PROPOSAL FOR A
QUALITY ASSURANCE FRAMEWORK
AND SUPERVISION STRATEGIES

Ministry of Health, Eritrea

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I am grateful for the support of the USAID Mission in Eritrea which made this assignment possible.
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<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>COPE</td>
<td>Client Orientation/Provider Efficiency</td>
</tr>
<tr>
<td>DPT</td>
<td>Diphtheria, Pertussis, and Tetanus Vaccine</td>
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<td>EPI</td>
<td>Expanded Program on Immunization</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>IEC</td>
<td>Information, Education, and Communication</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PRA</td>
<td>Participatory Rural Appraisal</td>
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<td>QA</td>
<td>Quality Assurance</td>
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<td>SEMISH</td>
<td>State of Eritrea Management Information System for Health</td>
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<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>TT</td>
<td>Tetanus Toxoid</td>
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<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
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PURPOSE

The purpose of this document is to—

- Review the current status of quality assurance in, and supervision of, health facilities, health stations, health centers, and hospitals in Eritrea.

- Propose a framework for quality assurance and supervision that—
  - fosters capacity building at the zonal and sub-zonal levels.
  - strengthens the link between zonal plans and the use of data from the State of Eritrea Management Information System for Health (SEMISH) for decisionmaking.
  - considers the best options for supervision given existing human and other resources.
  - ensures approaches nominated are demonstrably user-friendly.
  - ensures approaches selected are demonstrably sustainable.
  - addresses mechanisms for follow up after training.

- Propose strategies and options for implementation of the quality assurance and supervision framework.

Proposed approaches focus on quality assurance (QA) and supervision of health facilities by zonal staff and are intended for further discussion with ministry and project staff. The quality assurance and supervision framework is based on interviews with project staff and Ministry of Health (MOH) personnel, and on a review of quality assurance documents. Quality assurance is interpreted broadly, with external supervision considered as one of several means to improve and maintain the quality of health services. Other methods rely on internal and external approaches (to the facility) and include self-assessments, client interviews, facility-based training, and peer review meetings at national, zonal, and sub-zonal levels.

Hospitals, especially the national reference hospital Mekane Hewit in Asmara, have special needs to assure and continuously improve the quality of clinical services provided by different specialty departments. Additional internal quality assurance and supervision methods are proposed for the 19 hospitals operated in Eritrea in 1997 and are presented in a separate section of this document.

Performance audits of zonal offices and operations by central MOH staff are important but are not part of this scope of work. The implementation of an entire quality assurance program that includes both a QA-unit at the MOH level under the director general, and a national QA committee is already in progress (Ministry of Health, 1997) and not a subject of this document. Suffice it to mention that the QA-unit will be responsible for the quality of clinical health services at hospitals at this stage of development. Moreover, the MOH has either completed or will soon finalize guidelines and standards for all essential service areas of the ministry, including targets needed as benchmarks for quality assurance.
This proposal attempts to be consistent with the vision, objectives, and activities of the quality assurance program discussed by the MOH, and considers the time line of training events planned. Ideas presented here build on already existing supervision practices in Eritrea, including—

- Regular facility visits
- Use of checklists
- Periodic staff meetings

Suggestions are intended to further expand the technical aspects of these existing quality assurance and supervision approaches and to supplement the MOH plan for a QA program. Improving quality assurance and supervision through tested and applied methods as proposed could very well be implemented at the same time that the national QA program is established, since the program addresses an immediate need of the zones which have included supervision training in their work plans.

The following two tables provide an overview of the basic elements of the quality assurance and supervision framework and the tools and instruments described in later sections of this report. Recommendation are presented separately for health stations/centers and hospitals.

Table 1. Summary of Quality Assurance and Supervision Approaches and Tools for Health Stations and Health Centers

<table>
<thead>
<tr>
<th>Quality Assurance and Supervision Tools</th>
<th>For External Supervision</th>
<th>For Internal Self-assessment</th>
<th>Combined Approach †: Peer Review</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor Checklist</td>
<td>X</td>
<td></td>
<td>(X)</td>
<td>Zonal QA Team</td>
</tr>
<tr>
<td>Staff Checklist</td>
<td></td>
<td>X</td>
<td>(X)</td>
<td>Facility QA Team</td>
</tr>
<tr>
<td>Discussion Guide</td>
<td></td>
<td>+</td>
<td>X</td>
<td>Zonal* QA Team (Facility QA Team)</td>
</tr>
<tr>
<td>Client/Patient Exit Interview</td>
<td></td>
<td>X</td>
<td>(X)</td>
<td>Community Group (facility to support)</td>
</tr>
<tr>
<td>Household Opinion Poll</td>
<td></td>
<td>X</td>
<td>(X)</td>
<td>Community Group (facility to support)</td>
</tr>
<tr>
<td>Focus Group (PRA)</td>
<td>X</td>
<td>X</td>
<td>(X)</td>
<td>Community Group or Facility Staff</td>
</tr>
<tr>
<td>HMIS Indicators</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Zonal* QA Team Zonal HMIS Office Facility QA Team</td>
</tr>
</tbody>
</table>

† Peer review can be done during staff meetings at the zonal and sub-zonal levels.

(X) Results from observations and interviews are used during peer review.

* Discussion guides can be used at zonal, sub-zonal, and facility levels, but necessary skills exist mainly at the first two levels.
Table 2. Summary of Quality Assurance and Supervision Approaches and Tools for Hospitals

<table>
<thead>
<tr>
<th>Quality Assurance and Supervision Tools</th>
<th>For “External” Supervision*</th>
<th>For Internal Self-assessment</th>
<th>Combined Approach †: Peer Review</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical/Mgm’t Checklist</td>
<td>X</td>
<td></td>
<td>(X)</td>
<td>Hospital QA Team</td>
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<tr>
<td>Clinical/Mgm’t Checklist</td>
<td></td>
<td>X</td>
<td>(X)</td>
<td>Department QA Team</td>
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<td>Simulated Patient Encounter</td>
<td>X</td>
<td></td>
<td>(X)</td>
<td>Hospital QA Team</td>
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<tr>
<td>Discussion Guide</td>
<td></td>
<td>+</td>
<td>X</td>
<td>Hospital QA Team</td>
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<tr>
<td>Client/Patient Exit Interview</td>
<td>X</td>
<td>(X)</td>
<td></td>
<td>School of Health Sciences</td>
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<td>Focus Group</td>
<td></td>
<td>X</td>
<td>(X)</td>
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<tr>
<td>Medical Record Review</td>
<td>X</td>
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<tr>
<td>Patient Flow &amp; Waiting Time Assessment</td>
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<td>X</td>
<td>(X)</td>
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<td>Clinical Case Review</td>
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<td>Hospital HMIS</td>
<td>X</td>
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<td>Hospital QA Team</td>
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<td>SEMISH Indicators</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Hospital QA Team</td>
</tr>
</tbody>
</table>

* A supervisor is external to a hospital department, but s/he belongs to hospital management and to the hospital’s QA team; this could also mean someone external to the hospital (i.e., MOH staff).
† Peer review can be done during medical staff meetings.
(X) Results from observations and interviews are used during peer review.
+ Discussion guides can be used during departmental and hospital staff meetings.

WHAT DOES QUALITY OF SERVICES MEAN?

Service quality is one important factor that increases both the likelihood of desired health outcomes in a target population, and client satisfaction through the delivery of effective services consistent with current professional knowledge. Broadly speaking, one can distinguish between technical quality and management quality or systems capacity as such:

- **Technical quality** focuses on *client-related events* where services or interventions are delivered according to established protocols and international or local standards (i.e.,...
assessment, treatment and counseling of patients); additional provider characteristics determine whether or not clients are satisfied (i.e., communication between care giver and patient).

- **Management quality or systems capacity** focuses on *points-of-service or service providers* that meet established norms (i.e., drug availability, recent training of medical staff); it also relates to management and administrative *events or processes* that take place according to established protocols and standards (i.e., supervision visits).

The measurement of health outcomes in quantitative terms (i.e., mortality, morbidity, or utilization of services) is not the purpose of quality assurance and supervision. Health outcomes are measured through special surveys and advanced hospital information systems. Quality assurance and supervision focus on processes that, under reasonable assumptions, lead to improved outcomes. These processes include—

- Information of clients/patients (IEC)
- Provision of an essential package of services
- Competent and well trained service providers
- Access to essential drugs and supplies
- Choice of family planning methods
- Standard clinical practices, including diagnosis and treatment
- Safe injection practices (EPI and treatment)
- Privacy and confidentiality
- Continuity of care and services (i.e., antenatal, growth monitoring)
- Efficient administrative processes (i.e., patient registration, short waiting times)

**PROBLEM DEFINITION**

According to MOH sources, supervision is carried out in all six zones in Eritrea, and the situation has improved since a 1995 systematic facility assessment that looked at supervision of health stations and health centers. Currently there are 153 health stations and 53 health centers, with most facilities operated by the MOH, and about 37 by different missionary organizations. The Southern and Central zones have already introduced supervisory checklists—the Southern Zone uses them systematically and extensively. While supervision has been carried out mainly by the zonal health management team, sub-zones in the Southern Zone have assumed supervision functions since their creation in 1996. Despite this remarkable progress, challenges do remain, especially since supervision remains very uneven between zones. The following is a brief summary of past findings and current issues.

According to a 1995 assessment (Asfaha et al., 1995), supervision of health facilities was irregular (i.e., not monthly or quarterly), and was not systematically assessing the quality of services (i.e., not using a checklist). Results show that 78 percent of 18 facilities had at least 1
supervision visit during the 6 months before the assessment. The degree to which supervision was carried out varied from zero to six visits in this six-month period. These numbers seem relatively high, but they probably underestimate the problem because the sample of 18 out of about 200 facilities is biased towards facilities with easy access. Even though the assessment did not find much variation by region, interviews with zonal medical officers in preparation of this proposal show different constraints in each zone. Medical Officers in zones that cover vast geographic areas (i.e., Gash-Barka Zone) could only make less frequent and shorter visits to remote facilities, while in zones with a high population density and with a better road infrastructure (i.e., Central Zone, including Asmara), facility visits were more regular. In only 33 percent of the facilities was a supervision schedule available. Thirteen percent of the health workers received some on-the-job training by the supervisor during the visit.

MOH staff in Asmara and from the zonal offices mention two major causes for inadequate supervision: too few supervisors available and the lack of training. Some zonal offices have the only means to visit health facilities: the recently created sub-zones have no separate office structures and no means to carry out external supervisory functions. While, in theory, health centers supervise the health stations in their catchment area, not all have the means to do so in practice, with the Southern Zone being probably the most advanced. Zonal offices typically have 6 to 8 staff, covering technical program areas such as PHC, malaria control, environmental health, communicable disease control, pharmacy, and administration, but such staffing is not sufficient to supervise 25 to 50 facilities on a monthly or quarterly basis if it takes 1 to 2 days per facility for travel time. Hospital staff do not play a role in supervision so far, but could be available.

Supervisors on the zonal level have not had much training in quality assurance and supervision. This, and the lack of an instrument (like a checklist) in most zones, leads to supervision that is administrative in nature without a systematic assessment of service quality nor immediate support of health workers to improve technical skills. The lack of training is probably also a reason why supervision is not planned systematically. For example, supervision schedules are rarely used, with the Southern Zone being the exception. Additional constraints are related to transportation which, while available in general, is not sufficient to support frequent trips by multiple teams.

In-service training of health workers has been scarce and does not include quality assurance measures that can be implemented by facility staff directly in collaboration with the community, such as self-assessment and client interviews. Zones seem to hold general staff meetings with facility managers regularly (i.e., quarterly in Anseba and Southern zones), but again the focus seems to be more administrative than technical.
WHY DEVELOP A QUALITY ASSURANCE AND SUPERVISION FRAMEWORK AND STRATEGIES?

Without a framework and various implementation strategies, the problems outlined above cannot be addressed in a systematic and effective way. Key concepts of the quality assurance and supervision approach can be determined by considering the following:

- Support health workers and managers in implementing their workplans and in solving problems (facilitative supervision).
- Make problem solving a participatory process by supervisors working hand-in-hand with facility staff.
- Increase the efficiency of supervision through multi-disciplinary teams.
- Implement quality assurance and supervision as a routine process that follows established schedules.
- Use existing information (SEMISH), user-friendly checklists, and other tools to objectively assess processes and implement solutions.
- Link the content of quality assurance and supervision directly to the zonal and sub-zonal action plans as an important measure of successful implementation of activities.
- Make quality assurance and supervision sustainable by finding an appropriate combination of external, internal, and peer review processes commensurate with available human, financial, and other resources.

PROPOSED QUALITY ASSURANCE AND SUPERVISION FRAMEWORK AND STRATEGIES

Quality assurance covers a wide variety of approaches and tools that essentially depend on two review processes of service delivery and management activities: external and internal reviews (see Figure 1). Regardless of which process is chosen or whether both are combined, quality assurance requires that practical standards and guidelines be established in essential health service areas and management practices, to include clinical guidelines for patient treatment, norms for community outreach, and financial accounting standards.

External reviews have different purposes. They serve as an external (performance) audit or control to evaluate a health care provider's compliance with established administrative norms and technical standards. On the other hand, reviews that emphasize a supportive rather than a control role serve as on-the-job training and are the focus of this proposal. The implementation of
supervision using user-friendly tools is described in several documents published by WHO and other organizations (DiPrete, 1993).

Checklists, like those published by the Primary Health Care Management Advancement Programme, have been used successfully in many countries and for different types of services, and documentation of such experience appears in peer review journals and project reports. The Southern and Central zones of Eritrea have already introduced the use of supervision checklists.

Supervision by personnel external to the health facility is just one possibility in assessing and supporting service quality. A widely used method of family planning programs that constitutes an internal process is called Client Orientation/Provider Efficiency (COPE). The method consists of client interviews and a self-assessment by facility personnel, and can be adapted to other health services. The COPE approach is not just a collection of easy-to-use assessment tools; its main strength is a changed philosophy about supervision which stresses facilitation and participation of service providers and clients. Experience with COPE has been gathered and published in AVSC International reports for over ten countries.

In addition, internal approaches have the advantage that no expenses for personnel and logistics are required because no special visits are involved. However, facility staff need to be well trained in applying methods of internal review, and external supervisors are often needed to facilitate the process during their routine visits.

Finally, both external and internal processes can be combined into a peer review involving staff from other facilities and zonal health offices and that rely on findings from self-assessments by facility staff and supervision checklists. “Peer review” means that staff in similar positions
analyze and discuss each other’s findings and experiences, focusing on what one can learn from each other to improve services without explicitly judging who is better or worse. Peer review is used extensively in the United States, where it relies mainly on information systems data and medical record reviews. Given the resources available in Eritrea, a more direct exchange of experiences is proposed that builds on the existing practice of holding regular staff meetings at the zonal level, where problems and issues are currently raised and discussed.

Any quality assurance and supervision approach relies on information collected through different tools or instruments. Information collection is important, as it should make the assessment as systematic, objective, and reliable as possible. To that extent, existing data sources should be used (i.e., key indicators provided by the SEMISH and facility registers: see Appendix A). However, these sources often contain only limited information about service quality and additional instruments are needed. One tool most often used is a “checklist” that resembles a questionnaire requiring simple YES or NO answers. The same or somewhat adapted checklists can be used for both external and internal quality assurance processes.

A comprehensive collection of quality assurance and supervision tools has been published by the Quality Assurance Project (Franco et al., 1992). The collection focuses on various techniques in analyzing a problem and presenting information in a logical manner. Which tools are useful depends on the problem to be investigated and the resources available.

TOOLS AND INSTRUMENTS FOR QUALITY ASSURANCE AND SUPERVISION OF HEALTH STATIONS/CENTERS

The following section describes some of the tools and instruments in more detail. Tools and instruments for hospitals are presented in Appendix B.

Checklists

Checklists are merely a recommended tool to collect information in a systematic and objective way; the use of this information by facility staff and supervisors is what is most important. Checklists guide the quality assessment process through a series of questions that address key technical and management activities at a health facility. In its simplest form these questions can all be answered with either a “YES” or a “NO.” More complex lists register answers on a rating scale or in absolute numbers and are more suitable for surveys than for quality assurance purposes. Answers to questions in a checklist can be obtained by either interviewing and/or observing health workers during client/patient activities, or by administrative processes. Checklists are useful for external, internal, and combined peer review processes.

The questions themselves should reflect the current technical standards in such areas as maternal and child health, reproductive health, malaria control, HIV/AIDS and STD control, tuberculosis control, and environmental sanitation. Instead of covering all potential aspects of a certain
service, it is better to focus on a few, yet crucial elements and to assess these in great detail. This in-depth approach yields reliable and objective results, as it reduces human error by depending less on the knowledge and experience of the supervisor.

Checklists must be short to be practical. Long checklists will either yield inaccurate results, or make the assessment a mechanical process without using the information. In an integrated quality assurance and supervision process covering all technical areas, checklists will invariably become too long and should be applied in parts or sections over time instead of implemented all at once. An example of a rather long integrated checklist which requires priority setting to be practical is shown in Appendix D, Sample 1.

The guidelines published by the Primary Health Care Management Advancement Programme probably provide the most in-depth examples of checklists for all essential health services and management processes. However, their contents need to be adapted for current clinical and service standards.

Discussion Guide

Discussion guides use the same themes included in a checklist, but are not in the form of a detailed questionnaire. The guides ask broad questions like, “Are caretakers counseled in the use of oral medication?” and do not provide for recorded answers. The guide is intended for a structured group discussion rather than an assessment.

Client/Patient Interview

Health workers may have the best intentions of delivering high quality services, but the client/patient is the ultimate judge of satisfaction. A short interview after services have been received, also called an “Exit Interview,” is a useful tool to find out whether client/patient needs and expectations have been met.

Because health workers provide the services, and the client/patient depends on health workers’ best intentions to do so, the client/patient is unlikely to be very critical about the services received if the health care provider conducts the interview. A neutral person should interview the client/patient to increase the validity of responses (i.e., members of women and youth associations, school teachers).

Complicated sampling techniques are not required for quality assurance purposes unless it is an operations research activity. It is sufficient to interview 10 to 12 clients or patients leaving the clinic, selected one after the other. The best times are probably during the busy morning or afternoon clinic hours. An example is shown in Appendix D, Sample 2.
**Household Opinion Poll**

A client/patient interview will only capture information from people who have actually used services. However, many people who need services don't have access to them or they lack information about the services' usefulness. For curative care, access can be as low as 20 percent. Therefore, it is very important to go to households that are known to have needed care or other services, but are not using them. For example, if HMIS data show that vaccination coverage of DPT3 or measles is less than 50 percent, it is necessary to find out why caretakers do not bring their children to the clinic, assuming that vaccines are available.

This instrument is a simple questionnaire similar to a client/patient interview, called a household opinion poll. The questions address specifically whether and why certain services are not used, and what would convince people to access them. Again, the interviews are better conducted by non-health workers, if available.

The household opinion poll is different from a household survey. No sampling is required and, based on prior knowledge, households are selected that do not use services. The questions ask for opinions, but do not try to quantify certain behaviors. Usually 10 to 12 household interviews provide useful information and are best conducted in the immediate neighborhood of the interviewer, as they require some knowledge about one's neighbors. See example given in Appendix D, Sample 3.

**Focus Groups (Participatory Rural Appraisal)**

Going to households can be time consuming for interviewers. An alternative method often used in social sciences is the focus group approach, which is a semi-structured discussion of selected topics with a small group of women, men, or both. Usually a group of 10 to 15 participants works best, because in larger groups it is difficult to keep focused and to record participant answers. Focus group discussion can take the place of exit interviews and household opinion polls. A market day might provide a good opportunity to get a group of women or men together to discuss, for example, vaccination and antenatal care. Questions to be answered by the focus group must be prepared in advance, and the most important answers are recorded by the focus group leader.

**Key Indicators from SEMISH**

All the above mentioned tools require some additional data collection effort and should only be used in addition to HMIS data for a few key indicators. Any kind of quality assurance and supervision process should start with information already available.

Indicators related to quality provided by SEMISH include coverage estimates for essential services (i.e., vaccination, antenatal care, maternity services, reproductive health, diarrhea, pneumonia, and malaria cases treated). Admission rates for diseases and conditions that are
preventable provide some indication of whether preventive services are effective. This includes admissions of acute watery diarrhea cases with dehydration, severe pneumonia, and malaria. A list of key indicators for local performance monitoring is shown in Appendix A.

PRINCIPLES OF QUALITY ASSURANCE AND SUPERVISION

The development and successful implementation of a quality assurance and supervision process in Eritrea should be—

- **Information based** (use of existing information and additional data collection)
- **Target driven** (improve services measurably by comparing standards and norms)
- **Integrated** (all programs are covered, and programs undertake QA efforts jointly in a team approach)
- **Supportive and facilitating** (facility staff solving problems jointly with supervisor, enhancing technical and management skills)
- **Affordable** (all operating costs are covered by facility and zonal budgets)

OPERATIONAL SOLUTIONS AND IMPLEMENTATION ISSUES

Based on interviews in developing this proposal, two supervision approaches work in Eritrea: a 6-month cycle employed by the Southern Zone, and a 3-month cycle used in the Anseba Zone. Differences exist between both approaches and are depicted in Figure 2. In the Southern Zone, sub-zones have an active role in supervising health stations every two to three months. In the Anseba Zone, sub-zones have little or no supervisory role, though it is planned that they will join zonal teams in visits to facilities in their catchment area. The reason for these two different roles lies mainly in the availability of transport: In the Southern Zone all sub-zonal focal point facilities (mainly health centers and a few hospitals) have a vehicle; this is not the case in the Anseba Zone. Both zones hold regular quarterly staff meetings, which in the Southern Zone are attended by all facility managers.

Because the availability of resources varies between zones, it is recommended that both models continue their current approach. In both models, visits to health facilities are months apart and relatively short. Therefore, in addition to external supervision, quality assurance combining external and internal processes is recommended in order to implement a supportive and problem-solving approach. Ideally this would be a process of visits to all facilities every two to three months by the zonal and/or sub-zonal health management team, combined with an internal self-assessment process using a few of the instruments already described in earlier chapters.
External supervision and internal self-assessment tend to focus on one facility at a time, but an important element of continuous quality improvement is learning from the experience of others. This could be done best through a quarterly peer review meeting as an extension of the staff meetings already held. Staff meetings could be reorganized by adopting a problem identification/solving approach for the entire meeting. Topics covered would still include general administrative, management, and service delivery issues, but also would use information from self-assessments, supervision visits, and other data sources. All attendees would be able to share their experiences and contribute to solutions—the heart of the peer review process. Peer review meetings could also be used to train staff in quality assurance methods and to establish the quality improvement topics addressed during a quality improvement cycle. The important events of a quality improvement cycle are depicted in Figure 3.
Ideally, peer review/staff meetings would be held every quarter. It seems most feasible that facility managers meet at zonal headquarters, as already practiced in the Southern Zone. Facility staff usually collect salaries monthly at zonal headquarters (usually one or two staff members are delegated the authority to collect for all staff), as well as drug supplies when needed, and no additional trips would be required if meetings are scheduled accordingly. Other facility staff could also meet at the sub-zonal focal point facility approximately every three months. Such a system of external and internal quality assurance processes would only function if these events are clearly scheduled and a quality improvement agenda is established. Every health worker in the facility, sub-zonal, and zonal offices needs to be informed of and participate in this process. Schedules are not only important for those who participate in meetings, but also establish who will be on duty while other staff are absent. Health stations with only one or two staff members might have to participate less frequently in events outside their facility.

Integration: A Team Approach to Quality Assurance and Supervision

Quality assurance and supervision should be carried out by a quality improvement team. Each level, facility, sub-zone, zone, and national office should have such a team, though team composition would vary according to available staff. Activities should be integrated to the extent feasible to assure an efficient use of resources, but at the same time personnel with the best competence in different technical areas need to be part of the quality improvement teams. This means that at zonal and national levels these teams should be composed of all major program personnel, while at sub-zonal levels a few staff would be responsible to cover all essential services. Figure 4 shows how functions become more integrated as one moves from national to zonal teams and closer to the primary-care level.

To improve quality through a supportive process, external supervision requires that a certain amount of time be spent with facility staff. If visits are short—lasting a few hours—the time is merely sufficient to check clinical and administrative processes without allowing for feedback and joint problem solving with facility staff. Checklists become merely a mechanical approach in identifying what is wrong and in advising staff of corrective actions from the top down. The supervision team might have to spend a day—or more in large facilities—to participate with facility staff in a problem-solving process. However, given the limited staff resources on zonal and sub-zonal levels, additional personnel should be used to increase the size of health management teams.

Interviewees during this exercise consistently mentioned that hospital staff at zonal and sub-zonal levels should be given a role in the quality assurance and supervision process. Senior nurses, midwives, and doctors should be included in visit teams for at least a few days every quarter. However, there are two essential issues that must be addressed so that hospital staff become competent members of a quality assurance process covering all essential preventive and curative services:
Clinical care staff at hospitals, especially secondary or higher level referral facilities, need a thorough orientation in primary care and public health to understand the significance of essential services and the resource limitations at the primary-care level. If primary-care staff have been trained in the latest service delivery techniques (i.e., integrated management of childhood illnesses), assurances must be given that members of the health management teams have up-to-date skills in these areas.

Hospital doctors are allowed private practice activities after their official hours and face a loss of income if they take part in supervision visits. The government should compensate physicians through an appropriate per diem payment during their participation as members of the health management team. The current allowance might be sufficient if the number of days required per quarter is small and if it becomes part of every senior staff member’s job description to be part of quality improvement teams within the zone.

The MOH should consider issuing necessary policies that will facilitate the implementation of an integrated quality assurance and supervision approach. Involving hospital staff, doctors, and perhaps nurses and midwives could relieve existing staff in the zonal health office, and would
force personnel who render mostly curative care to become familiar with the latest approaches in
disease prevention and health promotion. The use of standardized checklists, discussion guides,
and interview instruments will facilitate this process.

Leadership and Training

The implementation of the quality assurance and supervision process requires leadership at the
facility, sub-zonal, and zonal levels, as well as adequate training. Table 3 describes the leadership
roles, training, and supervision responsibilities.

It would be an efficient use of time and other resources if initial training of facility managers was
done in conjunction with quarterly peer review/staff meetings. Each team leader has the
responsibility to jointly establish a quality improvement plan with other staff and to draw up a
schedule for the internal self-assessment process or external supervision visits. The start-up
sequence, and the two and four quality improvement cycles per year are summarized in Table 4,
followed by more detailed notes describing the tasks at each step (months are for illustrative
purposes only).

<table>
<thead>
<tr>
<th>Table 3. Roles and Responsibilities of Quality Improvement Teams</th>
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<tbody>
<tr>
<td><strong>Level</strong></td>
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<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Health Center/ Station</td>
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<tr>
<td>Sub-zone</td>
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<tr>
<td>Hospital</td>
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<tr>
<td>Zone</td>
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<tr>
<td>National</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Quality Assurance and Supervision Approach</td>
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<tr>
<td>------------------------------------------</td>
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<td></td>
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<tr>
<td>SEMISH Key Indicators</td>
</tr>
<tr>
<td>Peer Review Meeting Zone or Sub-zone</td>
</tr>
<tr>
<td>(quarterly, semi-annually)</td>
</tr>
<tr>
<td>Self-assessment</td>
</tr>
<tr>
<td>Supervision Visit by Zone</td>
</tr>
<tr>
<td>QA Activity by Sub-zone</td>
</tr>
<tr>
<td>Inter-zonal QA Meeting</td>
</tr>
<tr>
<td>(once or twice per year)</td>
</tr>
</tbody>
</table>
Detailed description of tasks—

1. **Early October:** Two to three days of peer review meetings at the zonal office. Train at least one staff per facility in quality assurance and supervision methods. Select one or very few technical/management topics for which to conduct a problem solving and process improvement exercise over the coming three months (the limit of one or a few topics is necessary so that everyone shares their experience). Staff review relevant key SEMISH indicators and complete a simple quality improvement plan. Staff return to their facilities and implement the quality improvement plan, starting with training of other facility staff and community volunteers, and with data collection in the facility and community.

2. **November:** Zonal team conducts supervision visits at all facilities of at least one day per facility. Supervisors observe key health worker actions in the morning, with the help of a checklist that is related to the topic(s) decided upon in January. They provide staff with immediate feedback, and review and discuss the progress of problem solving with staff and the community in the afternoon.

3. **Late December/Early January:** Two to three days of peer review meetings at the zonal office. Give a few hours of refresher training in quality assurance. Staff come prepared with SEMISH data, results from client/patient interviews, household opinion polls or focus groups, and a progress report on problem solving for the topic selected in January. Best solutions are presented and discussed in plenum or in groups, according to topic. New topics are introduced and decided upon for the following 3-month problem-solving cycle. Staff review relevant key SEMISH indicators and complete a simple quality improvement plan. Staff return to their facilities and implement the quality improvement plan, starting with the training of other facility staff and community volunteers, and with data collection at the facility and in the community.

4. **February:** Zonal team conducts supervision visits at all facilities of at least one day per facility. Supervisors observe key health worker actions in the morning, with the help of a checklist that is related to the topic(s) decided upon in March/April. They provide staff with immediate feedback, and review and discuss the progress of problem solving with staff and the community in the afternoon.

5. **Late March/Early April:** Two to three days of peer review meetings at the zonal office, with brief refresher training in quality assurance. Staff come prepared with SEMISH data, results from client/patient interviews, household opinion polls, or focus groups, and a progress report on problem solving for the topic selected in March/April. Best solutions are presented and discussed in plenum or in groups. New topics are introduced and chosen for the next 3-month problem-solving cycle. Staff review relevant key SEMISH indicators and complete a simple quality improvement plan. Staff return to their facilities...
and implement the quality improvement plan, starting with training of other facility staff and community volunteers, and with data collection in the facility and community.

This process continues following the 3-month cycle, with new topics or topics already covered, but focusing on different problems.

**ACTION PLAN**

The following is a *suggested* time line for developing the quality assurance and supervision approach, including a field test in either the Southern, Anseba, or Gash Barka zones until July 1997, and starting implementation in at least three zones in August.

- **April 1997:** Appoint a small quality assurance and supervision task force to finalize this proposal. MOH approves the proposal.

- **End April:** Eritrea delegation, ideally including zonal medical officers, attends the Mombasa Quality Assurance Conference to gain first-hand exposure to best practices in quality assurance and supervision.

- **Begin May:** Hold a meeting with all stakeholders listed below to agree upon a detailed implementation plan. All programs and projects commit to a date by which input is provided to the quality assurance and supervision instruments.

- **May 1997:** Draft the quality assurance and supervision processes and instruments, with input from all programs and projects as per agreed time line.

- **June 1997:** Test the quality assurance and supervision approach in Anseba Zone, as their annual action plan already includes this approach.

- **July 1997:** Hold a national quality assurance and supervision workshop where zonal staff are trained as trainers. Begin implementation in at least three zones.

- **Aug. 1997:** Begin implementation in the remaining zones.

- **Sep.-Oct.** Follow up by central MOH staff.

- **Nov./Dec.:** Evaluation of quality assurance and supervision and adjustments.

This schedule assumes that a few key MOH and zonal staff will have sufficient time to lead the development and implementation of the quality assurance and supervision approach, and that technical assistance will be provided by various donors. See Appendix C for a list of contacts.
The Mombasa Quality Assurance Conference at the end of April offers a unique opportunity to get this process started in Eritrea. It will help to establish a national quality assurance policy and program, and the experience from case studies will contribute to the rapid development of practical quality improvement processes at the zonal, sub-zonal, and facility levels.
REFERENCES


APPENDIXES
APPENDIX A

KEY INDICATORS FOR THE LOCAL LEVEL
Even though SEMISH will include these indicators in its standard reports, facility staff should calculate them immediately at month’s end and routinely monitor the performance of service delivery activities. SEMISH’s primary role here should be to provide zonal and national averages for peer comparison. Responsibilities are italicized, and monitoring tools are in regular type face.

### Key Performance Indicators for Health Centers and Health Stations

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Responsibility</th>
<th>Calculation</th>
<th>Monitoring Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Measles Coverage Ratio (under 1 year)</strong></td>
<td>[Resp: EPI Staff]</td>
<td><em>(Children under 1 vaccinated in %)</em></td>
<td>Cumulative monthly line chart with target</td>
</tr>
<tr>
<td><strong>2. Vaccination Drop-out Rate (DPT3-DPT1)</strong></td>
<td>[Resp: EPI Staff]</td>
<td><em>(DPT1 Coverage - DPT3 Coverage in %)</em></td>
<td>Monthly bar chart with target</td>
</tr>
<tr>
<td><strong>3. Growth Monitoring Coverage Ratio (under 2 y.)</strong></td>
<td>[Resp: Facility Staff]</td>
<td><em>(Children under 2 weighted in %)</em></td>
<td>Cumulative monthly line chart with target</td>
</tr>
<tr>
<td><strong>4. Antenatal Care Coverage Ratio (first visits)</strong></td>
<td>[Resp: ANC Staff]</td>
<td><em>(Pregnant women with 1st ANC visit in %)</em></td>
<td>Cumulative monthly line chart with target</td>
</tr>
<tr>
<td><strong>5. Attended Delivery Coverage Ratio</strong></td>
<td>[Resp: Maternity Staff]</td>
<td><em>(Deliveries at facility or by trained TBAs in %)</em></td>
<td>Cumulative monthly line chart with target</td>
</tr>
<tr>
<td><strong>6. Women with TT2+ Coverage Ratio</strong></td>
<td>[Resp: ANC Staff]</td>
<td><em>(Women age 15–49 completed TT2+ in %)</em></td>
<td>Cumulative monthly line chart with target</td>
</tr>
<tr>
<td><strong>7. Family Planning Continuation Rate</strong></td>
<td>[Resp: Reproductive Health Staff]</td>
<td><em>(Registered users with repeat visit based on schedule in %)</em></td>
<td>Monthly bar chart with target</td>
</tr>
<tr>
<td><strong>8. Diarrhea Coverage Ratio (under 5 years)</strong></td>
<td>[Resp: Medical Care Staff]</td>
<td><em>(Children treated for diarrhea in %)</em></td>
<td>Cumulative monthly line chart with target</td>
</tr>
<tr>
<td><strong>9. Pneumonia Coverage Ratio (under 5 years)</strong></td>
<td>[Resp: Medical Care Staff]</td>
<td><em>(Children treated for pneumonia in %)</em></td>
<td>Cumulative monthly line chart with target</td>
</tr>
<tr>
<td><strong>10. Malaria Coverage Ratio (under 5 years)</strong></td>
<td>[Resp: Medical Care Staff]</td>
<td><em>(Children treated for malaria in %)</em></td>
<td>Cumulative monthly line chart with target</td>
</tr>
<tr>
<td><strong>11. Days Out-of-Stock of Antimalarial</strong></td>
<td>[Resp: Pharmacy Staff]</td>
<td><em>(Number of days: Count of days with no drug in stock)</em></td>
<td>Monthly bar chart with target</td>
</tr>
<tr>
<td><strong>12. Days Out-of-Stock of Antibiotic (pneumonia)</strong></td>
<td>[Resp: Pharmacy Staff]</td>
<td><em>(Number of days: Count of days with no drug in stock)</em></td>
<td>Monthly bar chart with target</td>
</tr>
<tr>
<td><strong>13. Feedback Received for Cases Referred</strong></td>
<td>[Resp: Facility Manager]</td>
<td><em>(Referred case with feedback from hospital in %)</em></td>
<td>Monthly bar chart comparing cases referred with cases with feedback</td>
</tr>
</tbody>
</table>

*Note:* In the table, the `Resp:` field indicates who is responsible for the indicator. The calculation formulas and monitoring tools are provided for each indicator.
## Key Performance Indicators for Hospitals

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td><strong>Admission Rate for Diarrhea (under 5 years)</strong> [Resp: Pediatric &amp; OPD Staff]</td>
<td>Children under 5 with diarrhea admitted in %: <strong>-------------------------------------------</strong> 100</td>
</tr>
<tr>
<td></td>
<td>Tool: Bar chart comparing Outpatients with Admissions</td>
<td>Children with diarrhea seen as outpatients</td>
</tr>
<tr>
<td>2</td>
<td><strong>Admission Rate for Pneumonia (under 5 years)</strong> [Resp: Pediatric &amp; OPD Staff]</td>
<td>Children under 5 with pneumonia admitted in %: <strong>------------------------------------------</strong> 100</td>
</tr>
<tr>
<td></td>
<td>Tool: Bar chart comparing Outpatients with Admissions</td>
<td>Children with pneumonia seen as outpatients</td>
</tr>
<tr>
<td>3</td>
<td><strong>Admission Rate for Malaria (under 5 years)</strong> [Resp: Pediatric &amp; OPD Staff]</td>
<td>Children under 5 with malaria admitted in %: <strong>--------------------------------------------</strong> 100</td>
</tr>
<tr>
<td></td>
<td>Tool: Bar chart comparing Outpatients with Admissions</td>
<td>Children with malaria seen as outpatients</td>
</tr>
<tr>
<td>4</td>
<td><strong>Average Length-of-Stay for Diarrhea (under 5, adult)</strong> [Resp: Pediatric, Internal Medicine Staff] Tool: Monthly line chart with peer average comparison</td>
<td>Number of bed days by all diarrhea patients in days: <strong>-----------------------------------</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of patients with diarrhea</td>
</tr>
<tr>
<td>5</td>
<td><strong>Average Length-of-Stay for Pneumonia (under 5, adult)</strong> [Resp: Pediatric, Internal Medicine Staff] Tool: Monthly line chart with peer average comparison</td>
<td>Number of bed days by all pneumonia patients in days: <strong>-----------------------------------</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of patients with pneumonia</td>
</tr>
<tr>
<td>6</td>
<td><strong>Average Length-of-Stay for Malaria (under 5, adult)</strong> [Resp: Pediatric, Internal Medicine Staff] Tool: Monthly line chart with peer average comparison</td>
<td>Number of bed days by all malaria patients in days: <strong>-----------------------------------</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of patients with malaria</td>
</tr>
<tr>
<td>7</td>
<td><strong>Average Length-of-Stay for Hernia Surgery (5+ above)</strong> [Resp: General Surgery Staff]</td>
<td>Number of bed days by all hernia patients in days: <strong>-------------------------------------</strong></td>
</tr>
<tr>
<td></td>
<td>Tool: Monthly line chart with peer average comparison</td>
<td>Number of patients with hernia surgery</td>
</tr>
<tr>
<td>8</td>
<td><strong>Average Length-of-Stay for Cesarian Section</strong> [Resp: Maternity Staff]</td>
<td>Number of bed days by all cesarian patients in days: <strong>-----------------------------------</strong></td>
</tr>
<tr>
<td></td>
<td>Tool: Monthly line chart with peer average comparison</td>
<td>Number of patients with cesarian section</td>
</tr>
<tr>
<td>9</td>
<td><strong>Cesarian Section Rate</strong> [Resp: Maternity Staff]</td>
<td>Delivered with cesarian section in %: <strong>--------------------------------------</strong> 100</td>
</tr>
<tr>
<td></td>
<td>Tool: Bar chart comparing all deliveries with cesarian section</td>
<td>Total deliveries at the hospital maternity</td>
</tr>
<tr>
<td>10</td>
<td><strong>Proportion of Outpatients Referred (under 5, adult)</strong> [Resp: OPD Staff]</td>
<td>Number of patients referred in %: <strong>--------------------------------------</strong> 100</td>
</tr>
<tr>
<td></td>
<td>Tool: Bar chart comparing outpatients &amp; referred patients</td>
<td>Total number of outpatients</td>
</tr>
</tbody>
</table>
APPENDIX B

TOOLS AND INSTRUMENTS FOR QUALITY ASSURANCE AND SUPERVISION OF HOSPITALS
The following sections describe some of the tools and instruments in more detail. Tools and instruments for health stations and health centers are presented earlier in this paper.

Checklists
Checklists are merely a tool to collect information in a systematic and objective way; the use of this information by hospital staff and supervisors is most important. Checklists guide the quality assessment process through a series of questions that address key technical and management activities at a health facility. In its simplest form these questions can all be answered with either a "YES" or a "NO." More complex lists register answers on a rating scale or in absolute numbers, and they are more suitable for surveys than for quality assurance purposes. Answers to questions in a checklist can be obtained either by interviewing and/or observing health workers during client/patient activities, or administrative processes. Checklists are useful for external, internal, and combined peer review processes.

The questions themselves should reflect the current clinical standards in such areas as medical care, surgery, pediatric care, obstetric/gynecologic care, maternity care, infectious disease treatment, psychiatric care, or dental care. Each department should have a checklist for its specialty. Instead of covering all potential aspects of a certain service it is better to focus on a few yet crucial elements, and to assess these in great detail. This in-depth approach yields more reliable and objective results, and reduces human error by depending less on the knowledge and experience of the supervisor.

Checklists need to be short to be practical. Long checklists will either yield inaccurate results, or make the assessment a mechanical process without using the information.

Simulated Patient Encounter
This approach can be applied in conjunction with a checklist. If a certain procedure or the care of a patient with a specific diagnosis shall be evaluated, the supervisor may have a long waiting time until the appropriate patient presents itself. To shorten this time period a simulated patient can be sent, for example a student. Instead of observing how a health worker deals with a real patient, a person simulates a certain condition following some standardized symptoms. This can happen with or without the knowledge of the health worker. In the latter case a clear quality assurance policy needs to be established by the facility that is communicated to and discussed with all staff, otherwise this approach could have a very negative impact on staff morale.

Discussion Guide
Discussion guides use the same themes included in a checklist, but are not in the form of a detailed questionnaire. The guides ask broad questions like, "Is clinical care staff washing hands between care given to individual patients?" and do not provide for recorded answers. The guide is intended for a structured group discussion rather than an assessment.

Client/Patient Interview
Health workers may have the best intentions of delivering high quality services, but the client or patient is the ultimate judge of satisfaction. A short interview after services have been received, also called an "Exit Interview," is a useful tool to find out whether client/patient needs and expectations have been met.
Because health workers provide the services and clients/patients depend on health workers’ best intentions to do so, clients/patients are unlikely to be very critical about the services received if the health care provider conducts the interviews. A neutral person should interview client/patients to increase the validity of responses (i.e., students from the School of Health Sciences in Asmara).

Complicated sampling techniques are not required for quality assurance purposes unless it is an operations research activity. It is sufficient to interview 10 to 12 clients or patients leaving the clinic, selected one after the other. This can be done for both inpatients and outpatients.

**Focus Groups**

Interviews of clients or patients may not bring out all good suggestions. Interaction in a group tends to stimulate more creative responses. A method often used in social sciences is the focus group approach, which is a semi-structured discussion of selected topics with a small group of women, men or both. Usually a group of 10 to 15 participants works best, because larger groups are difficult to keep focused and to record participant answers. Questions to be answered by the focus group have to be prepared in advance and the most important answers need to be recorded by the leader of the focus group. Focus groups could be conducted by students of social sciences or from the School of Health Sciences in Asmara. Hospital staff can also conduct them after appropriate training.

**Medical Records Review**

Clinical standards of care are often assessed through a retrospective medical record review, including drug treatment practices and the use of diagnostic tests. Criteria of interest are recorded manually in a tally form or, ideally, in a computer spreadsheet or database program like Epi-Info. A systematic random sampling technique may be most appropriate. For example, every 20th record is selected after choosing the first record number from a random number table. The interval between records is determined by the total sample size and the number of records available. Sample size calculations take into account the desired statistical precision for the findings of interest based on the expected frequency of these events (i.e., the proportion of clinical malaria cases with a positive blood test).

**Patient Flow and Waiting Time Assessment**

A major source of frustration and dissatisfaction for clients and patients is an excessive amount of time spent waiting to receive services. Waiting times are best measured and bottle necks are identified through a patient flow and queuing analysis. In its simplest form this analysis uses time logs at various service stations in a hospital or any other type of facility. For example, the following event sequence could be timed:

- Upon entering the facility the client’s/patient’s arrival time is noted
- Time after registration is completed
- Time when seen by a triage nurse or doctor
- Time after consultation is completed
- Time entering laboratory for tests
- Time when tests are completed
- Time to see the doctor again
- Time after second visit is completed
• Time when patient consults pharmacist
• Time after drugs have been received
• Time client/patient leaves hospital premises

This time log will show how long a client or patient waits between different services compared to
the time that s/he actually receives services and where the longest waiting times occur. Based on
this analysis hospital management can decide which stations require more staff or whether
registration procedures should be shortened. Several simple computer programs exist that
facilitate the actual waiting time and flow of patient analysis at various times of the day (i.e.
Quick Quant Plus).

Clinical Case Review
A regular review of cases that represent an unusual diagnosis and clinical profile is standard
practice in hospitals. Often a special weekly staff meeting is set aside for this purpose. Instead of
focusing only on the clinical aspects, the case review could also cover the process and the quality
of care received. All staff who are part of the care process should be present. In health centers
and stations this is relatively easy to accomplish, whereas in hospitals the review should be held
on a departmental level, due to the large number of staff involved. Careful moderation is
necessary to avoid highly technical presentations and to keep the discussions on the lessons that
staff can learn, rather than assigning blame if processes have failed.

Hospital HMIS
SEMISH provides very useful information about both overall volume by ICD-10 code and
average length of stay for each diagnostic category. However, this information is too limited for
quality improvement purposes in a hospital, and requires a more complex HMIS that is based on
individual client/patient encounters. More detailed information on a patient level is needed (i.e.,
the proportion of diagnosed malaria cases with a positive blood test which requires a link
between medical and laboratory records). Data should also be available on both a department and
an individual physician level to compare case loads and other characteristics, such as admission
rates, average length of a hospital admission, ward daily census and occupancy rate. Case
fatalities cannot be used as a quality measure unless it is adjusted for patient characteristics and
severity of illness. The latter should be recorded routinely upon admission following a standard
classification similar to Diagnosis Related Groups that are used in the USA and other severity
adjustment methods.

Key Indicators from SEMISH
All the above mentioned tools require some additional data collection effort. They should only be
used in addition to HMIS data for a few key indicators. Any kind of quality assurance and
supervision process should start with information already available.

Indicators related to quality provided by SEMISH, including admission rates for diseases and
conditions that are preventable, provide some indication as to whether preventive services are
effective. This includes admission of acute watery diarrhea cases with dehydration, severe
pneumonia, and malaria. A list of key indicators for local performance monitoring is shown in
Appendix A.
APPENDIX C

RESPONSIBILITIES FOR THE QUALITY ASSURANCE PROCESS
The following MOH personnel are responsible for the overall development and implementation of the quality assurance and supervision approach:

Dr. Afewerki Abraham, MOH, Director General, Health Services
Dr. Iyob Tecle, MOH, Head of Planning and Programs
Mrs. Berhana Haile, MOH, Head of SEMISH
Dr. Mismay Ghebrehiwot, MOH, Director of PHC
Dr. Michael Ghebrehiwot, Director, Mekane Hiwet Hospital, Asmara

The development of a detailed quality assurance and supervision implementation plan will include the following zonal and facility MOH personnel:

Dr. Andom Oremariam, Zonal Medical Officer, Anseba Zone
Dr. Kesete Araia, Zonal Medical Officer, Gash-Barka Zone
Dr. Mineab Sebahtu, Zonal Medical Officer, Central Zone

The following projects and programs will develop specific technical areas of the quality assurance and supervision approach according to the state-of-the-art in the respective fields:

Dr. Nosa Orobaton, BASICS, Maternal and Child Health
Dr. Saba Mebrahtu, UNICEF, Maternal and Child Health
Dr. Filli Said Filli, MOH, Head of EPI
OMNI, Nutrition
Dr. Ghirmay Andemichael, SEATS, Reproductive Health
Mr. Temesgen Araya, UNFPA, Family Planning
Dr. Goitom Mebrahtu, MOH, Head of CDC
Dr. William Brady, UNAIDS, HIV/AIDS and STD
Dr. Tewelde Ghebremeskel, MOH, Head of Tuberculosis and Leprosy Control
Dr. Elmi A Duale, WHO, District Management and Supervision
APPENDIX D

SAMPLE TOOLS AND INSTRUMENTS FOR QUALITY ASSURANCE AND SUPERVISION
The following samples are attached as illustrative examples of the tools and instruments described in this report. Although some of these examples have been developed for use in other fields (i.e., family planning, reproductive health), they serve as potential models for the development of quality assurance and supervision instruments in other aspects of public health. They have been included here to serve as a basis and should be adapted for the quality assurance framework ultimately adopted by the MOH.

Sample 1, a health center supervision checklist developed by USAID/BASICS in Zambia, is divided into two parts. Part I, "Core Health Facility Activities," aims to gather data on facility infrastructure and cleanliness, I-E-C materials, data registers, finance and administration, type and quality of service provision, logistics, and commodities. Part II focuses on specialized health center activities such as community health worker and traditional birth attendant training, water and sanitation, and maternal services. Even though this checklist is still in an early developmental stage, it is included because it attempts to integrate all important technical programs. For routine implementation the list should be shortened considerably.

Sample 2, a series of questions developed by AVSC International as part of the Client-Oriented Provider-Efficient (COPE) method, is primarily used for quality improvement in family planning and reproductive health services (AVSC International, 1995). The COPE method focuses on internal assessment of quality. The method consists of self-assessment by facility personnel combined with client interviews. Its strength lies in the participation of both providers and clients. Although originally developed for use in family planning programs, the COPE method is an instrument that can be uniquely adapted to other health services.

Sample 3, a rapid service quality assessment checklist developed by the Primary Health Care Management Advancement Programme, can be used by supervisors during regular supervisory visits to identify strengths and weaknesses in service provision. Completed checklists are utilized to give feedback to service providers, and can be used as a self-assessment tool by providers to identify areas for improvement. The list is only one of about twenty, but shows clearly the advantage of the PHC/MAP approach (for example, simplicity, few questions that capture the essence of programs, and all observations included on a single sheet).

Sample 4 is a collection of different self-assessment and client survey instruments for health care providers in the United States (American Hospital Association, 1991). The source provides very practical guidelines on designing self-assessment tools and conducting assessments. The attached samples reflect the health care system in the United States and are too general. They therefore need to be adapted to the country context, as well as the technical specialty or program to be evaluated. However, the forms are very simple to implement and use. They provide a useful introduction of a routine quality improvement process that does not overburden staff with lengthy and complex questionnaires.

The examples appended to this report cover household visits (PHC/MAP) and facility based observations (BASICS/Zambia and AVSC). Technical areas include maternal and child health, malaria control, family planning, STDs, tuberculosis, vitamin A and iron supplementation, and environmental health. These checklists deal with topics such as registration, record keeping, inventories of essential drugs and equipment, observation of health worker performance of clinical and administrative tasks, community relations, educational activities, safety issues,
client/patient privacy, confidentiality and dignity, facility management and supervision, staff knowledge and skills, and client/patient satisfaction.

To apply these checklists in practice, a few priority topics and issues should be selected among the many possibilities. The guiding principle should be to focus on one issue at a time and to assess the problem with a minimum number of questions. Quality assurance processes should foremost enable professionals to use the information and to take action.
Appendix D
Sample #1
Health Centre Supervision Checklist
16 March 1997

Date: ____________________________ Health Centre ____________________________
In-charge ________________________ Supervisors _______________________________

Part I - Core Health Facility Activities

A. Facilities, grounds and buildings
Walk around the health centre with the in-charge and answer the following questions:

YN 1. Are the grounds around the health centre and staff houses free from waste?
YN 2. Is there a functioning and clean toilet for staff and patients at the facility?
YN 3. Is there adequate seating and space for waiting patients?
YN 4. Are all of the rooms in the health centre clean?
   - floors swept
   - trash put in trash boxes and not left out
YN 5. Are all linen materials which are in use and in storage clean?
YN 6. Is there an ORT corner fully functional with the following present—
   - table, seating for mother and child
   - potable water (✔ if supply appears adequate)
   - 2 large cups (500 ml), 2 medium cups (250 ml)
   - 1 tablespoon (10 ml), 1 teaspoon (5 ml)
   - ORS sachets (✔ if supply appears adequate)
   - the ORT register is complete
YN 7. Private consultation room for confidential counseling
   (Family Planning, STDs, etc...) and private physical exam (gynae, STDs)

B. Records, Reports and Wall charts
YN 8. Is the following information displayed on wall charts or maps—

   - map of health centre catchment area displaying—
     - boundary of catchment area
     - communities
     - roads
     - markets
     - health centres
     - NHMTs
     - CHWs
     - trained TBAs
     - rivers, springs and other major water sources

   - vital statistics for the catchment area—
     - total population for current year
     - under-fives
     - under-ones
     - women of childbearing age
     - expected pregnancies in current year
☐ immunisation monitoring chart correctly filled in and up-to-date showing—
  ☐ the number entered for measles vaccinations is the same as on the MF-47
  ☐ the cumulative numbers are added correctly; and
  ☐ the point is plotted correctly to correspond with the cumulative vaccinations
  ☐ current estimate of measles vaccination coverage

☐ Is the first-antenatal-attendance monitoring chart displayed, correctly filled in and up-to-date?
  ☐ the number entered for first antenatal visits is the same as on the MF-47
  ☐ the cumulative numbers are added correctly; and
  ☐ the point is plotted correctly to correspond with the cumulative visits and the month

9. What is the current estimate of first antenatal attendance coverage for this area? ___%  
YN 10. Is there a copy of the MF-47 on file for last month, and has it been sent to the district?

C. Review of the Outpatient Register for the past month

YN 11. Is there a registration book in which diagnoses are listed? 

If Yes —
  How many of the patients seen in the last month had more than one diagnosis written in the register? ___
  a.) of the last 10 cases of “diarrhea” or “gastroenteritis” or “A.G.E.”, how many were treated with ORS? ___
  b.) of the last 10 cases of upper respiratory tract infection (URTI) or cold/not pneumonia, how many were treated with antibiotics? ___

D. Review of the Antenatal Register for the past month

YN 12. Is the antenatal clinic register correctly filled in and up-to-date?

YN 13. Are there notations in the antenatal register for high-risk pregnancies, and are special follow-up activities specified for these women?

YN 14. Have the following antenatal services taken place in the past quarter?
  ☐ outreach antenatal clinics?
  ☐ community participation regarding maternal care and referral?
  ☐ community discussions on danger signs of pregnancy and delivery?

YN 15. Is there a register of RPR results for antenatal patients?

E. Review of the Tuberculosis Treatment Register for the past month

YN 16. Is the tuberculosis treatment register correctly filled in? 

Note: Answer “No”, if data missing or incorrect. Explanations should be given for missing data.

17. How many TB patients have defaulted in the past 3 months? ___
18. Do records reflect that defaulters were visited at home?

19. How many sputum positive reports at two months were not followed up? 
   _____ (number)

20. Number of new patients started on treatment in the previous 3 months? _____

21. Number of patients completing treatment in past 3 months? _____

22. Number of TB patients not responding to treatment referred to the district? _____

23. How many patients are receiving DOTS treatment? _____

F. Financial

24. How much money did you collect from user fees, since the last supervision visit? _____

25. Is there a financial committee that monitors expenditures and are minutes of 
   meetings available? _____

26. Does the total amount of money collected on user fees last month correspond with 
   the total amount of the receipts in the receipt book? _____

27. Is the cash from user fees for last month available or if it was collected, can it be confirmed by the District Accountant that it has been banked? _____

28. Does the number of receipts issued last month for user fees match with the number of user fee paying patients according to the outpatient (+/- inpatient) register(s)? _____

29. Does the staff know which patients are exempted from paying user fees?
   □ Children under 6 years and patients above 65 years
   □ Treatment for chronic diseases like TB, diabetes, hypertension
   □ STD, antenatal and other MCH services
   □ If patients have truly no means to pay (approved by the Dept. of social welfare)

G. Services provided

30. Are the following services available more than once weekly? (Supermarket)
   □ childhood immunisation
   □ antenatal care
   □ family planning

31. Is there a UCI outreach programme? If yes, how many times last month? _____
    How many sites last month? _____

32. Is there an AIDS home-based care programme functioning? 
   If Yes—
   how many patients are presently receiving treatment? _____
   □ records complete
   What supplies are being distributed in past month days?
H. Personnel

33. How many staff and of which cadre are working at the health centre?

[ ] Doctor
[ ] Environmental Health Technician
[ ] Clinical Officer
[ ] Laboratory Technician
[ ] Registered nurse
[ ] Classified Daily Employee
[ ] Enrolled nurse
[ ] other: _______________________
[ ] Community Health Worker
[ ] other: _______________________

YN 34. Was there a staff meeting held last month? Note: To answer “Yes” there must be minutes of the meeting, including names of the participants

YN 35. Were there other health facility committees which met in the past 3 months? Specify which (housing, drugs & therapeutics, discipline etc) and verify minutes

I. Equipment, Supplies and Stationary

YN 36. Are each of the following items of equipment present and in working order?

☐ salter scale/weighing bag  ☐ steam steriliser
☐ adult scale  ☐ steriliser stove
☐ blood pressure cuff  ☐ measuring tape
☐ clinical thermometer  ☐ (for measuring fundal height)
☐ foetal stethoscope  ☐ vaccine carrier
☐ stethoscope  ☐ ice packs
☐ timer for health worker seeing ☐ wash stand and basin
  children
☐ vaginal speculum

YN 37. Is there a dental tray present?

YN 38. Are supplies of the following available in adequate quantities?

☐ water for washing hands  ☐ sterile syringes (1 mo supply)
☐ potable water  ☐ sterile needles (1 mo supply)
☐ soap for washing hands  ☐ cotton wool
☐ fuel for steriliser stove  ☐ IUD kits

YN 39. Are adequate supplies of the following forms/stationary available?

☐ outpatient register  ☐ Children’s clinic cards
☐ tally forms for UCI  ☐ ante natal cards
☐ MF-47  ☐ EDP report forms
☐ Notifiable disease report form  ☐ blank stock cards
☐ receipt books  ☐ TB cards
☐ OPD cards/record books

YN 40. Are laboratory services available?

If Yes — is the following equipment available?

☐ microscope  ☐ haemoglobinometer
☐ centrifuge  ☐ reagents for blood films (1 mo supply)
☐ cell counter  ☐ urine dipsticks (1 mo supply)
☐ glass microscope slides (1 mo supply)
J. Vaccine Supply and Cold Storage

YN  41. Has the vaccine refrigerator maintained an acceptable temperature, and is its present temperature between 0°C and 8°C?

YN  42. Has the refrigerator temperature chart been filled out twice daily for the past month?

43. For how many days in the last 3 months does the stock books show each of these vaccines out-of-stock?
   Measles: ___ days; DPT: ___ days; Polio: ___ days; BCG: ___ days; TT: ___ days
   □ Vaccine stock book not current

YN  44. Is a 2 week supply of fuel available?
### K. Drugs and Contraceptives

<table>
<thead>
<tr>
<th></th>
<th>stock card present</th>
<th>recorded = actual</th>
<th>days o/s last month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child health/Malaria</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chloroquine tabs</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Cotrimoxazole tabs</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>ORS sachets</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Pyrimethamine-sulfa tabs</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Vitamin A capsules/tabs</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td><strong>Maternal health/Family Planning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methylergotamine injection</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Condom</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Contraceptive pill</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Depopovera</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td><strong>STDs/Tuberculosis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzathine penicillin</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Ethambutol tabs</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Isoniazid + Ethambutol tabs</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Pyrazinamide</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Rifina</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV Fluids and giving sets</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Ferrous Sulphate</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
</tr>
<tr>
<td>Folate</td>
<td>□ Yes  □ No</td>
<td>□ Yes  □ No</td>
<td>___ days</td>
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</tbody>
</table>
Y N 46. If there is a maternity facility, the following drugs, at a minimum, will be present in adequate amounts for the deliveries which occur in this unit—

- gentamicin
- procaine penicillin
- tetracycline ointment
- amoxicillin
- gentamicin 0
- Vitamin A
- procaine penicillin 0
- tetracycline ointment 0
- amoxicillin 0
- anticonvulsants
- lidocaine 2%
- mebendazole
- BCG
- ampicillin injectable

Y N 47. Are drugs handled in an appropriate manner?
- How are new drugs stocked when they arrive? (✓ for: stock rotation)
- What do you do with expired drugs? (✓ for: return to district)
- Are there any drugs on the floor? (✓ for: none)

L. Malaria/Child Health
(including UCI, diarrhea, pneumonia, nutrition and malaria)

48. Observation of Assessment of the Sick Child 2 Months to 5 Years

Health Worker's Name: ____________________________

CO ZEN EHT RN MD CDE

Health Worker trained with 11 day MCI course: Yes No

Age of child: ________ months

Does the health worker greet the mother?

Does the health worker ask about or does the mother volunteer—

Danger signs
- not able to drink or breast feed?
- vomits everything?
- convulsions?
- lethargy or unconsciousness?

Cough or difficulty breathing
- for how many days?
- raise the shirt?
- count breaths?
- look for chest indrawing?

Diarrhoea
- for how many days?
- is there blood in the stool?
- offer fluid or observe breastfeeding?
- skin pinch of the abdomen?

Fever in the past 24 hours
- for how many days?
- has Chloroquine been given at home for this illness?
- examine for stiff neck?

Immunization
- ask to see immunization care?
- due for vitamin A?

Feeding (if under 2 yrs or very low weight)
- do you breastfeed your child?
- if yes, how many times in 24hrs?
- does the child take any other food?
- if yes, what foods or fluids?
- how many feedings per day?
Drugs prescribed

<table>
<thead>
<tr>
<th></th>
<th>Does health worker correctly explain—</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Dose</td>
</tr>
<tr>
<td></td>
<td>□ Frequency</td>
</tr>
<tr>
<td></td>
<td>□ Duration</td>
</tr>
<tr>
<td></td>
<td>□ Dose</td>
</tr>
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<td></td>
<td>□ Frequency</td>
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<td></td>
<td>□ Duration</td>
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<tr>
<td></td>
<td>□ Dose</td>
</tr>
<tr>
<td></td>
<td>□ Frequency</td>
</tr>
<tr>
<td></td>
<td>□ Duration</td>
</tr>
</tbody>
</table>

YN 50. Does a health worker ask any open-ended questions to determine whether the mother understands how to give the medicines prescribed?

YN 51. Does the health worker advise—
- □ Increase the frequency of meals or breastfeeding
- □ Reduce or stop other foods other than breastmilk
- □ Begin or increase the frequency of complementary foods
- □ Give food that is thicker or enriched (e.g. with sugar, oil, ...)

YN 52. Does the health worker advise on when to bring the child again?

YN 53. Does the health worker advise mother to return with child immediately for:
- □ Develops a fever or fever does not go away
- □ Drinking poorly (if child has had diarrhoea)
- □ Blood in the stool (if child has had diarrhoea)
- □ Breathing fast or difficult (if child has been coughing)
- □ Child becomes worse for any reason

Part II Specialised Health Centre Activities

M. Community Partnership/Health Communication

54. How many NHCs are in the catchment area of this health centre? ____
   and how many are active? ____

YN 55. Was there a meeting with all the NHMCs in the catchment area last month?
- □ if yes are there minutes available
- □ if no, why did meeting not take place?

56. Describe one activity carried out by/with NHCs in the last quarter:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

57. What is the total number of CHWs (active and inactive) in the catchment area?
   ____ How many of these are active? ____

58. How many CHWs submitted any reports in the last 3 months? ____
   Note: confirm that reports are on file
59. Was each active CHW supported at least once in the last quarter?
   Note: To answer, "Yes", there must be a report of the support visit.

60. What is the total number of active trained TBAs in the catchment area? __

61. How many active trained TBAs submitted any reports in the last 3 months? __
   Note: Confirm that reports are on file

62. Was each active trained TBA supported at least once in the last quarter?
   Note: To answer, "Yes", there must be a report of the support visit.

63. Approximately how many times did staff spend outside the health centre in the last month providing outreach services on one of the 6 health thrusts? ____ times

64. How many different sites did staff visit outside the health centre in the last month to provide outreach services on one of the 6 health thrusts? ____
   Note: ask about which sites were visited and which community groups participated

65. What development NGOs are functioning in the catchment area, and what programmes are they undertaking?

66. What activities are being conducted by the health centre in conjunction with NGOs?

N. Environmental Health

Sanitation and waste management

67. Does the health worker know—
   □ the population of the catchment area?
   □ the number of households in the catchment area?
   □ the average number of persons per household?
   □ how many households have pit or VIP latrines?
   □ how many households have flush toilets? (where applicable)
   □ how many households have refuse pits?

68. Are there promotional programmes underway on excreta disposal in this area?

69. Does the health worker maintain statistics on faecal borne diseases in this area?

70. How many new pit latrines have been constructed in the past quarter?

71. How many health education meeting on hygiene has he held in the past month?
   _______ (check diary for number)

72. Is there uncollected or undisposed waste lying around the area?
   □ if Yes, has the health worker suggested any alternative methods of disposal to the community? ( ✔ if yes)
   □ if Yes, what is this alternative?
73. Is the excreta and waste disposal system at the health centre adequate and safe?

74. Is there a malaria control programme being conducted?
   If Yes, what is included in the programme?

75. How many visits to the community has the health worker conducted in the past month in conjunction with a community representative to check on sanitation issues?

Water

76. Does the health worker know—
   - the number of households served by protected wells or boreholes?
   - the number of households served by communal taps?
   - the number of households with mains water connections?
   - the number of villages with protected wells or boreholes?
   - how many villages are within 0.5 km of a protected water source?

77. Does the health centre have a stock of water treatment chemicals for emergencies?

78. Does the health worker regularly check the chlorine level of the water supply to the health centre (check his or her record book)?

79. How many NGOs or cooperating agencies have water activities in this area?

80. If these are present, does the health worker attend their meetings? (check diary)

81. Is the health worker using any IEC materials to protection of water sources?

82. Has the health worker conducted any meetings about water supply sources with communities without protected sources? (Check the diary)

83. How many water sources has the health worker inspected in the preceding quarter about which he or she has written a report?

O. Observation of Family Planning service delivery

84. Did the health worker display the following actions
   - greeted the patient in a friendly manner
   - encouraged questions
   - ensured privacy
   - provided a health talk about family planning
   - carried out screening or management of STDs
YN  85. Were the following clinical procedures carried out?
   □ TT status checked
   □ if needed TT given
   □ blood pressure checked
   □ patient checked for anaemia
   □ legs checked for oedema or varicose veins
   □ weight checked
   □ abdomen palpated
   □ RPR done during this pregnancy

P. Health Centres with a maternity facility

General observation

YN  86. Does the facility have the following—
   □ delivery room
   □ telephone or radio in working condition
   □ transport facilities for patients (where applicable)
   □ adequate light (hurricane light minimum)

YN  87. Did this health centre maintain the following records for recent deliveries—
   □ partograms filled in properly
   □ blood pressure checked and recorder four-hourly
   □ foetal heartbeat checked hourly
   □ vaginal examination done four-hourly

Supplies and equipment for maternity and postnatal services

YN  88. The following delivery equipment is present
   □ chitle forceps
   □ episiotomy scissors
   □ suture needles
   □ needle holder
   □ artery forceps
   □ cord scissors
   □ ring (sponge) forceps
   □ infant laryngoscope
   □ bag & mask for neonatal resuscitation
   □ neonatal mucus extractor
   □ clinical thermometer
   □ tooth forked forceps
   □ incinerator

YN  89. The following consumables are present in adequate amounts for the deliveries
   which occur in this unit—
   □ linen/cloth to dry the baby
   □ gauze/cotton wool
   □ plastic sheeting
   □ cord clamps/ties
   □ suture material
   □ maternity pads
   □ IV giving sets
   □ disinfectant
   □ partograph forms
   □ syringes
   □ needles
   □ gloves
Observation of services in a postnatal clinic

YN 90. The following activities were carried out by the health worker—
- checked the date of delivery by card and by asking the mother
- verified how many postnatal visits had been made after this delivery
- carried out a physical examination on the mother including—
  - abdomen
  - eyes/tongue
  - vagina
  - breasts
  - blood pressure
- examined the baby for any abnormalities, colour, weight, activity

YN 91. The following health education was provided to the mother—
- family planning
- immunisation
- breast feeding
- growth monitoring
Appendix D
Sample #2
Clients' Right to Safety

This guide relates to safety issues, particularly screening, infection prevention, and reporting of complications. The team for this guide might include hospital ward or maternal and child health staff, a surgeon or ancillary ward member, a housekeeper or cleaner, as well as family planning service providers. If your site performs sterilizations, a member of this team should conduct a Sterilization Record Review.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: “PROBLEM. RECOMMENDATIONS, BY WHOM, BY WHEN.” If you are aware of a problem that is not addressed on this guide, please include it.

GENERAL SAFETY, SCREENING, AND FOLLOW-UP

Screening includes client evaluation from several perspectives. The information needed will depend on the service being requested: general health and medical history, behavior, social history, physical exam, and laboratory testing. When looking at screening practices at your facility, please consider these different perspectives.

1. Do staff feel they have sufficient guidance, updates, and backup to provide safe services?

2. Are all contraceptives in stock within the expiration date?

3. Is the right equipment available to provide services efficiently and safely?

4. Are staff well informed about the potential health benefits and contraindications for the different methods offered?

5. Are clients informed about the warning signs of potential complications? Are they told to seek medical attention or return to the facility if these symptoms occur?

6. Are clients told that if they have a problem they should return to the clinic without waiting for their follow-up appointment?

7. Is there a plan for routine follow-up for all methods of family planning?

8. Do staff routinely record and review causes of complications in order to improve clinical practices?
9. Is a qualified clinician always available for consultation in case of complications?

10. Are staff aware of the procedure for reporting a family planning–related death, even though occurrence of this is rare?

**INFECTION PREVENTION**

11. Are written infection-prevention guidelines, charts, posters, leaflets, and handbooks available for staff? Do staff understand and follow the guidelines for protecting themselves and others during their work?

12. Are disposable needles and syringes used whenever possible? Are reusables properly sterilized?

13. Are sterile or high-level disinfected gloves available when necessary?

14. Are needles and other sharp objects placed in safe containers before disposal?

15. Are reusable materials and instruments decontaminated in a 0.5% chlorine solution for 10 minutes before further processing? Do staff have enough buckets, bowls, and bleach to ensure that chlorine solution is always available where it is needed?

16. Are soiled surfaces (examination couches, operating tables, etc.) wiped with 0.5% chlorine solution after each procedure?

17. Are decontaminated instruments and materials washed and rinsed well before further processing?

18. Are reusable materials sterilized or high-level disinfected before use? Are methods for high-level disinfection understood by staff?

19. Is equipment for sterilizing reusables available and functioning? Are proper chemicals for sterilization and high-level disinfection available and used correctly?

20. Do staff wear heavy-duty gloves to clean dirty instruments and to dispose of contaminated waste?

21. Is contaminated waste disposed of in a safe way (for example, burning or burying)?

22. Do all staff wash their hands after handling waste?

23. Do staff fully understand infection-prevention techniques?
Clients’ Right to Privacy and Confidentiality

Clients have a right to privacy and confidentiality during the delivery of services and during counseling and physical examination. The team for this guide could include receptionists, guards, physicians, clerks, or any other staff.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: “PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN.” If you are aware of a problem that is not addressed on this guide, please include it.

1. Does your facility have a private space where clients will not be observed or overheard during family planning counseling?

2. Are there ways to ensure that there are no interruptions during client counseling (for example, signs and locks on doors)? Do these work?

3. Do staff explain to clients what type of examination is being done, and why?

4. Do clients have privacy during examinations?

5. When a third party is present during counseling or examination, do staff explain that person’s presence and ask the client’s permission? If case discussions are held in the presence of a client, are clients given the opportunity to be involved in discussions?

6. Do staff respect client confidentiality by not discussing a client except to get advice from other clinic personnel?

7. Is access to client records strictly controlled?

8. Do all staff respect the client’s right to confidentiality—for example, by keeping information from the client’s spouse, partner, or parent if the client so desires?

OTHER ISSUES YOU THINK ARE IMPORTANT

10. __________________________________________

11. __________________________________________

12. __________________________________________
Clients’ Right to Dignity, Opinion, and Comfort

This guide combines the three closely related “rights” to dignity, opinion, and comfort. Team members could include family planning or other reproductive health providers and counselors, receptionists, doormen, etc.

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: “PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN.” If you are aware of a problem that is not addressed on this guide, please include it.

1. Do all staff (doormen, receptionists, family planning staff, accounts staff, lab and pharmacy staff, etc.) treat clients with courtesy, consideration, attentiveness, and with full respect to their dignity?

2. Are the women and men who come to your facility treated the way you would want to be treated?

3. Do staff use language that clients will understand?

4. Do staff encourage clients to ask questions?

5. Do staff respect clients’ opinions?

6. Do staff perform physical examinations and other procedures with the client’s dignity and modesty in mind? Is the client’s comfort addressed during physical exams?

7. Do staff ask clients about ways to improve services or about other services they might like?

8. The list below describes some areas of the facility that family planning or other reproductive health clients may use. Do you think these are pleasant, comfortable areas (for example, is there enough space, and is the space well organized, clean, well lit, comfortable, well ventilated, and pleasant)?

- Registration/reception
- Counseling areas
- Waiting areas
- Examination rooms
- Pharmacy
- Operating room (reception/scrub and gowning/operating area)
- Gynecology wards
• Maternity wards
• Delivery rooms
• Emergency/casualty treatment areas
• Recovery and waiting (ward area/toilet)
• Toilet facilities

9. Are all parts of your facility always clean?

10. Are enough staff available at times when the clinic is busiest?

11. Are staff in the clinic fully occupied and well utilized during the entire time they are working?

12. Do you think client waiting times for services are reasonable?

13. Are clients served in the order in which they arrive?

14. Are records organized so that retrieval is quick and easy?

15. Is the time clients spend in contact with a health worker generally satisfactory?

16. Do new clients spend enough time with health workers?

17. Do you routinely give the maximum amount allowed of contraceptive supplies (for example, pills, condoms, spermicide) at any one time so that clients do not have to return too often?

18. Do you try to minimize the number of visits that a client has to make?

19. Are follow-up visits scheduled with the convenience of the client in mind?

20. Are staff nonjudgmental toward clients who have an induced abortion?
Staff Need for Good Management and Supervision

*Health workers function much better in a supportive working environment that combines good management and supervision. The team working on this guide should include representatives from management, as well as family planning or other reproductive health service providers.*

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: “PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN.”

*If you are aware of a problem that is not addressed on this guide, please include it.*

1. Does your facility have a family planning committee? Does it work well?
2. Do you regularly hold staff or committee meetings to discuss family planning services?
3. Do staff feel that they are part of a family planning team and are able to give suggestions to the management and the family planning committee (if one exists) about services? Does management encourage this?
4. Do staff at this facility follow guidelines set by the ministry of health, a government department, or agency headquarters?
5. Does management provide constructive feedback to all staff on family planning issues? Is management supportive, encouraging, and respectful of staff?
6. Do staff feel that supervision within the facility is adequate?
7. Does the support that your facility gets from your headquarters organization always meet your needs?
8. Do staff feel that the facility emphasizes and is committed to the provision of quality family planning services?
9. Are there strong links between the different departments or wards? For example, do staff share family planning information, give referrals, visit other parts of the facility to give health talks, etc.?
10. Do staff in the facility always give due respect and attention to workers from other departments and to community workers who may have referred clients? Are there guidelines for referring clients for family planning?
11. Is there a mechanism through which community-based distribution workers can discuss issues with facility-based workers?

12. Are clinic reports submitted regularly and on time? Do staff assess the quality of family planning services by discussing data from clinic reports? Are reports sent to headquarters used to give feedback to clinic staff?

13. Are all clients’ family planning records completed properly? Is all essential information included?

14. Do staff ever interview clients to measure their satisfaction with family planning services?

15. Is someone routinely assigned responsibility for:
   - Family planning counseling in the clinic
   - Giving talks on family planning to clients in the clinic or in hospital wards
   - Coordinating sterilization services
Staff Need for Information, Training, and Development

For a site to be able to provide quality family planning services, staff need to be well informed and well trained. The team working on this guide might include family planning or other reproductive health service providers and ward or operating room staff (in a hospital).

If a question raised below is a problem at your facility, or if you think the question needs to be further discussed, write your comments on the flipchart paper in the following format: “PROBLEM, RECOMMENDATIONS, BY WHOM, BY WHEN.”

If you are aware of a problem that is not addressed on this guide, please include it.

1. Are staff familiar with the ministry of health or institutional guidelines on family planning and infection prevention? Do staff have access to them?

2. Do all staff know when and where family planning services are available? Do all staff know the contraceptive methods that are offered?

3. Do all staff feel able to give basic family planning information?

4. Are updates and in-service training provided to keep staff well-informed?

5. Do enough staff in the facility have the skills necessary for counseling clients, including groups with special needs (for example, men, postpartum and postabortion women), on all methods? Are counseling staff always available during clinic hours?

6. Do enough staff have information to give to men and women about sexually transmitted diseases (STDs), including HIV infection? Do staff know how to show clients how to use a condom?

7. Do family planning staff feel competent to do STD screening by asking questions about exposure to risk of contracting STDs and by clinical screening?

8. Have all staff involved in giving family planning information observed a tubal occlusion, vasectomy, Norplant implant insertion or removal, and an IUD insertion or removal?

9. Does the facility have enough trained providers skilled in family planning and other reproductive health issues. Is there enough in-service training?
10. Are there enough doctors, clinical officers, or nurse-midwives who are competent in all methods offered that involve a clinical procedure (tubal occlusion, vasectomy, IUDs, Norplant implants, injectables)?

11. Do all staff in wards or clinics know enough about infection prevention? (For example, do staff know how to make up a 0.5% solution of chlorine from locally available bleach or chlorine that will kill HIV and the Hepatitis B virus?)
CLIENT-INTERVIEW FORM

Directions: Introduce yourself to the client. Explain that the purpose of the interview is to learn how clients feel about services offered at the facility and to get the client’s suggestions on how services might be improved. Stress that the interview is confidential and that the client's name will not be used. Adapt the questions listed here to your facility and the client you are interviewing. Record any additional information the client volunteers. Thank the client for her or his assistance.

1. Why did you come to the clinic today?

2. Did you get what you came for? If not, why not?

3. Have you been given information about family planning? □ yes □ no
   
   If yes: What methods did you hear about?
   
   If no: Would you have liked to get family planning information?

4. If you came for family planning, did you get the method you wanted?
   □ yes □ no

   If yes: What instructions were you given about your method?
   Do you have any more questions about your method?

   If no: Why not?

5. What do you like best about this clinic?

6. What do you like least about this clinic?

7. What suggestions do you have to help us improve services at this clinic?

8. Is there anything else you would like to tell us?

Interviewer comments:
Appendix D
Sample #3
### Rapid service quality assessment checklist
#### PHC household visit

1. Health facility ____________
2. Observer ____________
3. Regular supervisor ____________
4. Date ____________

**Instructions:** Mark "yes" (Y) if the service provider carries out these activities during observation. For interview questions, mark "yes" (Y) if the client responds correctly.

<table>
<thead>
<tr>
<th>Observation number/registration and documentation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>TOT</th>
<th>Problems identified</th>
<th>Actions taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Are all children under 5 registered on the family health card?</td>
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<td>6. Are all women over 16 registered on the family health card?</td>
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<td>7. Was information updated during the visit?</td>
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<td><strong>Immunization</strong></td>
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<td>8. Was this visit recorded in health centre records?</td>
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<td>9. Discuss the importance of vaccination?</td>
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<td>10. Review the immunization status of all children &lt; 5?</td>
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<td>11. Vaccinate or arrange for vaccination of children who need to be immunized?</td>
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<td>12. Review vaccinations needed and the appropriate dates with mother?</td>
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<td>13. Answer mother's questions about vaccination?</td>
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<td><strong>Growth monitoring</strong></td>
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<td>14. Review the growth cards of all children &lt; 5?</td>
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<td>15. Weigh children or refer them as appropriate?</td>
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<td>16. Discuss changes in weight with the mother and give nutritional advice?</td>
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<td>17. Answer mother's questions about growth monitoring and nutrition?</td>
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<td>18. If there are any malnourished children in the house did the health worker check to be sure that nutritional counselling, food supplementation, and/or medical attention are being received as indicated?</td>
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<td>19. Ask if any children in the household have diarrhoea?</td>
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<td>20. If yes, recommend ORT, and help the mother to prepare and administer it?</td>
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<td>21. If no, review the importance of ORT and encourage mother to use it in future diarrhoea episodes?</td>
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<td>22. Answer mother's questions about ORT?</td>
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<td>23. Demonstrate how to make ORS solution, or invite mother to a demonstration if necessary?</td>
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</table>
## Self-Assessment: Do You Have the Quality Management Mind-Set?

Instructions: Next to each item, place a check in the column reflecting your answer. (Disregard the circles; they will be used for scoring your answers later.)

1. Do you believe that customers have unrealistic expectations and that you can never really satisfy them?  
   - Yes  
   - No

2. Are you and your staff clear about how your internal and external customers define quality?  
   - Yes  
   - No

3. When faced with different ways to do things, do you decide on the basis of what’s best for your customers?  
   - Yes  
   - No

4. Do you devote time and energy to collecting feedback from your customers?  
   - Yes  
   - No

5. Are you satisfied with how your department is working as long as you don’t hear complaints?  
   - Yes  
   - No

6. Do you often communicate a vision of excellence that constitutes a stretch from the way things are currently working?  
   - Yes  
   - No

7. Do you avoid confronting staff even when their performance warrants it?  
   - Yes  
   - No

8. Do you communicate ambitious performance expectations to all employees?  
   - Yes  
   - No

9. Do you feel more gratified when you solve problems for your employees than when they solve them without your help?  
   - Yes  
   - No

10. Do you feel proud of your employees when they bend the rules creatively to satisfy a customer’s need?  
   - Yes  
   - No

11. Do you feel insecure at the thought that your staff can function very well without you?  
    - Yes  
    - No

12. Do you see your role as that of coaching, providing tools, and running interference, thereby enabling your employees to serve their customers?  
    - Yes  
    - No

13. Do you balk at employees’ requests because you think employees should be grateful for what they already get from work?  
    - Yes  
    - No

14. Do you consider your employees as customers whose satisfaction is key to the success of your department?  
    - Yes  
    - No

15. Do you begrudge the time it takes to nurture, recognize, and support employees?  
    - Yes  
    - No

16. Do you devote more quality time and energy to the retention of good staff than to the recruitment of new people?  
    - Yes  
    - No

17. When problems arise, do you feel relieved after you’ve put out the fire and can move on to business as usual?  
    - Yes  
    - No

18. Do you usually take on a new project or set a new goal only in response to a request from your boss?  
    - Yes  
    - No

(Continued on next page)
19. Are you a person known for making good things happen?

20. Do you feel too busy to do anything more than handle one crisis after another?

21. Do you habitually search for new and better ways within your span of influence?

22. Do you receive new ideas with skepticism rather than enthusiasm?

23. Do you deal with mistakes and frustrations as learning experiences?

24. Do you avoid experimenting with new ways for fear of repercussions?

25. Do you feel impatient when problems persist over time, and do you want to proceed to solve them?

26. Do you spend a lot of time "trying" and much less time "finishing"?

27. Do you track results in order to hold yourself accountable?

28. Do you overanalyze a problem instead of moving to solve it?

29. Do you take the initiative to seek out other managers to help you with problems or projects?

30. Would other managers characterize you as territorial?

31. Do you confront other managers whose actions or inactions have a negative impact on the effectiveness of your department?

32. Are you cynical about solving problems that cut across departmental lines?

33. Do you ask your staff for suggestions and ideas about how the organization, not just your department, can be strengthened?

34. Do you withhold information from employees about the organization’s status for fear it will dampen their morale?

35. Do you accept responsibility for helping staff understand difficult administrative decisions so that they retain their faith in the organization’s leadership?

36. Do you find yourself resenting decisions that affect your staff negatively even if you know these decisions are wise for the organization?

37. Do you help others see the good in the organization?

38. Are you more likely to complain than to take action to make things better?

39. Are you a positive force for change in your organization?

40. Do you see change and experimentation as threats more than as adventures?

Scoring: Count the number of checks inside the circles. The highest possible score is 40. The higher your score, the more you already think in ways that support the customer-driven process of continuous quality improvement.

### Self-Assessment: Do You Have the Skills Involved in Customer-Driven Management?

**Instructions:** For each item below, ask yourself the following questions:

- In my span of influence, do I see to it that this is done regularly? Yes or no?
- On a scale from 1 to 4 (1 = low, 4 = high), how effective are my current methods?

<table>
<thead>
<tr>
<th></th>
<th>Do I do this? (Yes/No)</th>
<th>My effectiveness (1/2/3/4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I see to it that everyone on our team knows precisely who our internal and external customers are.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I see to it that we consult our customers to identify their expectations by using focus groups, interviews, or other methods.</td>
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<tr>
<td>3</td>
<td>I have identified reliable measures of the extent to which we meet customer expectations and professional standards.</td>
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<tr>
<td>4</td>
<td>I translate customer expectations and professional standards into clear operational requirements.</td>
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<tr>
<td>5</td>
<td>I identify critical control points in our service that influence the effectiveness of the process and customer satisfaction.</td>
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<tr>
<td>6</td>
<td>I identify and install performance measures at each critical control point.</td>
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<tr>
<td>7</td>
<td>I see to it that customer satisfaction is monitored regularly using reliable methods.</td>
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<tr>
<td>8</td>
<td>I see to it that performance at critical control points is monitored regularly using reliable methods.</td>
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<tr>
<td>9</td>
<td>I make sure performance results are communicated to our staff in a clear, helpful way.</td>
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<tr>
<td>10</td>
<td>I make sure we communicate performance results to senior management in a way that's useful to them.</td>
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<tr>
<td>11</td>
<td>I regularly convene staff to interpret our results and decide what to do about them.</td>
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<tr>
<td>12</td>
<td>When performance improves, I recognize staff for the improvement and help them appreciate a job well done.</td>
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<tr>
<td>13</td>
<td>Based on our data, I see to it that we prioritize improvement opportunities.</td>
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<tr>
<td>14</td>
<td>I have in place a reliable and regular system for pursuing improvements.</td>
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<tr>
<td>15</td>
<td>I use a variety of techniques to involve staff in making improvements.</td>
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<tr>
<td>16</td>
<td>I follow a rational and systematic approach to making improvements that follows a PDCA cycle.</td>
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<tr>
<td>17</td>
<td>I use a variety of quality improvement tools to address problems and opportunities for improvement.</td>
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<tr>
<td>18</td>
<td>I facilitate groups or teams convened for the purpose of making improvements.</td>
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<tr>
<td>19</td>
<td>I actively analyze work processes, identifying suppliers, inputs, steps in the process, and customers of the process and their expected outputs.</td>
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<tr>
<td>20</td>
<td>I can name our two current top priorities for improvement and describe a clear approach we are using to pursue them.</td>
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</table>

**Scoring:**

- First, target the actions that you don’t currently take. Consider instituting some vehicle for initiating them.
- Second, look at the question of quality. For the actions that you do take, how effective are you? Also, to what extent are you consistently using the skills in your job? Target as opportunities for continuous self-development those skills that you need to strengthen and apply to the job.
### Figure 10-3. Example of Form to Summarize Focus Group Results

<table>
<thead>
<tr>
<th>Customer Group: Physicians*</th>
<th>Systems/Procedures That Work Well for Our Physicians</th>
<th>The Specific Strengths</th>
<th>Systems That Our Physicians Find Unfriendly</th>
<th>Their Specific Observations and Frustrations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart retrieval postdischarge</td>
<td>Chart retrieval postdischarge</td>
<td>Helpful staff</td>
<td>Admissions from ER to inpatient beds</td>
<td>Takes too long</td>
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<tr>
<td></td>
<td></td>
<td>Quick location of charts</td>
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<td>Patient not kept informed</td>
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<tr>
<td>Valet parking</td>
<td>Valet parking</td>
<td>Rapid access to car</td>
<td>Turnaround of lab results</td>
<td>Lost results</td>
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<tr>
<td></td>
<td></td>
<td>Convenience</td>
<td></td>
<td>Slow turnaround</td>
</tr>
<tr>
<td>Utilization review of diagnosis</td>
<td>Utilization review of diagnosis</td>
<td>Length-of-stay guidelines helpful</td>
<td>Nuclear medicine</td>
<td>Results not on charts</td>
</tr>
<tr>
<td>Social services’ early involvement in discharge planning</td>
<td>Social services’ early involvement in discharge planning</td>
<td>Physician input honored Discharge support planned in time</td>
<td>Information entry on patient charts</td>
<td>Lost information Delays Incomplete</td>
</tr>
</tbody>
</table>

*You received many complaints from physicians about systems in your department that are not customer-friendly. You hold a focus group for physicians to find out the specifics so you can target improvement opportunities. You summarize the results on a chart like this one.*
Figure 10-4. “Service Report Card” Survey

Dear Office Manager,

Our Admitting Department wants to do its part in making it easy for you to meet your patients’ needs in our hospital. Will you please help by completing and returning the attached “Service Report Card” that asks you to evaluate our services? The card is already addressed and stamped for your convenience. Thank you very much.

1. Courtesy: When you call Admitting, how courteous are the people who handle your calls?
   
   very rude 1 2 3 4 very courteous

2. Speed: When you call Admitting, how quickly do we meet your needs?

   very slowly 1 2 3 4 very quickly

3. Follow-through: When people in Admitting tell you they’ll get back to you about something (e.g., with information, an answer to your question, etc.), how likely are they to follow through as promised?

   not likely at all 1 2 3 4 very likely

4. Competence: When you deal with our department, how competent are staff in meeting your needs?

   very incompetent 1 2 3 4 very competent

5. How do we compare to other hospitals? If you admit patients to other hospitals, how do you rate our department’s effectiveness in meeting your needs—compared to departments in other hospitals?

   much worse 1 2 3 4 much better

6. What is your biggest frustration with our department?

7. Please add any further comments and suggestions.

Thank you.

Figure 10-5. Pharmacy Department Survey Instrument to Monitor Its Service to Nursing

1. In filling routine orders, the Pharmacy is timely untimely
2. In filling STAT orders, the Pharmacy is quick to respond slow to respond
3. The attitude of Pharmacy personnel is professional unprofessional
4. Drug information supplied by the Pharmacy is useful not useful
5. The Pharmacy's response to changing needs is appropriate inappropriate
6. The hours of Pharmacy coverage are adequate inadequate
7. The procedures to use Pharmacy services are efficient cumbersome


Figure 10-6. Survey Instrument to Monitor Patient Perception of Medication Service

Will You Help Us Improve Our Services?

Our pharmacy and nursing departments work together to provide you with the medication you need while you're under our care. These two departments are currently working together to enhance their service and solve any problems that patients are having with medication.

Will you please help by sharing your experience with us?

1. Have you had any problems with your medications while you’ve been here? Please describe:

2. Have medications been:

<table>
<thead>
<tr>
<th></th>
<th>often</th>
<th>rarely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivered on time?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Explained to you?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Correct item?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Given courteously?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Available when needed?</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

3. How can we improve our services related to medications?

Your responses will be kept strictly confidential. Please leave this completed form on your meal tray. Your response will be very helpful to us. Thank you very much.

Figure 10-7. Internal Customer Survey: Psychiatric Hospital's Rating of Different Departments

<table>
<thead>
<tr>
<th>A. Center Nursing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The unit interacts with other departments with respect aloofness 1 2 3 4</td>
</tr>
<tr>
<td>2. The unit follows other departments' applicable procedures cooperatively uncooperatively 1 2 3 4</td>
</tr>
<tr>
<td>3. The unit responds to other departments' requests quickly reluctantly 1 2 3 4</td>
</tr>
<tr>
<td>4. The operation of the unit on day shift appears organized disorganized 1 2 3 4</td>
</tr>
<tr>
<td>5. When there are interdepartmental problems, the staff approaches resolutions as team members dictators 1 2 3 4</td>
</tr>
<tr>
<td>6. The perception of care on this unit is excellent poor 1 2 3 4</td>
</tr>
<tr>
<td>7. Communication to other departments of changes on the unit that affect them is timely after the fact 1 2 3 4</td>
</tr>
<tr>
<td>8. Communication to other departments about changes on the unit that affect them is clear unclear 1 2 3 4</td>
</tr>
<tr>
<td>9. Unit personnel usually project attitudes that are positive negative 1 2 3 4</td>
</tr>
<tr>
<td>10. Care and concern for the patients appear to be primary an afterthought 1 2 3 4</td>
</tr>
<tr>
<td>11. When it comes to sensitivity to patients, the staff's performance is excellent poor 1 2 3 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Dietary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The cafeteria environment is comfortable uncomfortable 1 2 3 4</td>
</tr>
<tr>
<td>2. The variety on the menu is very good poor 1 2 3 4</td>
</tr>
<tr>
<td>3. Cafeteria services are provided efficiently inefficiently 1 2 3 4</td>
</tr>
<tr>
<td>4. Monthly cafeteria specials are wonderful awful 1 2 3 4</td>
</tr>
<tr>
<td>5. The staff is courteous and helpful consistently inconsistently 1 2 3 4</td>
</tr>
<tr>
<td>6. The cleanliness of dishes and serviceware is excellent poor 1 2 3 4</td>
</tr>
<tr>
<td>7. Therapeutic visitation to the patient is timely untimely 1 2 3 4</td>
</tr>
<tr>
<td>8. Special functions are done with imagination routinely sporadically 1 2 3 4</td>
</tr>
</tbody>
</table>

(continued on next page)
Figure 10-7. (Continued)

9. Communication between dietary and other departments is open restrained
10. Criticism and suggestions are accepted readily reluctantly

C. Diagnostic Services
In measuring turnaround time in performing the test and returning the results:

<table>
<thead>
<tr>
<th>Service</th>
<th>Prompt</th>
<th>Too Slow</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The EKG service is</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>2. The EEG service is</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>3. The ECT service is</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>4. The laboratory service is</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>5. The radiology service is</td>
<td>1 2 3 4</td>
<td></td>
</tr>
<tr>
<td>6. The CT scanning service is</td>
<td>1 2 3 4</td>
<td></td>
</tr>
</tbody>
</table>

D. Business Office
1. When bills are prepared for patients or insurance carriers, the information is accurate inaccurate
2. When bills are prepared for patients or insurance carriers, the information is timely slow
3. Personnel are courteous rude
4. Personnel are responsive unresponsive

E. Purchasing
1. In an emergency, purchasing is responsive unresponsive
2. Turnaround time from initial paperwork to receipt of order is timely too long
3. Our understanding of the purchasing process, i.e., paperwork, corporate interface is very good needs refreshing
4. Inquiries about purchasing are handled quickly slowly

F. Central Supply
1. Routine turnaround of orders is timely too slow
2. Emergency response to orders is prompt too slow
3. Stock levels are appropriate inappropriate
4. The clerk is generally responsive unresponsive

Figure 10-8. Simple Spot Survey of Technologist’s Performance

| How would you rate the behavior of the technologist who performed your procedures? |
|---------------------------------|----------------|----------------|
| Very rude                       | Explained procedure poorly/not at all |
| 1                               | 1               |
| 2                               | 2               |
| Very courteous                  | Explained procedure thoroughly and well |
| 3                               | 3               |
| 4                               | 4               |
| Explained procedure              | Handled me \_very roughly \_very gently |
|                                 | 1               |
|                                 | 2               |
|                                 | 3               |
|                                 | 4               |

Other comments (and please feel free to complain so we know what to fix):

Please drop in the Survey Box, ask your transporter to drop it in for you, or ask your nurse to drop it in the in-house mail. Thank you so much for your help.


Tips

Following are two important tips in designing and planning your surveys:

1. Consult your customers. Too often, surveys are written and used without consulting customers. As a result, people ask questions about quality attributes they think are important to customers but may not be. Consultations with customers should be built into the survey design process to determine what is important to customers so that you can ask the right questions. Your survey should also be tested on customers to iron out the kinks and make it easy to read, understand, and answer.

2. Develop good survey questions. Good questions are essential to the success of your survey and the following guidelines may be used to formulate them:
   - The good survey question is clear, easy to read, and easy to understand. It is user-friendly as determined by respondents.
   - The good survey question gives the respondent a range of possible responses. Questions that require a yes–no type of answer do not usually provide helpful information because they force people to choose extreme answers that might not reflect their true opinions. For example, if you asked, “Were nurses courteous?” many people might say yes because some of the nurses were courteous and the respondents would not want those nurses to think they weren’t appreciated even though other nurses were rude.

   It is helpful to give respondents four to six choices. More than six is unnecessary and misleading because most people cannot make that many distinctions. Fewer than four choices gives too narrow a set of possibilities and forces people to make judgments they may not feel comfortable with. Some people recommend against an odd number of choices because noncommittal people often pick the middle alternative. When you give an even number of choices, people have to decide whether they lean in one direction or another. As a result, you learn more.