

ABSTRACT

Evaluation of the Service Provision of Emergency Obstetric Care in a Tertiary Care Centre: A Clinical Audit

Francis Paul¹, Kent Kong Kian Keong^{2*}, Jennifer Tan³, Anna Lee En Moi³, Alen Lim Chung Chieh¹

¹ Administration Office,
Duchess of Kent Hospital, Sandakan,
Sabah, Malaysia

² Clinical Research Centre,
Duchess of Kent Hospital, Sandakan,
Sabah, Malaysia

³ Nursing Department,
Duchess of Kent Hospital, Sandakan,
Sabah, Malaysia

* Corresponding author's email:
kentkongkk85@gmail.com

Keywords: obstetrics emergency,
obstetrics emergency protocol,
obstetrics red alert

NMRR Research ID:
NMRR-18-2067-42538

Introduction: Maternal death is a sensitive health indicator being monitored closely by the Ministry of Health. Obstetric emergency (OE) protocol is introduced to manage OE and to improve maternal outcome. However, there is no national OE guideline available and the OE protocol varies among different institutions. The current audit aims to evaluate the service quality during OE in Duchess of Kent Hospital (DOKH) in accordance with OE protocol DOKH revision-2017. **Methods:** This was a retrospective clinical audit on the quality of service provision during OE from Jan to June 2018 in terms of response time (< 5 minutes), presence of discipline team from anaesthesiology and discipline team from obstetrics and gynaecology (O&G), the appropriateness of triggering obstetrics emergencies and outcome. The audit standard for adherences was set at 95% (set by DOKH quality assurance team). **Results:** Total of 29 cases of OE were reported in 2018. Up to 24 (82.8%) cases were attended by O&G team and 17 (58.6%) cases by anaesthesiology team within a 5-minute response time. Both discipline teams were present on-site during all the OE. A total of 27 (93.1%) cases were triggered in adherence to the OE protocol. Only 27 (93.1%) cases were attended by specialists from O&G and 16 (55.2%) cases by anaesthesiologists respectively. Not all specialists attended the patients on-site but rather depended on their team to report. A total of 12 cases (41%) were admitted to ICU. The case with mortality was 1 (3.45%) with the

diagnosis of subdural and intraparenchymal bleed after 4 days of ICU care. **Conclusion:** The overall adherence to OE protocol was not satisfactory. Educational workshops will be conducted among the two disciplines to

improve the critical response time to OE. A formal meeting will be conducted to discuss the possible solution to the mandatory review by the specialists for every OE as a strategy to improve the quality of services.