IMPROVING THE QUALITY OF PAEDIATRIC CARE

Operational guide for facility-based audit and review of paediatric mortality

World Health Organization

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Executive summary

Substantial global progress has been made in reducing the number of child deaths since 1990; however, many preventable deaths still occur because of poor quality of care, particularly in low-resource settings. In order to reduce the number further, the quality of child health care and the factors that contribute to the deaths should be examined. Understanding the circumstances and the spectrum of factors that lead to a child's death or disease can prevent other deaths, poor health outcomes or disability. Auditing and reviewing child deaths and morbidity is important for improving the quality of care in hospitals and other health facilities that provide care for children. Death auditing and review are also essential for identifying life-saving public health interventions and reforms at local, state and national levels.

All health facilities that care for children, especially hospitals, should have an effective system for death reviews. Review of and response to maternal and perinatal deaths are functioning successfully in many low- and middle-income countries. This involves collecting accurate information from routine clinical data and recording and reporting maternal and perinatal deaths, where they occur, why and what could be done differently to prevent similar deaths. Child deaths are, however, rarely audited and reviewed, and there has been no guidance.

Audits and reviews provide an accurate history that can indicate how a similar death or adverse outcome could be avoided in the future. Not all deaths are preventable, but an audit fulfils the obligation of health professions to learn and improve the quality of care continuously. Auditing also shows bereaved families that their child's life was important, the death is being taken seriously and health professionals are committed to learning and improving their practice.

This document provides guidance for establishing and conducting child death reviews as part of overall quality improvement. The guidance describes the key components of national, subnational and facility mortality and morbidity audit and review systems. It outlines the principles for conducting meetings on child death audits in hospitals in such a way that staff are engaged and supported. The six steps in the audit cycle are: (i) identifying cases, (ii) collecting information, (iii) identifying the causes of death and potentially modifiable factors, (iv) recommending solutions or actions, (v) implementing an action plan and making changes and (vi) monitoring and evaluating the process and the outcomes and refining practice as necessary.

The annexes provide simplified International Classification Disease (ICD) 11 codes for child death audits and reviews and standard reporting forms, which could be adapted to local and national contexts.

INTRODUCTION AND DEFINITIONS