renal disease, hypothyroidism, etc) based on history, examination and investigations</li> <li>□ Cases that need further examinations are appropriately referred</li> </ul>		
<p><b>6.4 Management of children with growth failure (acute or chronic malnutrition)</b></p>	<p><b>Score</b></p>	<p><b>Comments</b></p>
<ul style="list-style-type: none"> <li>□ Children with malnutrition due to inadequate nutritional intake are managed with: <ul style="list-style-type: none"> <li>- appropriate nutritional counselling</li> <li>- regular follow up</li> <li>- involvement of social services, if needed</li> </ul> </li> <li>□ Children with malnutrition due to other causes (e.g. cystic fibrosis, celiac disease, hypothyroidism) are managed by specialised centres, according to international guidelines</li> </ul>		

**SCORE FOR 6. CASE MANAGEMENT OF ANAEMIA AND GROWTH FAILURE**

KEY PRACTICES/ITEMS	SCORE
6.1 Differential diagnosis and investigations for anaemia	
6.2. Management of anaemia	
6.3 Identification of children with growth failure (acute or chronic malnutrition) and differential diagnosis	
6.4 Management of children with growth failure (acute or chronic malnutrition)	
<b>CHAPTER 6 SCORE</b>	

**SUMMARY**

<p><b>MAIN STRENGTHS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
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**MAIN WEAKNESSES:**

- 1.
- 2.
- 3.
- 4.
- 5.

**COMMENTS:**

- 1.
- 2.
- 3.
- 4.
- 5.

## 7. Case management of major chronic conditions

**Objective:** to evaluate basic case management for major chronic conditions

**Sources of data:**

- ◆ Documents and records:
  - Written guidelines and protocols (use also ANNEX 11.1)
  - Clinical logs: characteristics of hospitalised children – notice if there are patterns/ stereotypes which can indicate low QoC (e.g. frequent hospitalisation of children without indications)
  - Medical records: review medical charts
- ◆ Observation of real cases
- ◆ Case scenarios
- ◆ Interviews with staff
- ◆ Structured interviews with mothers and other members of the family (see SECTION 4)

7.1 Type I diabetes	Score	Comments
<ul style="list-style-type: none"> <li>□ Type I Diabetes is correctly suspected in children with a presentation suggesting it (e.g. polyuria, weight loss, etc)</li> <li>□ Diagnosis is correctly made, based on glycaemia and urine test</li> <li>□ Guidelines for management of diabetic chetoacidosis exist and are in agreement with international standards</li> <li>□ All paediatricians know the basic principles on how to adjust the insulin scheme for a child with diabetes when he/she suffers from any acute episode such as diarrhoea or fever</li> <li>□ All paediatricians know the basic principles of follow up (such as the interpretation of a glycemic diary)</li> </ul>		
7.2 Celiac disease	Score	Comments
<ul style="list-style-type: none"> <li>□ Celiac disease is correctly suspected in children with a presentation suggesting it (e.g. failure to thrive, persistent anaemia)</li> <li>□ Cases are correctly referred for diagnostic confirmation (antibodies, intestinal biopsy)</li> <li>□ Guidelines for management exist are in agreement with international standards</li> <li>□ All paediatricians know the basic principles on how to recommend a diet for celiac disease patients</li> <li>□ All paediatricians know the basic principles of follow us (such as when to suspect lack of adherence to diet)</li> </ul>		
7.3 Asthma	Score	Comments
<ul style="list-style-type: none"> <li>□ Asthma is correctly suspected in children with a presentation suggesting it (e.g. recurrent episodes of bronco-obstruction)</li> <li>□ Cases are correctly referred for diagnostic</li> </ul>		

<p>confirmation (respiratory functions test etc)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Guidelines for management exist and are in agreement with international standards</li> <li><input type="checkbox"/> All paediatricians know the basic principles on how to treat an acute crisis</li> <li><input type="checkbox"/> All paediatricians know the basic principles of follow up (such as when to suspect inappropriate asthma control)</li> </ul>		
<b>7.4 Cystic fibrosis</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Cystic fibrosis is correctly suspected in children with a presentation suggesting it (e.g. failure to thrive, recurrent respiratory infections)</li> <li><input type="checkbox"/> Cases are correctly referred for diagnostic confirmation (sweat test, genetic tests)</li> <li><input type="checkbox"/> Guidelines for treatment exist and are in agreement with international standards</li> <li><input type="checkbox"/> All paediatricians know the basic principles of follow up (such as when to suspect a respiratory infection)</li> </ul>		
<b>7.5 Paediatric HIV/AIDS</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> HIV is correctly suspected in children with a presentation suggesting it (e.g. tuberculosis, recurrent infections, failure to thrive)</li> <li><input type="checkbox"/> Diagnosis is correctly made, based on HIV testing</li> <li><input type="checkbox"/> Guidelines for treatment exist and are in agreement with international standards</li> </ul>		
<b>7.6 Leukaemia</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Leukaemia is correctly suspected in children with a presentation suggesting it (e.g. blood count results)</li> <li><input type="checkbox"/> Cases are correctly referred for diagnostic confirmation</li> <li><input type="checkbox"/> Guidelines for management exist and are in agreement with international standards</li> <li><input type="checkbox"/> All paediatricians know the basic principles of follow up (such as when to suspect a relapse of the disease based on the blood count)</li> </ul>		
<b>7.7 Development disorders</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Child development is appropriately assessed in all children according to international guidelines</li> <li><input type="checkbox"/> Children with developmental abnormalities or delays are referred to specialist for a diagnosis</li> </ul>		

**SCORE FOR 7. CASE MANAGEMENT OF CHRONIC CONDITIONS**

<b>KEY PRACTICES/ITEMS</b>	<b>SCORE</b>
7.1 Type I diabetes	
7.2 Celiac disease	
7.3. Asthma	
7.4 Cystic fibrosis	
7.5 Paediatric HIV/AIDS	
7.6 Leukaemia	
7.7 Development disorders	
<b>CHAPTER 7 SCORE</b>	

**SUMMARY**

<p><b>MAIN STRENGTHS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>MAIN WEAKNESSES:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>COMMENTS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>

## 8. Supportive care

**Objective:** to evaluate quality of supportive care

**Sources of data:**

- ◆ Documents and records:
  - Written guidelines and protocols (use also ANNEX 11.1)
  - Clinical logs: characteristics of hospitalised children – notice if there are patterns/ stereotypes which can indicate low QoC (e.g. frequent hospitalisation of children without indications)
  - Medical records: review a minimum of 35 files randomly chosen from the last 1-3 months (see ANNEX 3.1)
- ◆ Observation of real cases
- ◆ Case scenarios
- ◆ Interviews with staff
- ◆ Structured interviews with mothers and other members of the family (see SECTION 4)

<b>8.1 Promotion of breastfeeding</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> The facility is a Baby Friendly hospital</li> <li><input type="checkbox"/> WHO code of breast milk substitute marketing is followed</li> <li><input type="checkbox"/> Breastfeeding is actively supported</li> <li><input type="checkbox"/> Breast feeding difficulties (e.g. “not enough milk”, refusal to breastfeed) are overcome</li> <li><input type="checkbox"/> Expressed breast milk is given with cup or NG-tube when the young infant is unable to feed or if the mother is not available all the time</li> </ul>		
<b>8.2 Nutritional management of the sick child</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Staff knows and apply the principles for feeding sick infants (see Pocket Book for details)</li> <li><input type="checkbox"/> Nutritional needs of all patients are covered, according to age and ability to feed</li> <li><input type="checkbox"/> Appropriate complementary food is offered at least 3 times a day to breastfed infants of over 6 months of age</li> <li><input type="checkbox"/> Feedings are offered at least 5 times a day to non-breastfed infants of 6 to 24 months of age</li> <li><input type="checkbox"/> A sufficient caloric intake (100 calories/kg for children under 10 kg,) is provided, if necessary by naso-gastric tube for children unable to feed.</li> </ul>		
<b>8.3 Use of intravenous fluids</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Intravenous fluids are given only when indicated</li> <li><input type="checkbox"/> Appropriate fluids are chosen</li> <li><input type="checkbox"/> The flow rate is monitored closely</li> </ul>		
<b>8.4 Management of fever</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Treatment of fever with drugs is restricted to</li> </ul>		

children with axillary temperature > 38.5 or uncomfortable or distressed <input type="checkbox"/> Adequate drugs (dosage, frequency) are prescribed		
<b>8.5 Management of pain</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Pain is routinely monitored <input type="checkbox"/> Adequate drugs are used to prevent and treat pain <input type="checkbox"/> There is no routine use of sedative drugs		
<b>8.6 Blood transfusion</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Blood transfusion is administered based on precise, selected indications <input type="checkbox"/> Only screened blood is used <input type="checkbox"/> The flow rate is monitored		
<b>8.7. Oxygen therapy</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Pulse oximetry is used to determine the presence of hypoxemia and to guide administration of oxygen <input type="checkbox"/> Children with hypoxemia receive appropriate oxygen therapy <input type="checkbox"/> Children living at $\leq 2500$ m above sea level receive oxygen therapy if their oxygen saturation is $\leq 90\%$ <input type="checkbox"/> Nasal prongs are the preferred method for delivery <input type="checkbox"/> Children with hypoxemia are closely monitored using pulse oximetry		
<b>8.8 Toys and play therapy</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Appropriate toys and play therapy are available at hospital level <input type="checkbox"/> Specific support is provided to children with long duration of stay		

**SCORE FOR 8. SUPPORTIVE CARE**

KEY PRACTICES/ITEMS	SCORE
<b>8.1 Promotion of breastfeeding</b>	
<b>8.2 Nutritional management of the sick child</b>	
<b>8.3 Use of intravenous fluids</b>	
<b>8.4 Management of fever</b>	
<b>8.5 Management of pain</b>	
<b>8.6 Blood transfusion</b>	
<b>8.7 Oxygen therapy</b>	
<b>8.8 Toys and play therapy</b>	
<b>CHAPTER 8 SCORE</b>	

## SUMMARY

### MAIN STRENGTHS:

- 1.
- 2.
- 3.
- 4.
- 5.

### MAIN WEAKNESSES:

- 1.
- 2.
- 3.
- 4.
- 5.

### COMMENTS:

- 1.
- 2.
- 3.
- 4.
- 5.

## 9. Monitoring and follow-up

**Objective:** To evaluate the practices related to monitoring and follow-up for hospitalised children

**Sources of data:**

- ◆ Documents and records:
  - Written guidelines and protocols (use also ANNEX 11.1)
  - Medical records: review a minimum of 35 files randomly chosen from the last 1-3 months (see ANNEX 3.1)
- ◆ Observation of real cases
- ◆ Interviews with staff
- ◆ Structured interviews with mothers and other members of the family (see SECTION 4)

9.1 Monitoring of individual progress	Score	Comments
<ul style="list-style-type: none"> <li>□ Roles and responsibility on monitoring are clearly defined at hospital level, both for doctors and nurses</li> <li>□ At the time of admission, a monitoring plan is prescribed according to the severity of the child's condition</li> <li>□ A standard monitoring chart is used with the following information: child details; vital signs; clinical signs depending on condition; treatments given, feeding, and outcome</li> </ul>		
9.2 Reassessment and monitoring by nurses	Score	Comments
<ul style="list-style-type: none"> <li>□ Key risk signs are monitored and recorded by the nurse twice a day and at least 4 times a day for critically ill children</li> <li>□ Doses and time of administration are recorded by the nurse in the medical records for each medication given</li> <li>□ If IV fluids or medicines are given, the following relevant information are recorded in the medical record: type of infusion, total amount, infusion speed, time of start and time of end of infusion</li> <li>□ Additional special monitoring is performed and recorded appropriately when needed to follow the progress of particular conditions</li> <li>□ Nurses use the results of children monitoring to alert the physicians of problems or changing status warranting their attention</li> </ul>		
9.3 Reassessment by doctors	Score	Comments
<ul style="list-style-type: none"> <li>□ Children are re-assessed by a doctor after admission and reviewed at least once a day, twice for seriously ill children (if there is a specific policy, this professional could be an experienced midwife/nurse)</li> </ul>		
9.4 Follow up after discharge	Score	Comments



<ul style="list-style-type: none"> <li><input type="checkbox"/> If needed, follow up is arranged before discharge in the health facility closest to the child's home that can provide the necessary follow up treatment</li> <li><input type="checkbox"/> Every child receives a discharge note providing information on the condition and on the hospitalisation period</li> </ul>		

**SCORE FOR 9. MONITORING AND FOLLOW-UP**

	Score
<b>9.1 Monitoring of individual progress</b>	
<b>9.2 Reassessment and monitoring by nurses</b>	
<b>9.3 Reassessment by doctors</b>	
<b>9.4 Follow up after discharge</b>	
<b>CHAPTER 9 SCORE</b>	

**SUMMARY**

<p><b>MAIN STRENGTHS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>MAIN WEAKNESSES:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>COMMENTS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>

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# **SECTION 3**

## **POLICIES AND ORGANISATION OF SERVICES**

**10. Infection prevention**

**11. Guidelines and audit**

**12. Access to hospital care and continuity of care**

**13. Children's and their caretakers' rights to accessible, respectful,  
and holistic care**

## 10. Infection prevention

**Objective:** To evaluate the integrated prevention, control and management of hospital associated infections for both curative and preventive activities.

**Source of data and instructions:**

- ◆ Documents and records: policies, protocols and guidelines (use also ANNEX 11.1)
- ◆ Observation of equipment and practices in all areas that serve children
- ◆ Informal talks with staff provide a complementary source of information

10.1 Infection control policies	Score	Comments
<ul style="list-style-type: none"> <li>□ A National or regional infection control programme is implemented in the hospital</li> <li>□ Infection control policies and protocols are developed and disseminated</li> <li>□ Key data are collected for monitoring purposes, (such as % infection, infection sites) and regularly analysed and discussed</li> <li>□ Regular staff training and supervision on infection prevention is provided</li> <li>□ A system is in place for incident monitoring (accidental exposure, needle puncture, etc)</li> <li>□ A staff health check-up policy is in place</li> <li>□ There is a policy for patients' personal hygiene and for staff's personal hygiene (nails, uniforms)</li> <li>□ Policies do not contain ineffective and resource wasting procedures, such as:               <ul style="list-style-type: none"> <li>- Ultraviolet lamp for disinfection</li> <li>- Restriction of family visits</li> <li>- Routine policy of changing clothing and footwear when entering intensive care units</li> <li>- Routine environmental sampling</li> </ul> </li> </ul>		
10.2 Hand washing	Score	Comments
<ul style="list-style-type: none"> <li>□ Hand washing written procedure or flow chart is attached near or above wash basins (WHO, National/Regional, local language)</li> <li>□ Adequate facilities and supplies for proper hand washing (Clean water, Soap bar and soap rack which drains, Soap dispenser cleaned thoroughly on regular basis, Waterless, alcohol based hands rub, Disposable towels or clean towels)</li> <li>□ Hand washing is performed by health staff               <ul style="list-style-type: none"> <li>- Before and after medical and nursing procedures</li> <li>- Between patient contact</li> </ul> </li> </ul>		
10.3 Use of gloves	Score	Comments
<ul style="list-style-type: none"> <li>□ Non sterile gloves are available</li> <li>□ Non sterile gloves are used in a proper way:               <ul style="list-style-type: none"> <li>- Separate pair for each patient</li> <li>- When handling soiled instruments</li> </ul> </li> </ul>		

<ul style="list-style-type: none"> <li>- When touching blood, body fluids</li> <li>- No touching “around” with dirty gloves</li> <li><input type="checkbox"/> Sterile gloves are available</li> <li><input type="checkbox"/> Sterile gloves are used for aseptic techniques</li> <li><input type="checkbox"/> Double gloving in case of high risk of gloves perforation or with patients with HIV, HBV, HCV</li> </ul>		
<b>10.4 Patients’ and staff personal hygiene</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> There are adequate services (toilets, showers) to ensure patients’ and staff’s personal hygiene</li> </ul>		
<b>10.5 Isolation</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> A specific area is dedicated to cases requiring isolation</li> <li><input type="checkbox"/> Isolation precautions follow evidence based guidelines</li> </ul>		
<b>10.6 Laundry</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Clean linen is stored separately from soiled linen</li> <li><input type="checkbox"/> Clean linen is transported separately from soiled linen</li> <li><input type="checkbox"/> Used linen (sheets, cotton blankets) are washed in hot water (70°C to 80°C) with detergent and disinfectant</li> </ul>		
<b>10.7 Management of wastes</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Clearly defined procedures and protocols for collection and handling of wastes are applied</li> <li><input type="checkbox"/> Waste is transported in a dedicated trolley which is not used for any other purpose and is cleaned regularly</li> <li><input type="checkbox"/> Incinerator is functioning properly</li> <li><input type="checkbox"/> Sharps are collected and stored in sharps containers (plastic or metal box, marked with appropriate label and closed lid)</li> <li><input type="checkbox"/> Waste storage areas are clearly identified</li> </ul>		
<b>10.8 Sterilization</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Steam or heat sterilization is available</li> <li><input type="checkbox"/> Instruments/equipment are cleaned or decontaminated before sterilization</li> <li><input type="checkbox"/> Sterilized instruments and equipment are stored in protecting packaging (dust, moisture, humidity, insects)</li> <li><input type="checkbox"/> The storage system clearly indicates which items are sterile</li> <li><input type="checkbox"/> The sterilization system is used properly: <ul style="list-style-type: none"> <li>o (Time, Temperature, Packing, Monitoring and tracking, Quality control)</li> </ul> </li> </ul>		

**SCORE FOR 10. INFECTION PREVENTION**

<b>KEY ITEMS</b>	<b>Score</b>
10.1 Infection control policies	
10.2 Hand washing	
10.3 Use of gloves	
10.4 Patients' and staff personal hygiene	
10.5 Isolation	
10.6 Laundry	
10.7 Management of wastes	
10.8 Sterilization	
<b>CHAPTER 10 SCORE</b>	

**SUMMARY**

<p><b>MAIN STRENGTHS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>MAIN WEAKNESSES:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>COMMENTS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>

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## 11. Guidelines, training and audit

**Objective:** To evaluate the existence, dissemination and use of evidence based guidance in clinical practice; to assess audit and use of case reviews to improve QoC

**Source of data and instructions:**

- ◆ Documents and records: policies, protocols and guidelines; training outlines and records; case files; records of audit meetings
- ◆ Observation of practice, availability of guidelines and supporting material to assist implementation of the guidelines in all areas that serve children
- ◆ Interviews with randomly selected staff (see section on interviews); informal talks with staff provides a complementary source of information

<b>11.1 Guidelines are available</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Use Annex 11.1 to review availability</li> <li><input type="checkbox"/> Guidelines and protocols are available on an appropriate range of topics</li> <li><input type="checkbox"/> Job aids or other material to assist implementation to clinical practice are available</li> </ul>		
<b>11.1 Guidelines are used</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Guidelines and protocols are printed, distributed, and easily available for use in the areas in which they are relevant</li> <li><input type="checkbox"/> Staff has been trained on the guidelines and protocols, or adequate mechanisms have been put in place to ensure guideline dissemination among the staff</li> <li><input type="checkbox"/> New staff are orientated to key guidelines and protocols when they start work</li> <li><input type="checkbox"/> There is a committee (group of people) responsible for periodical review and update of protocols and job aids</li> </ul>		
<b>11.3 Learning resources are available</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> At least one recent paediatric nursing textbook is readily available (not older than 5 years)</li> <li><input type="checkbox"/> At least one recent paediatric textbook is readily available (not older than 5 years)</li> <li><input type="checkbox"/> At least one recent general nursing textbook is readily available (not older than 5 years)</li> <li><input type="checkbox"/> There is a computer with a working internet connection to ensure access to update health care literature and sources of e-learning</li> </ul>		
<b>11.4 In service training is provided</b>	<b>Score</b>	<b>Comments</b>

<ul style="list-style-type: none"> <li><input type="checkbox"/> There is an overall programme for in service training for all relevant staff</li> <li><input type="checkbox"/> Training update sessions related to practice take place regularly, including drills (simulated practice), use of emergency charts, equipment etc.</li> <li><input type="checkbox"/> Training includes practical sessions such as role plays</li> <li><input type="checkbox"/> There is a period of supervision or mentoring for newly appointed staff</li> </ul>		
<p><b>11.5 Continuous professional education is provided</b></p>	<p><b>Score</b></p>	<p><b>Comments</b></p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> There is a national continuous education and professional development program endorsed by the hospital</li> <li><input type="checkbox"/> Doctors and nurse are actively encouraged by the administration of the facility to follow national continuous education and professional development programs</li> <li><input type="checkbox"/> Courses of medical English are offered to improve access to resources in English</li> </ul>		
<p><b>11.6 Team working is encouraged</b></p>	<p><b>Score</b></p>	<p><b>Comments</b></p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Regular staff meetings are held to discuss organizational aspects of care</li> <li><input type="checkbox"/> All staff are involved in these meetings <ul style="list-style-type: none"> <li><input type="checkbox"/> Nurses</li> <li><input type="checkbox"/> Doctors</li> <li><input type="checkbox"/> Other health workers</li> </ul> </li> <li><input type="checkbox"/> Nurses and staff from other specific disciplines (e.g. laboratory staff) run their own periodic meetings</li> </ul>		
<p><b>11.7 Audit and review process is in place</b></p>	<p><b>Score</b></p>	<p><b>Comments</b></p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> A policy or protocol requires regular audits and reviews to take place</li> <li><input type="checkbox"/> There is a committee (group of people) responsible for organizing audits and case reviews: <ul style="list-style-type: none"> <li><input type="checkbox"/> as routine</li> <li><input type="checkbox"/> in response to an incident or concern</li> </ul> </li> </ul>		
<p><b>11.8 Audit and case reviews are conducted</b></p>	<p><b>Score</b></p>	<p><b>Comments</b></p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Case reviews are conducted to analyse and discuss all cases of deaths</li> <li><input type="checkbox"/> Case reviews are conducted to analyse and discuss cases of severe complications</li> <li><input type="checkbox"/> Case reviews involve all team members</li> </ul>		

<p>including nurses</p> <ul style="list-style-type: none"><li>□ Case reviews are conducted based on updated, evidence-based clinical guidelines and local protocols</li><li>□ Case reviews are conducted in a confidential setting with a no-blame attitude</li><li>□ Case reviews discuss contributing factors and causes of substandard care</li><li>□ Recommendations from reviews are developed and implemented</li><li>□ A quantitative method is used to evaluate adherence of clinical management of cases to evidence based guidelines</li></ul>		
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## ANNEX 11.1 Availability of guidelines and protocols

Use the following table to check availability of essential guidelines7protocols, together with local protocols or materials to assist implementation of guidelines such as job aids, pocket and wall charts. Note that the list is not exhaustive but includes only essential guidelines.

### Definitions:

- **National guideline/protocol/policy:** developed at country level.
- **Local protocol/procedures:** developed at hospital level. These take into account the availability of services at hospital level (e.g. lab working hours, availability of intensive care and subsequent need for case-referral or not etc)

	National	Local	Job Aids (describe)
<b>Pharmacy</b>			
Essential children's medicine list			
Pharmacy product procurement system			
Storage of drugs (including disposal of expired drugs and donations)			
System for distribution to hospital wards			
Ward management of medicine supplies			
Monitoring of adverse medicine reaction			
<b>Equipment</b>			
Use and maintenance of equipment			
Suction equipment			
Pulse-oxymeter			
Oxygen concentrator, or other equipment for the delivery of oxygen			
Nebuliser			
Multi-functions monitors			
Glucometer			
Radiant warmer, other heating systems			
Mechanical ventilators			
<b>Laboratory and blood bank</b>			
Quality control procedures			
Use of blood for transfusions (including blood screening)			
<b>Case management</b>			
Emergency triage and treatment			
Severe Respiratory distress			

Shock			
Convulsions			
Hypoglycemia			
Pneumonia			
Broncho-obstruction			
Other respiratory diseases			
Diarrhoea			
Other conditions presenting with fever (specify)			
Anaemia			
Growth delay			
Chronic diseases (specify)			
<b>Supportive care</b>			
Breastfeeding and child nutrition			
Management of fever			
Management of pain			
Oxygen therapy			
Play therapy			
Provision of health information relevant to child health care			
<b>Infection prevention</b>			
Hand washing / hand hygiene			
Use of gloves			
Management of wastes			
Use of detergents and disinfectants			
Isolation precautions			
Patients' personal hygiene			
Staff health check-up			
<b>Audit systems</b>			
Audit and review of case management			
<b>Continuity of care</b>			
Criteria for case referral from PHC and to a higher level of care			
Procedures in case of an abandoned child/other procedures to activate social services			
<b>Children rights</b>			
Informed consent			
Counselling and communication and			

respectful care			
Procedures for collecting complaints from hospital users			

**SCORE FOR 11. GUIDELINES AND AUDIT**

KEY ITEMS	Score
11.1 Guidelines are available	
11.1 Guidelines are used	
11.3 Learning resources are available	
11.4 In service training occurs	
11.5 Continuous professional education occurs	
11.6 Team working is encouraged	
11.7 Audit and review process is in place	
11.8 Audit and case reviews are conducted	
<b>CHAPTER 11 SCORE</b>	

**SUMMARY**

<p><b>MAIN STRENGTHS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>MAIN WEAKNESSES:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>COMMENTS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>

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## 12. Access to hospital care and continuity of care

**Objective:** to evaluate whether there are gaps in access to care and in continuity of care

**Source of data and instructions:**

- ◆ Documents and records: guidelines/procedures on referral process from primary care to hospital and from the hospital to higher levels of care (use also ANNEX 11.1);
- ◆ individual records for referral notes, appropriateness of referral and compliance with guidelines (minimum 20 records)
- ◆ Interviews with staff members and with mothers and other members of the family on their experience of access to care and continuity of care (see section on interviews)

\* When evaluating economical barriers (point 11.2 and 11.4), ask about all types of fees: admission fees and cost of medicines, laboratory investigations, examinations, equipment and supplies. A “critical barrier” is defined as a cost high enough to represent, for some families, a barrier to seeking and obtaining hospital care or to cause a woman/family to borrow money to be able to have access to care.

11.2 Coordination with primary health care (PHC)	Score	Comments
<ul style="list-style-type: none"> <li>□ There are explicit guidelines/procedures agreed with PHC on case referral, including:                             <ul style="list-style-type: none"> <li>- Explicit criteria for case referral to the hospital and other health services</li> <li>- Use of referral note (i.e. a note specifying reasons for referral and treatment given)</li> <li>- Adequate information to mothers/families regarding available services, opening times, costs, and where services are located</li> <li>- Criteria and procedures for hospital transport</li> <li>- Hospital procedures to triage referred cases</li> </ul> </li> <li>□ Systems are in place to provide regular communication with PHC (e.g. meetings are organised with PHC to discuss statistics on case referral and to audit specific cases, such as all mortality/severe cases)</li> <li>□ The hospital management, or specific units (such as paediatric department) carry out activities (training and or supervision, development of protocols) aimed at improving the quality of case management at PHC level and of referral from PHC facilities (such as for example, discussion of cases referred based on IMCI criteria)</li> </ul>		
12.2 Access to hospital	Score	Comments
<ul style="list-style-type: none"> <li>□ Access to hospital is not restricted based on race, ethnicity, cultural or religious grounds</li> <li>□ Lack of hospital transport is not a barrier to hospital access</li> <li>□ Cost of transport is not a barrier to hospital access*</li> <li>□ Hospital fees are not a critical barrier to hospital access*</li> <li>□ Information about hospital fees is clearly provided</li> </ul>		



<p>to women and family members and fees are displayed in the ward/hospital</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> There are no unofficial payments requested by staff from women or families</li> <li><input type="checkbox"/> Users' perception of quality of hospital care is not a barrier to hospital access</li> </ul>		
<b>12.3 In hospital continuity of care</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> There are systems in place to ensure appropriate communication among clinical staff members on case management, (e.g. procedure to ensure communication on staff shifts; clinical meetings, etc) both for doctors and for nurses</li> <li><input type="checkbox"/> There are systems in place to ensure communication among different clinical services in the hospital in order to integrate case management of women and their newborns (e.g. paediatric department and reanimation)</li> <li><input type="checkbox"/> There are systems in place to ensure communication among different health services, (e.g. clinical services and social services)</li> </ul>		
<b>12.4 Referral to a higher level of care or to other health services</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> There are explicit guidelines/procedures agreed with other hospitals/health services on case referral, including: <ul style="list-style-type: none"> <li>- Explicit criteria for case referral (including for referral to social services)</li> <li>- Use of referral note (i.e. a note specifying reasons for referral and treatment given)</li> <li>- Adequate information to mothers/families regarding the services to which the case is referred, cost (if any), and where services are located</li> <li>- Criteria for hospital transport</li> <li>- Hospital procedures to triage referred cases</li> </ul> </li> <li><input type="checkbox"/> Lack of transport is not a barrier to referral (including a cause of delayed referral)</li> <li><input type="checkbox"/> Cost for transport is not a barrier to referral (including a cause of delayed referral)*</li> <li><input type="checkbox"/> Fees or other costs are not a critical barrier to referral*</li> <li><input type="checkbox"/> Systems are in place to provide regular communication with other hospitals/health services (e.g. meetings with other hospital and health services to discuss statistics on case referral and to audit specific cases, including all mortality/severe cases)</li> <li><input type="checkbox"/> Continuity of care is not compromised by separation of service provision based on age, or common condition (e.g. patients with diarrhoea are referred to infectious disease hospital)</li> </ul>		
<b>12.5 Discharge</b>	<b>Score</b>	<b>Comments</b>

<ul style="list-style-type: none"><li data-bbox="159 208 898 383">□ For each child at discharge a discharge note is given, containing all essential information to PHC services, health professionals and /or other services (e.g. social services) involved in continuity of care</li><li data-bbox="159 383 898 526">□ The discharge report contains all essential information for caretaker provided in a clear and culturally appropriate way</li></ul>		

**SCORE FOR 12. ACCESS TO HOSPITAL CARE AND CONTINUITY OF CARE**

<b>KEY PRACTICES/ITEMS</b>	<b>Score</b>
<b>11.1 Coordination with primary health care (PHC)</b>	
<b>12.2 Access to hospital</b>	
<b>12.3 In hospital continuity of care</b>	
<b>12.4 Referral to a higher level of care or to other health services</b>	
<b>12.5 Discharge</b>	
<b>CHAPTER 12 SCORE</b>	

**SUMMARY**

<p><b>MAIN STRENGTHS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>MAIN WEAKNESSES:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>COMMENTS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>

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### 13. Children’s and their caretakers’ right to accessible, respectful, and holistic care

**Objective:** To assess the fulfilment of the right of children and their caretakers to accessible respectful and holistic care in all hospital policies and practices.

**Source of data and instructions:**

- ◆ Review of existing policies, protocols and guidelines (use also ANNEX 11.1)
- ◆ Medical records
- ◆ Direct observation of existing structures and practices
- ◆ Interviews and informal talks with hospital manager, health professionals and mothers

<b>13.1 A charter on children’s rights is adopted and made readily available</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ The hospital has adopted a charter (or written policies) that specifies the rights of children and their caretakers</li> <li>□ The adopted charter is based on international standards</li> <li>□ Health professionals know the contents of the charter and are aware of their role in implementing it</li> <li>□ A process exists to monitor the implementation of the charter, act on existing gaps and update charter as needed</li> <li>□ The charter is written in a way to be understandable to all service users, including translation in local languages</li> <li>□ The charter is clearly visible in all areas that serve children and their caretakers               <ul style="list-style-type: none"> <li>- Out-patients</li> <li>- Emergency</li> <li>- Paediatric ward</li> <li>- Other departments serving children</li> </ul> </li> </ul>		
<b>13.2 Care is financially accessible to all</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Hospitalization and related treatments and supplies do not imply significant costs for the families or such costs are subsidized for those not able to pay</li> <li>□ Clear information is provided regarding services that are free of charge and services that have a cost (including hospitalization, laboratory tests, medicines, food, bed linen etc. for mothers and newborns)</li> <li>□ Unofficial payments to individual staff or hospital are prohibited</li> </ul>		
<b>13.3 Care is provided without any discrimination</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li>□ Care is provided without limitation by race, ethnicity, religion</li> <li>□ Attention is given to providing signage and information in ways that are understandable by people with low literacy or</li> </ul>		

speaking minority languages		
<b>13.4 Logistics are adequate to ensure timely access</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Timely transport is ensured for referrals to and from the hospital <input type="checkbox"/> Out-patient services have opening times that facilitate access <input type="checkbox"/> Waiting times are minimized for outpatient visits and admissions <input type="checkbox"/> Administrative procedures do not delay emergency care		
<b>13.5 Continuity of care is ensured</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Functioning links exist between : <ul style="list-style-type: none"> <li>- Primary care services and the hospital</li> <li>- Hospital and primary care</li> <li>- Hospital and higher level hospital</li> </ul> <input type="checkbox"/> Mothers/caretakers hold the essential information on health status and care of their children (baby/child card or booklet) <input type="checkbox"/> A referral note is given to caretakers <input type="checkbox"/> A discharge report is given to caretakers <input type="checkbox"/> The discharge report contains all essential information to PHC services, health professionals and /or other services (e.g. social services) involved in continuity of care <input type="checkbox"/> The discharge report contains all essential information for caretaker provided in a clear and culturally appropriate way <input type="checkbox"/> Communication flow between hospital and PHC services is ensured through periodic meetings		
<b>13.6 Unnecessary hospital stay, procedures and treatments are avoided</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Unnecessary hospitalization is avoided <input type="checkbox"/> Unnecessarily long hospitalizations are avoided <input type="checkbox"/> Unnecessary investigations and treatments are avoided <input type="checkbox"/> Unnecessary medicines are not prescribed <input type="checkbox"/> Movement is not restricted unless there is a medical need for restriction <input type="checkbox"/> Children are always admitted in paediatric wards/rooms even if their health problem pertains to specialties (e.g. surgery)		
<b>13.7 Pain is avoided and correctly managed</b>	<b>Score</b>	<b>Comments</b>
<input type="checkbox"/> Painful procedures are avoided when less invasive alternatives are available (e.g oral drugs are preferred to injections, if with equal proven efficacy) <input type="checkbox"/> Procedures are planned to minimize pain and discomfort: <ul style="list-style-type: none"> <li>- Blood testing (frequency of blood draws and number of separate draws)</li> <li>- Other painful procedures</li> </ul> <input type="checkbox"/> During painful procedures and situations, pain is minimized		

<ul style="list-style-type: none"> <li>- Pain evaluation is carried out whenever appropriate for the child's condition</li> <li>- Pain relief is provided whenever appropriate</li> </ul>		
<p><b>13.8 Privacy and confidentiality are ensured</b></p>	<p><b>Score</b></p>	<p><b>Comments</b></p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Cultural and religious beliefs and practices are respected</li> <li><input type="checkbox"/> Beliefs and practices that may result in risks to health or safety are discussed in a respectful manner</li> <li><input type="checkbox"/> Special attention and support is given to children with special needs and their caretakers</li> <li><input type="checkbox"/> Health professionals respond to the emotional concerns of children and their caretakers</li> <li><input type="checkbox"/> Adolescents are admitted in separate rooms</li> <li><input type="checkbox"/> Male and female older children and adolescents are admitted in separate rooms</li> <li><input type="checkbox"/> Children are always informed and examined in private areas</li> </ul>		
<p><b>13.9 Adequate and appropriate communication is ensured</b></p>	<p><b>Score</b></p>	<p><b>Comments</b></p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Health personnel are trained in communications skills</li> <li><input type="checkbox"/> Adequate information is provided to caretakers on the child's conditions, likely diagnosis, procedures and treatments</li> <li><input type="checkbox"/> Questions or requests for further information are encouraged</li> <li><input type="checkbox"/> Information is provided in a way that is culturally appropriate and easy to understand</li> <li><input type="checkbox"/> Information provided at discharge is written, clear and culturally appropriate</li> <li><input type="checkbox"/> Children with special needs and their caretakers receive additional attention and support</li> <li><input type="checkbox"/> Children over 6 and adolescents are asked about their condition directly and informed on all procedures and treatments</li> </ul>		
<p><b>13.10 Participation in care is encouraged</b></p>	<p><b>Score</b></p>	<p><b>Comments</b></p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Health professionals ask the mother and caretakers about the child condition and value their opinion</li> <li><input type="checkbox"/> Mothers and caretakers are encouraged to ask for staff support and guidance on how they can contribute to their child's care</li> <li><input type="checkbox"/> Children over 6 and adolescents are encouraged to contribute to their own care under staff supervision and guidance</li> <li><input type="checkbox"/> Written informed consent is requested for all major interventions and procedures</li> <li><input type="checkbox"/> There is a hospital policy fixing an age or other criteria at which the right to consent transfers to the child, in line with national/international legislation</li> <li><input type="checkbox"/> If mothers/caretakers are not available, hospital staff provides increased support, directly or through volunteers</li> <li><input type="checkbox"/> Mothers/caretakers are supplied with the means (long chairs,</li> </ul>		

<p>additional beds) to stay close to their children</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> If the mother is unable to remain with her hospitalized child, other family members are encouraged to stay with the child</li> <li><input type="checkbox"/> Unrestricted access of parents to their child is facilitated</li> <li><input type="checkbox"/> If the child stay is longer than a few days, the mother or other caretakers are offered an affordable place to stay close to the hospital</li> <li><input type="checkbox"/> Mothers / caretakers are allowed to visit a child in the ICU</li> </ul>		
<b>13.11 Child friendly environment</b>	<b>Score</b>	<b>Comments</b>
<ul style="list-style-type: none"> <li><input type="checkbox"/> The overall layout is child friendly, colourful and warm, with pictures and posters</li> <li><input type="checkbox"/> There are age appropriate books and toys</li> <li><input type="checkbox"/> There is a play-room</li> <li><input type="checkbox"/> There are volunteers or other staff to support play activities and entertain children particularly when family members are not available</li> <li><input type="checkbox"/> All children are encouraged and helped to play (even if they cannot leave their bed).</li> </ul>		

### SCORE FOR 13.3. RESPECTFUL CARE

KEY PRACTICES/ITEMS	Score
<b>13.1 A charter on children's rights is adopted and made readily available</b>	
<b>13.2 Care is financially accessible to all</b>	
<b>13.3 Care is provided without any discrimination</b>	
<b>13.4 Logistics are adequate to ensure timely access</b>	
<b>13.5 Continuity of care is ensured</b>	
<b>13.6 Unnecessary hospital stay, procedures and treatments are avoided</b>	
<b>13.7 Pain is avoided and correctly managed</b>	
<b>13.8 Privacy and confidentiality are ensured</b>	
<b>13.9 Adequate and appropriate communication is ensured</b>	
<b>13.10 Participation in care is encouraged</b>	
<b>13.11 Child friendly environment</b>	
<b>CHAPTER 13 SCORE</b>	



**SUMMARY**

**MAIN STRENGTHS:**

- 1.
- 2.
- 3.
- 4.
- 5.

**MAIN WEAKNESSES:**

- 1.
- 2.
- 3.
- 4.
- 5.

**COMMENTS:**

- 1.
- 2.
- 3.
- 4.
- 5.

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# **SECTION 4**

## **Interviews**

**ANNEX 4.1 Interview with staff**

**ANNEX 4.2 Interview with the mother of the child, and/or with other members of the family/other caregivers**

## ANNEX 4.1 Interview with staff

### Introduction

The interviews are an essential part of the assessment process and the interviewers are an integral part of the assessment team. The interviewers should be accurately selected and receive adequate time and support prior to the assessment to become familiar with the assessment purposes and with the interview tools. They should know how to introduce themselves and conduct the interviews in a way that will gain the trust of the person being interviewed, how to summarize the findings, including reporting relevant quotes. All this information will be used to provide feedback to the hospital staff during the final session.

Hospital managers should be informed prior to the visit that staff and mothers will be interviewed during the assessment and that the interviewers will select who to interview. This is important to ensure that the choice of staff and mothers is independent from the hospital management. Hospital managers should help the interviewers find a suitable place for the interviews. The other members of the assessment team should be available to support and assist the interviewers during their work.

### Instructions for the interviewers

#### a) Prepare for interviewing

**Review the questionnaire:** Please read the whole questionnaire before you start interviewing so that you are familiar with it. If anything is unclear or if you don't understand the meaning of some questions please ask the assessors for help. You can practise the questionnaire with another member of the team if you are new to this type of interviewing. Some questions/sections are applicable only to staff and others only to students. Where it is not specified the question/section applies to both staff and students.

**Find where to interview:** During the interview it is important that nobody else can hear what the member of staff is saying, that he/she feels secure and comfortable, and that he/she can concentrate on your questions. Therefore, before you start it is best to select an office or other suitable space where you and your respondent can talk alone and where disturbance is kept to a minimum. You may need to use different rooms to be near where the staff are working to keep the time staff are away from their clinical duties to a minimum. Ask staff and managers to help you if you have difficulty finding a suitable place.

**Choose who to interview:** Consider interviewing members of all staff categories that exist in the maternity and neonatal care departments (such as nurses, paediatricians, other doctors in charge of children, including students and other health professionals, heads of departments) and try to interview **at least 2 members of staff from each category**. Consider including some ancillary staff also (porters, cleaners etc) if these people have a high level of contact with mothers. Ask for the list of staff in service during the days of the assessment; this was also requested in the first part of the assessment. In order to maintain privacy and confidentiality look for each member of staff individually rather than give the list of names to a manager or other staff member to gather the people on the list to be sent to you for interview.

Prepare the required number of interview forms.

#### b) Conduct the interview

**How to approach staff:** We would like to record the honest opinions of hospital staff. For this reason, it is important that each member of staff you approach understands the aims of the interview, knows and trusts that the interview is completely confidential. Make sure you explain to him/her, that:

- the interview aims to find out directly from staff about their experience working for this hospital and their opinions about how things can be improved,
- he/she is free to choose to take part or not,
- the interview will be conducted in a private space, at a time suitable to them,

- there are no “correct” answers, and he/she is free to refuse to answer particular questions,
- colleagues and managers will NOT be told what he/she says in the interview,
- what he/she says in the interview may be used to report and give feedback on working conditions and QoC in the hospital, however his/her name will NOT be mentioned and will NOT appear in any written document.

**How to conduct the interview:** The questionnaire is a guide for your conversation with the respondent. Please do not show him/her the questionnaire during the interview to avoid influencing his/her answers. Read out one question at a time. Only if the meaning is unclear to the respondent then use your own words to explain. At the end of certain questions, there are “Examples”. These aim to help you understand the kind of information we are looking for, however you should not read them aloud to the respondent to avoid influencing their answer. These examples are not the only “correct” answers.

Write the respondent’s answer to each question in the box on the right hand side. Do not pressurize the respondent to answer if they feel uncomfortable with any of the questions. Simply make note of this in the answer box and proceed to the next question. Report the answer preferably according a “yes”, “now” and “why” framework. Often the respondent may only give a short answer, such as “yes”, “no”. When he/she gives longer answers, try to record answers using the interviewee’s own words, rather than trying to summarise the view expressed. Recording the actual words used often helps to properly represent what the person is trying to say. When doing this, please put the comments in quotation marks. For example:

*“we have a real problem with the water supply, sometimes days go by without piped water, how can we wash our hands to prevent spreading infection?”*

If you need more space to write, please continue on a separate sheet.

**How to close the interview:** If the respondent wishes, at the end of the interview, you can read out to him/her what you wrote, and he/she is free to make changes. Hospital staff is often very busy, so make sure you thank each respondent for giving his/her time.

Please do not leave forms lying about or in a place where people who are not members of the assessment team can read them.

After each interview, make sure you read through the respondent’s answers and underline or circle sentences and quotations which appear particularly important and you think may be significant later when summarising all the interviews and giving feedback. You can also use the “strengths”, “weaknesses” and “comments” boxes at the end of the form to help you in this.

### Staff Interview with staff members

Country:	Region (Oblast):	City/Town:
Facility code:	Interview number:	

<b>PART 1: PROFESSIONAL DETAILS</b>	
<b>FOR STAFF ONLY:</b>	Responses
Profession/main professional qualification	
Department, Unit Role and responsibilities	
In your work, are you using your main professional qualification?	
In what year did you obtain your main professional qualification?	
Have you obtained any further professional special qualifications? Please give details (title, year)	
How many years have you practiced in this profession?	
How long have you been working in this hospital?	
How long have you been working in your department/area/role within the hospital?	
<b>FOR STUDENTS ONLY:</b>	Responses
Title of course	
Year of enrolment	
When do you expect to qualify?	
When did you start your practical placement in this hospital and when will you finish?	
Current department/clinical area of work	
When did you start your practical placement in this current ward/clinical area and when will you finish?	
Are there specific skills you are required to gain during your placement in this clinical area, and how will these be assessed? Please explain briefly:	
Do you have an assigned tutor or mentor among the clinical staff? <i>If yes:</i> <ul style="list-style-type: none"> <li>○ How many other students is this person mentoring at the moment?</li> <li>○ How often do you work shifts together with your tutor/mentor?</li> </ul>	

Who can you ask for explanations or support during your work here?	
Do you think there are too many/too few students?	
Do you feel you have too much/too little autonomy in your work here?	
<b>PART 2: HOSPITAL SUPPORT SYSTEMS</b>	
<b>Staffing</b>	
Do you think there is a sufficient number of staff in your clinical area?	
Is there a good combination of more and less experienced staff on duty at every shift?	
Is there a lack of any particular type of professional (e.g. paediatric nurses, specialist doctors)?	
If staffing is inadequate, is this worse at certain times (e.g. weekends, nights)?	
Is there often new staff (high turnover)? If so, what is your opinion of this?	
Other comments on staffing	
<b>Working conditions/staff incentives</b>	<b>Responses</b>
Is work far from your home? <i>If yes, is your travel difficult or expensive?</i>	
Does the hospital support you in finding accommodation?	
If you have children, does the hospital provide support with childcare or schooling?	
Are you satisfied with your work schedule and shift patterns?	
Do you think you receive a fair salary?	
Do you feel satisfied with your entitlement to sick leave and holidays?	
Are there any rewards available to staff who perform particularly well? <i>If yes: Please describe:</i>	
Are staff who don't perform well punished in any way? <i>If yes: Please describe:</i>	
Do you feel you have adequate information on hospital policies and choices that are	

relevant to you and your work?	
<b>Equipment and supplies</b>	<b>Responses</b>
Based on your experience, please comment on the availability and quality of the following items in your clinical area. If there are any deficiencies, please give specific examples:	
Laboratory tests	
Equipment (e.g. oxygen, etc. )	
Medicines, i.v. fluids, blood products	
Disposable care supplies (e.g. syringes, gauze, gloves)	
Water and electricity	
Cleaning and disinfecting products	
Beds, cots, linen	
Food for children	
Toilets and washing facilities for children	
Items for documenting care	
Other	
<b>System constraints/access</b>	<b>Responses</b>
Does it happen that children are referred to the hospital too late? If yes, why do you think this happens? <i>Examples-(DO NOT READ OUT LOUD):</i> <ul style="list-style-type: none"> <li>○ Cultural reasons</li> <li>○ Cost</li> <li>○ Transport</li> <li>○ Other</li> </ul>	
Are there any specific problems regarding children referred from primary care or peripheral health facilities? If yes, what type of problems? <i>Examples-DO NOT READ OUT LOUD:</i> <ul style="list-style-type: none"> <li>○ Lack of standard criteria for referral</li> <li>○ Timing of decision</li> <li>○ Inadequate treatment before referral</li> <li>○ Transport time</li> <li>○ Resistance by families because of cultural reasons or cost</li> <li>○ Other</li> </ul>	
Are there problems when you have to refer children to more specialized centers? If yes, what type of problems?	



<p><i>Examples-DO NOT READ OUT LOUD:</i></p> <ul style="list-style-type: none"> <li>○ Lack of standard criteria for referral</li> <li>○ Timing of decision</li> <li>○ Difficulties in giving adequate treatment before referral</li> <li>○ Transport time</li> <li>○ Resistance by families because of cultural reasons or cost</li> <li>○ Communication with the referral center</li> </ul>	
<b>PART 3: GUIDELINES, CASE MANAGEMENT, AND PATIENT'S RIGHTS</b>	
<b>Case management/Clinical guidance</b>	<b>Responses</b>
Do you feel you are sufficiently supported in your clinical practice?	
Do you feel standards and protocols are lacking in your area of work?	
Are there any written materials or wall charts to illustrate standards and protocols in your area of work ?	
Are there copies of full clinical guidelines/protocols available in the clinical area where you work?	
<p>If clinical guidelines are not available in your area, where would you obtain further guidance if needed?</p> <p><i>Examples-DO NOT READ OUT LOUD:</i></p> <ul style="list-style-type: none"> <li>○ Senior colleagues</li> <li>○ Library</li> <li>○ Internet resources</li> </ul>	
<p>Have you ever been involved in the development of local guidelines or protocols?</p> <p><i>If yes, please describe:</i></p>	
<p>Is access to internet available in</p> <ul style="list-style-type: none"> <li>-your unit/department</li> <li>- the hospital</li> </ul> <p>Is it available all the time?</p> <p>Specify</p> <p>Do you have a personal (home) access to internet ?</p> <p>Do you use it also for professional purposes?</p>	
<b>Audit and reviews</b>	<b>Responses</b>
<p>Are meetings held in your department /unit to discuss clinical cases?</p> <p><i>If yes:</i></p>	

<p>Do they take place regularly and if so how often? When was the last meeting? Did you attend? Do you think these meetings are useful? Are these meetings held to make decisions regarding specific cases or also to discuss aspects of care that need to be improved?</p>	
<p>Do practical solutions on how to improve care emerge from these meetings?</p>	
<p>Do you think these solutions have been implemented? <i>If yes, have things improved?</i></p>	
<p>Are members of staff who are believed to have made mistakes in the management of clinical cases reprimanded or punished? <i>If yes, how?</i></p>	
<p>Aside from clinical or organizational meetings, have you ever made any suggestions to managers or senior colleagues on how to improve care? <i>If yes, please describe:</i></p>	
<p><i>If you did make suggestions, were you listened to? Were any actions taken?</i></p>	
<p>Do you feel you are given enough opportunities to express your opinions on:</p> <ul style="list-style-type: none"> <li>○ possible risks or concerns related to particular aspects of care</li> <li>○ how to improve care</li> </ul>	
<p>Do you feel involved in decisions related to hospital policies and choices?</p>	
<p><b>Facility of accreditation or supervision visits</b></p>	<p><b>Responses</b></p>
<p>Do external accreditation/supervision visits take place in this hospital? <i>If yes, how often do these take place and who conducts them?</i> When did the last one take place?</p>	
<p>Were you informed in advance of when the visit would take place? <i>If yes, did you have to prepare for the visit? Please describe preparation undertaken:</i></p>	
<p>After the visit, were any changes implemented in your workplace? <i>If yes, please give a brief description:</i></p>	
<p>What is your opinion of</p>	

accreditation/supervision visits?	
<b>Patient information and rights</b>	<b>Responses</b>
Do you think that parents/caregivers of children are adequately informed on their child's condition and treatment plan?	
Who is in charge of providing this information to parents? <ul style="list-style-type: none"> <li>• A specific staff member (for example the head of unit)</li> <li>• Only doctors</li> <li>• All doctors and nurses</li> </ul>	
During the time the child stays in hospital, when do you think it is important or useful to provide information to parents/caregivers? <ul style="list-style-type: none"> <li>• At admission</li> <li>• Every day</li> <li>• At discharge</li> <li>• in all these circumstances</li> </ul>	
Do you think that family consent (and child consent if the child is older(adolescent) is required for all treatments and diagnostic investigations? If not, when do you think this consent is necessary?	
Do you feel you have enough time to provide information to children/families?	
Do you feel you should receive specific training or guidelines on how to communicate with parents/caregivers and children in an effective way?	
Do you have materials/job aids/leaflets, which can help you to provide information to children/families?	
Is pain relief considered as part of case management? If yes, in which circumstances (surgery, painful procedures, other)	
Do you think the pain relief drugs and methods available to children are adequate?	
Do you know if there is a children's charter of rights (or policy) in this hospital? If yes, where is it?	
What are the hospital policies to ensure privacy when collecting information from the child and his/her family?	

Are there any initiatives taken by the hospital managers to collect users' views on the quality of health care?	
<b>PART 4: PROFESSIONAL DEVELOPMENT AND WORKING CONDITIONS</b>	
<b>FOR STAFF ONLY: In-service training</b>	<b>Responses</b>
Are you required to complete a certain amount of in-service training or updates (e.g. continuous medical education)? <i>If yes:</i> <ul style="list-style-type: none"> <li>○ How many hours/credits do you need to get, and in what timeframe?</li> <li>○ Is this standard set by the hospital or at the national level?</li> </ul>	
Have you taken part in any training updates organized by the hospital in the last year? <i>If yes: please give details:</i> <ul style="list-style-type: none"> <li>○ Title and duration</li> <li>○ Did you attend during work time, or had to take unpaid time off work ?</li> <li>○ Who paid the course fee (e.g. yourself, the hospital, an external sponsor)?</li> <li>○ Did you receive extra money for taking part (e.g. per diem)?</li> </ul>	
Have you attended any training updates organized outside the hospital in the last year? <i>If yes: please give details:</i> <ul style="list-style-type: none"> <li>○ Timing and duration</li> <li>○ Did you attend during work time, had to take unpaid time off work to go, go in your personal time?</li> <li>○ Who paid the course fee (e.g. yourself, the hospital, an external sponsor)?</li> <li>○ Did you receive extra money for taking part (e.g. per diem)?</li> </ul>	
What is your opinion of the quality of the courses you attended in the last year?	
How useful and relevant to your practice have these courses been?	
<b>FOR STAFF ONLY: Staff rotation</b>	<b>Responses</b>
Do you regularly rotate between different clinical areas/wards? <i>If yes, how often do you rotate?</i>	
If you rotate, do you like this system? In your view, what are its advantages and	

disadvantages?	
<b>FOR STAFF ONLY: Career progression</b>	<b>Responses</b>
Are there any opportunities for progress in your career in this hospital? <i>If yes: please describe:</i>	
How do you feel about this?	
<b>FOR STAFF ONLY: Teamwork and personal support in the workplace</b>	<b>Responses</b>
Do you feel supported by colleagues? <i>If yes: in what ways do you support each other?</i>	
Do you feel supported by your manager(s)? <i>If yes: in what way do they support you?</i>	
Do you feel supported by members of other professions? <i>If yes: in what way do they support you?</i>	
Have you witnessed any interpersonal conflicts arising among staff?	
What steps are usually taken to resolve this kind of conflicts?	
Have you been formally assigned to a colleague/senior member of staff (not your manager) who you can go to in confidence to discuss all or some of the following: <ul style="list-style-type: none"> <li>○ Your professional development needs</li> <li>○ Conflicts or problems in your workplace</li> <li>○ Professional/ethical issues arising from the management of clinical cases</li> </ul>	
<i>If yes: how often do you have a meeting with this person?</i>	
<b>Overall job satisfaction:</b>	<b>Responses</b>
Are you thinking of staying in this job indefinitely, or would you prefer to leave? Why?	
Is there anything else that could be changed in order to improve your experience of working here? <i>If yes: Please describe:</i>	
Any further comments you would like to make?	

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**SUMMARY OF STAFF INTERVIEW**

**MAIN STRENGTHS:**

- 1.
- 2.
- 3.
- 4.
- 5.

**MAIN WEAKNESSES:**

- 1.
- 2.
- 3.
- 4.
- 5.

**COMMENTS:**

- 1.
- 2.
- 3.
- 4.
- 5.

## **ANNEX 4.2 Interview with the mother of the child, and/or with other members of the family**

### **Introduction**

The interviews are an essential part of the assessment process and the interviewers are an integral part of the assessment team. The interviewers should be accurately selected and receive adequate time and support prior to the assessment to become familiar with the assessment purposes and with the interview tools. They should know how to introduce themselves and conduct the interviews in a way that will gain the trust of the person being interviewed, how to summarize the findings, including reporting relevant quotes. All this information will be used to provide feedback to the hospital staff during the final session.

Hospital managers should be informed prior to the visit that staff and mothers will be interviewed during the assessment and that the interviewers will select who to interview. This is important to ensure that the choice of staff and mothers is independent from the hospital management. Hospital managers should help the interviewers find a suitable place for the interviews. The other members of the assessment team should be available to support and assist the interviewers during their work.

### **Instructions for the interviewers**

#### **a) Prepare for interviewing**

**Review the questionnaire:** Please read the whole questionnaire before you start interviewing so that you are familiar with it. If anything is unclear or if you don't understand the meaning of some questions please ask the assessors for help. You can practise the questionnaire with another member of the team if you are new to this type of interviewing. At the beginning of certain questions, there is a note specifying to which category of children the question is applicable. However, in general, you should also use your own judgment in deciding which questions are relevant to a particular child.

**Find an appropriate place for the interview:** During the interview, it is important that no members of staff can hear what the mother/other member of the family is saying because this might influence their answers. If possible, the interviewed person should be able to speak freely without other mothers or relatives or health professionals around, and feel comfortable to report experiences and focus on your questions. Therefore a suitable space where you and your respondent can talk alone should be identified. You may need to use different spaces as you interview individuals in different services or units. If you plan to take the person away from the ward for interview, inform duty staff that such person is with you. Ask staff and managers to help you find a suitable place.

**Choose who to interview:** You should plan to interview mothers/other members of the family of children who are admitted to the hospital or are being discharged. Efforts should be made **to interview at least 10 people**. Ideally, cases interviewed should include children with different diagnosis and with different characteristics, such as:

- children with respiratory infections;
- children with diarrhoea;
- children with other causes of fever;
- children with anaemia and/or growth failure;
- children with chronic conditions;
- children treated in the reanimation units;
- adolescents.

Prepare the required number of interview forms.

## **b) Conduct the interview**

***How to approach the person to be interviewed:*** We would like to record the truthful and frank opinions of the children's parents. For this reason, it is important that each individual you approach understands the aims of the survey and knows and trusts that the interview is confidential. Make sure you explain that:

- the interview aims to find out directly from users about their experience of being cared for in this hospital, and their opinions about how things can be improved,
- she/he is free to choose to be interviewed or not,
- the interview will be conducted in a quiet space so that other people can't hear,
- there are no "correct" answers, and she/he is free to refuse to answer to some questions,
- she/he can stop the interview at any time or if she needs a break, the interview can be continued later,
- members of staff will NOT be told what he/she says in the interview: the participation will not have any negative effect on the care the child receives during the rest of the stay,
- what he/she says in the interview will be used to give feedback on users' experiences about QoC in the hospital, in order to improve it.
- The name of the interviewed person will NOT be linked to the reported contents and will NOT appear in any written document.

***How to conduct the interview:*** The questionnaire is a guide for your conversation with the person you are interviewing. Do not show him/her the questionnaire during the interview to avoid influencing answers. Read out one question at a time. Only if the meaning is unclear you can use your own words to provide clarifications. Write the answer to each question in the box on the right hand side. Make sure you maintain an encouraging, friendly and non-judgemental attitude. Do not press the person into answering if she/he feels uncomfortable with any of the questions. Simply make a note of this in the answer box, and proceed to the next question. The interviewed person may only give short answers, such as "yes", "no". When he/she gives longer answers, try to record the answers using the interviewee's own words, rather than trying to summarize. Quoting the actual words used often helps to represent accurately what the person is trying to say. When doing this, please put the comments in quotation marks. For example:  
*"I really wanted to stay in the room with my child and hold his hand, but the nurse told me to go outside, and I felt really scared"*

***How to close the interview:*** If the person interviewed wishes so, at the end of the interview you can read what you wrote, and she/he is free to make changes. People can get tired easily at this time, so make sure you thank them for giving you their time.

Please do not leave forms in places where people who are not members of the assessment team can read them.

After each interview, make sure you read through the respondent's answers and underline or circle sentences and quotations which appear particularly important and you think may be worth quoting when giving feedback. You are encouraged to use the "strengths", "weaknesses" and "comments" boxes at the end of the form to report on key answers.



## Mother Interview

Country:	Region (oblast):	City/Town:
Facility code:	Interview number:	

<b>PART 1: PERSONAL INFORMATION AND ACCESS</b>	
<b>Personal details</b>	<b>Responses</b>
How old are you?	
What is your occupation?	
Is this your first child? <i>If no</i> , how many other children do you have? How old is she/he?	
<b>Access to care and care at PHC level</b>	<b>Responses</b>
Did you bring the child to a health professional or a PHC facility before coming to hospital? - if yes, What happened? Did they refer you to the hospital and if yes, why? - If not, why did you decide to come to the hospital?	
Did you have to pay any money at the PHC or upon hospital admission? <i>If yes</i> , was this cost a significant burden for you?	
Do you live far from this hospital, and how did you travel here?	
Did you have to obtain permission from your husband or other members of your family to come at this hospital? <i>If yes</i> , was this difficult?	
In general, was it easy or difficult to access this hospital?	
<b>PART 2: CARE AT ADMISSION</b>	
<b>Admission</b>	<b>Responses</b>
When you arrived at the hospital, how long did you have to wait before a health worker examined you?	
Did your child get a physical examination?	
Were you allowed to stay in the same room with your child during the initial examination?	

Did the health workers explain what they were doing?	
Could you understand what they were doing?	
Did the health workers explain what would happen next?	
What types of information did you receive with respect to the health of your child?	
What were the administrative procedures for admission?	
Did you feel comfortable and cared for during the admission procedures? <i>If not, how could it have been better?</i> At admission, were you given information about your rights and duties during hospital stay? If yes, what were you told? Was that information given orally or written? Was this information available on the hospital walls or somewhere else for consultation?	
<b>PART 3: CARE DURING HOSPITALISATION</b>	
<b>General care</b>	<b>Responses</b>
Do you know what was the initial diagnosis for your child's admission?	
Have you been told which investigations were carried out and what the results were?	
Have you been given explanation about what the treatments were	
Was your child feeling pain in any moment? Was any pain reliever administered?	
Have you been allowed to stay with your child during investigations (e.g. blood sampling, x-rays and others)	
How often did doctors and nurses check on the conditions of your child?	
Were you given the opportunity to ask questions regarding your baby at any time or only at a specific times?	
Could you understand what doctors said? How was their attitude towards you?	
Have you ever felt confused because	

different members of staff have given you conflicting advice or information?	
Have you been allowed to express your opinion on the care of your child and if so, what was the issue and was your point of view taken into consideration?	
Did you ask to read your medical documentation or the records of your baby (case records)? <i>If yes, were you allowed to read the records?</i>	
Did you receive any indication on how to take care of your child now that he/she is ill?	
Do you know what the diagnosis is now?	
How many days has your child been hospitalised so far? Do you know why it was decided to keep your child in hospital for this length of time?	
Did you receive information on what to do after discharge ?	
Did you receive any other information on how to take care of your child when he/she returns home (e.g nutrition, hygiene etc)	
Were you given an appointment for a follow up visit?	
<b>Rooms and hospital services</b>	
What do you think about the room that was assigned to your child in hospital ?  Have you been allowed to stay with your child all the time? If not, when were you allowed to stay with your child?	
Do you think there is enough privacy in the room?  How many other children were there in the same room?	
Did you receive information on your child here or in a separate place? If you did not receive information, did this represent a problem for you?	
Were you given the possibility to remain overnight?	

What facilities are available for overnight stay? Are they comfortable?	
In your view are there adequate hygiene facilities (toilets –showers)?	
Are you allowed to bring toys, children’s books etc. in the hospital? Is there any toy provided by the hospital? Is there a play room?	
Have other members of the family or friends been allowed to visit? If yes, is there a space to talk with them?	
Has your child been asked directly about how she/he felt or about her/his opinions on procedures, treatment , food or other aspects of care? Was this done in a separate room? Were you present?	
Did your child express any opinion or feeling about the way she/he was treated or was given explanations ?	
<b>Infant feeding</b>	<b>Responses</b>
How is your child fed?	
Does the child like hospital food?	
Is there any space for you to store or prepare food for your child?	
Have you been asked to bring your own food? For the child? Only for yourself?	
<i>If breastfeeding:</i> Have you had any problems with breastfeeding? If yes, what kind of problems:	
<i>If breastfeeding:</i> If you had problems, did the staff give you advice on how to solve these problems?	
<i>If breastfeeding:</i> If your baby is staying in a special area for sick babies, are you allowed to breastfeed your baby there?	
<i>If breastfeeding:</i> If your baby is too small or ill to suck, did the staff show you how to express your milk?	
Overall, do you feel you received enough support from the staff with feeding your baby? Please explain:	

<b>Cost</b>	
Have you had to pay for any services or products during your stay? Will you have to pay before you leave? <i>If yes, please specify how much you paid (will pay), and for what items:</i>	
Has it been/is it expensive for you to keep your baby in this hospital? Did you have to borrow money?	
<b>Overall satisfaction</b>	<b>Responses</b>
Overall, do you feel you received enough help from the staff to take care of yourself during your stay?	
Overall, do you feel the staff treated you with respect? Did they respect your personal wishes, your culture, your religion? Please explain:	
Overall, are you satisfied with the way staff members tried to prevent or reduce or manage pain and painful procedures? Please explain:	
Do you have any other comments or suggestions on how care could be improved for mothers and babies in this hospital?	
Would you know where and how to complain if you felt you had not been treated with respect and dignity?	

**SUMMARY OF MOTHER INTERVIEW**

<p><b>MAIN STRENGTHS:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>
<p><b>MAIN WEAKNESSES:</b></p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> <li>5.</li> </ol>

**COMMENTS:**

- 1.
- 2.
- 3.
- 4.
- 5.

**SECTION 5**  
**DELIVERING FEEDBACK ON  
ASSESSMENT FINDINGS AND  
FACILITATING THE DRAWING UP OF  
A PRELIMINARY PLAN FOR ACTION**

## ANNEX 5.1 Synthesising the assessment results

Before the end of the assessment this table should be completed in the course of a team discussion. It can help guide the delivery of the feedback on the assessment to the hospital staff.

<b>Hospital support system</b>	<b>Strengths</b>	<b>Weakness</b>	<b>SCORE</b>
1.1 Physical structure, staffing and basic services			
1.2 Statistics, health management information system, medical records			
1.3 Pharmacy management and medicine availability			
1.4 Equipment			
1.5 Supplies			
1.6 Laboratory support			
1.7 Ward infrastructures			
<b>Case management</b>			
2. Emergency triage and treatment			
3. Case management of respiratory diseases			
4. Case management of diarrhoea			
5. Case management of other conditions presenting with fever			



6. Case management of anaemia and growth failure			
7. Case management of main chronic conditions			
8. Supportive care			
9. Monitoring and follow-up			
<b>Organisation of services</b>			
10. Infection prevention			
11. Guidelines and audit			
12. Access to hospital care and continuity of care			
13. Children's and their caregivers' rights to accessible, respectful, and holistic care			

**Note: Scoring system**

3 = care corresponding to international standards (no need for improvement or need for minor improvements only);

2 = substandard care but no significant hazard to health or violation of human rights (need for some improvement to reach standard care);

1 = inadequate care with consequent serious health hazards or violation of children's rights, (e.g. omission of evidence based interventions or information with consequent risk for health or violation of human rights (need for substantial improvement to reach standard care)

0 = very poor care with consequent systematic and severe hazards to the health of children.

### ANNEX 5.2 Action plan at hospital level

Discuss the above summary of hospital findings with the senior hospital management, giving details and providing real examples as appropriate. Discuss their perception of the findings, and how action could be taken to improve services for mothers and babies. Discuss the importance and feasibility of each action. Write down a plan of action, using the following matrix (expand as needed).

PRIORITY PROBLEMS	ACTION NEEDED (INCLUDING REMOVAL OF BARRIERS) Identify actions needed at facility level and at national level	RESPONSIBLE PERSON AND TIMETABLE

### ANNEX 5.3 Action plan at national level

When the findings of the evaluation are discussed at a national/central level, it may help to use this matrix. Expand the matrix as needed.

<b>HEALTH SERVICE FUNCTION</b>	<b>PRIORITY PROBLEMS</b>	<b>ACTIONS NEEDED (INCLUDING REMOVAL OF BARRIERS)</b>	<b>RESPONSIBLE PERSON AND TIMELINES</b>
1. Stewardship and Governance			
2. Service Delivery			
3. Infrastructure And Commodities			
4. Human Resources			
5. Financing			
6. Information System			

**The WHO Regional Office for Europe**

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Ukraine  
United Kingdom  
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This tool allows for a systematic, participatory assessment of the quality of care provided to children at hospital level, and for developing a plan of action to improve quality of care. The primary use of the tool falls within the scope of a quality improvement approach at national level. When used within country-wide programmes the tool produces recommendations for national health authorities on how to improve the health system performance across its main functions, (i.e. governance, financing, human resources, essential medical products and technologies, health information systems, and service delivery). The tool can also be used in a single facility for internal audit purposes. Additional important functions of the tool include developing local capacities (through a peer to peer model) and promoting the adoption of evidenced based guidelines.

This second edition of the tool has been updated according to the new evidence and recommendations, previous experiences and lessons learned, and current emphasis given to patients' rights and equity.

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