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MINISTRY OF HEALTH - ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!
HEALTHIER CITIZENS FOR PROSPEROUS NATION!

Ethiopian Health Center Clinical Audit Guide And Tools





November 2021

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Abbreviations

AACAHB	Addis Ababa City Administration Health Bureau
CDC	Centers for Disease Control and prevention
CSD	Clinical Service Directorate
DPC	Disease Prevention Directorate
ECCD	Emergency and Critical Care Directorate
EPHCG	Ethiopian Primary Health Care Clinical Guideline
HE&PHCD	Health Extension and Primary Health Care Directorate
HQIP	Healthcare Quality Improvement Partnership
HFIP	Healthcare Finance Improvement Program
HSQD	Health Service Quality Directorate
HSTQ	Health Service Transformation in Quality
HSTP	Health Sector Transformation Plan
IHI	Institute for Healthcare Improvement
IMNCI	Integrated Management of Neonatal and Childhood Illness
ICAP	International Center for AIDS Care and Treatment Program
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JSI	John Snow Inc.
MCHD	Maternal and Child Health Directorate
MoH- Ethiopia	Ministry of health-Ethiopia
NI	Nutrition International
NICE	National Institution of Clinical Excellence
NQS	National Quality Strategy
NQSS	National Healthcare Quality and safety strategy
PHC	Primary Health Care
PSI	Population Service International
QI	Quality Improvement
RAND/UCLA	Research and Development/University of California at Los Angeles
WHO	World Health Organization

Foreword

During the implementation of the first Health sector transformation plan (HSTP), 2008-2012 EFY, improving the quality of healthcare was among the transformation agenda. To operationalize the HSTP MOH-Ethiopia developed and implemented the national healthcare quality strategy. The strategy established the quality management system in every healthcare administration and care delivery area. Additionally, during the execution of the strategy, several quality cadres have been trained, and they have designed and implemented several quality improvement projects. Similarly, in the HSTP-II improving the quality of healthcare is among the priorities and to materialize the plan MoH developed and introduced the National healthcare quality and safety strategy in which developing well functioning clinical audit system is one of the strategic initiatives put forward.

Health services quality directorate (HSQD) developed and launched the HSTQ document in 2016, which included a clinical audit guide and audit standards for selected topic areas. Following this, many hospitals started to utilize the tools and conduct clinical audits. With all its defects, HSTQ played a role in creating awareness and familiarizing leaders, quality improvement officers, and frontline HCWs with the process of clinical audit to some degree.

One great achievement that the ministry attained was the development of EPHCG, a guide that provides comprehensive information/algorithm to the care provider in the evaluation and management of a patient. The development of such document helped standardize the care delivery in health centers across the country, giving the precondition to initiate clinical audit practice in health centers.

Although the practice of clinical audit was gradually absorbed by hospitals, the directorate faced difficulties institutionalizing the practice in the primary health care tire system, particularly health centers, as the approach and the content of the audit standards in the HSTQ didn't match that of the health care delivery process in health centers.

Accordingly, this document is developed in a way it can be utilized to assess the appropriateness of care delivered within health centers. It is a result of multiple consultative workshops and meetings that involved different stakeholders and experts who are actively working in the service delivery and quality improvement activities at the PHC level and aimed to design a simplified tool tailored to the practice of health care delivery in health centers.

The document has two main sections. The first section is a clinical audit guide that depicts the concept, principles, method, and cycle of clinical audit. It describes international definitions of clinical audit, details of each five steps of clinical audit including how to select and set criteria/ standards, and how these concepts can be applied in health facilities whenever clinical auditing is planned and conducted. The second section comprises audit tools for prioritized topics which have been developed from relevant guidelines through consultative workshops with a wide range of stakeholders and experts. The document also includes forms and templates expected to be used in the different stages of the audit process, namely audit proposal form, audit registry form, and audit reporting form. These templates are introduced in this document in an attempt to forge the practice in line with best practice.

Thus it is with confidence I say that this document will ignite and facilitate the institutionalization of high quality, effective, and regular clinical audit practice within health centers to help identify gaps in quality of care and bridge those gaps to realize a better health outcome of decreased morbidity and increased patient experience.

I would like to call upon all stakeholders; Health centers, professional associations, implementing partners to work for the betterment of the clinical services and institutionalization of quality culture by promoting the regular clinical audit.



Dr. Hassen Mohammed

Director, Health Services of Quality Directorate

PART ONE

CLINICAL AUDIT GUIDE

1. Introduction

1.1. Background

The Ministry of health-Ethiopia has been working rigorously to ensure the quality and safety of healthcare. The major undertakings that have been implemented are formulation and execution of the quality strategies, establishing of the quality management structure, extensive capacity building in healthcare quality improvement, and creating public awareness on the high-quality healthcare system. Moreover, the common understanding of the importance of high-quality healthcare for the realization of universal health coverage has been created.

Several large-scale quality improvement initiatives have been launched and encouraging results were noted. The Ethiopian Hospitals Alliance for Quality is one of the initiatives that utilized quality concepts for the improvement of care delivery and outcomes. In the last three cycles, there has been a massive engagement of hospitals and recognition of the best performers. The Maternal and Neonatal Health quality, equity, and dignity (MNH-QED) - WHO-led Global initiative- that mainly operates by networking health facilities in the learning Woredas has been implemented for the last three years. Within this initiative, forty-eight (48) facilities were networked to reduce maternal and neonatal mortality by half and the QI approach has been employed to achieve the goal. Furthermore, other small-scale initiatives that aimed to improve the HIV and Hypertension quality of care have been undertaken paving the way for more strong initiatives.

To facilitate the learning and knowledge transfer, local and national level learning platforms have been organized. Among them, the National Healthcare Quality and Safety Summit takes a bigger stake bringing healthcare policymakers, academicians, partners, and professional and patient associations aboard to discuss the improvement strategies, to share the experience, and to take a common stance for improvement of the care delivery.

To help the implementation of HSTP-I, the health services quality directorate (HSQD) prepared clinical audit guidelines incorporated in a document called 'health sector transformation in quality-HSTQ'. The document guided the quality improvement methods and structure, clinical audit process, and set quality standards on national quality strategy disease priorities and other selected areas like data quality and patient safety and CRC.

To standardize the care delivery at the health center level the ministry of health developed the clinical guideline- Ethiopian Primary Healthcare Clinical Guideline-that promotes comprehensive assessment and management of patients. It provides an integrated symptom-based algorithm for systematic assessment and management of patients 5 years and above and consists of 98 adult symptoms; 37 child conditions and 25 chronic conditions. Series of training has been cascaded and many health centers have begun to utilize it.

Despite all efforts, the health system lacks a robust clinical audit system at the health center level. However, there were facility-based fragmented activities that resemble clinical audits that didn't lead to satisfactory improvement. Therefore, establishing a strong clinical audit program that uses the available clinical guidelines including the EPHCG and IMNCI is highly required to substantiate the improvement efforts.

1.2. Rationale

A growing body of research shows that there is a significant quality gap in the provision of health care along one or more quality dimensions- people-centeredness, safety, timeliness, effectiveness, efficiency, equity, and integration. Actions to improve the quality and safety of care provided require the introduction of a well-organized effective clinical auditing program as one component.

The review of best practices focused on the English NHS- pioneers in incorporating the clinical audit practice into contemporary healthcare improvement- showed that for clinical audit programs in health facilities to be successful two components need to be fulfilled; i.e. the use of appropriate methodologies and creating a supportive environment. Accordingly, flaws with the application of appropriate methods in terms of meticulous planning, designing of easy and workable audit standards and criteria, designing and monitoring of appropriate quality improvement plans based on identified gaps, linking audit findings with quality improvement projects(systematic management of change) together with the absence of an appropriate structure that can organize and provide the necessary support for auditors in building their capacity and designing and conducting effective clinical audits are among the prevailing limitation in the clinical audit practice in the Ethiopian Health System. Moreover, The inaccessibility of quality data because of poor data recording practice and the bulkiness of the data set required for audit bearing weight on the staff that is already burdened with other priorities are other deficiencies.

Also, the absence of a policy and strategy at the ministry level that defines the roles and responsibilities of stakeholders and sets a clear path towards the establishment of an effective clinical audit system made the practice fall far behind the best practices. Despite this, encouraging results have been seen in the practice of clinical audits in hospitals; QI teams are making efforts to regularly conduct audits using the tool and plan actions based on findings. Recognition and acceptance by healthcare providers and QI teams at the facility level are increasing.

Strengthening the efforts of clinical audit practice initiated at a hospital-level and broadening and intensifying the work to reach the primary health care tier where a majority of our population receives care from and therefore a significant portion of issues around the delivery of quality care arise from is of paramount importance.

Informed by the best practice, this document outlines the concept of clinical audit, steps in conducting a clinical audit, roles and responsibilities of involved stakeholders, and methods to track the progress of clinical audit projects. Moreover, based on the available clinical guidelines and protocols utilized in health centers by involving relevant stakeholders, simplified clinical audit tools on selected topic areas are developed and included to facilitate the regular conduction of clinical audits in health centers. The audit tools comprise measurement criteria that can be used to assess the appropriateness of the clinical service delivered in health centers. Therefore, this guide and tools will direct, standardize, and improve the effectiveness of the clinical audit practice in the Ethiopian health system at the primary health care level.

2. Definitions

2.1. Quality Improvement

Quality improvement (QI) is a continuous process whereby organizations iteratively test and measure changes in work routines, set and achieve ambitious aims, shift whole system performance, and spread best practices for rapid uptake at a larger scale to address a specific issue or set of issues they have determined to improve (1).

2.2. Clinical Audit

'A quality improvement process that seeks to improve patient care and outcomes through a systematic review of care against explicit criteria and the implementation of change' (2)

It involves the assessment of structure, process, and outcome of care against agreed explicit standards where changes are introduced based on identified gaps and further monitoring made to ascertain improvements (2).

2.3. Quality Committee/Counsel

A committee that is composed of department heads and selected experts in the health center that oversees the quality improvement efforts of the health center and mainstreams the QI concepts and activities in all departments.

2.4. Quality unit/focal

A formally organized structure that is responsible for the coordination and guidance of all QI activities in the health center.

2.5. Quality improvement team

Is a team that works in the specific unit/ward responsible for designing, implementing, monitoring, and reporting quality improvement activities. This team functions as an audit team.

3. Objectives

The objectives of this guide are to:

- Establish/strengthen the clinical audit system.
- To standardize the clinical audit in such a way that it's an integral part of QI activities.
- Help facilities to effectively conduct a clinical audit on the services they deliver.
- Guide the development of audit criteria for local audit priorities.

4. Scope

This document is intended to guide healthcare workers, quality improvement teams, and unit leaders practicing in health center set-up to understand the concepts and methodologies of clinical audit and conduct clinical audits as an integral part of mainstream clinical activities. It promotes awareness on clinical audit and guides to the achievement of best practices in clinical audit in health centers.

5. Conducting clinical audit

An effective clinical audit requires a structured system with competent leadership, involvement by all staff, and stress on team working and support (3). Therefore, Health center should integrate the healthcare clinical audit to the larger improvement effort (if it exists) or develop a clinical audit program.

6. Stages of clinical audit

A typical clinical audit has five stages: planning, standard selection, and criteria setting measuring performance against a standard, making improvement, and sustaining improvement.



Fig 1. Stages of clinical audit

6.1. Planning

Although the amount of preparation depends on the circumstance, whether it is a small audit conducted by an individual or a large audit involving multiple disciplines effective planning and preparation is key for a successful audit (3).

Preparation involves three main components: involving stakeholders, determining audit topic, and planning the delivery of audit field work (3).

Step 1: involving stakeholders

Three questions can guide to determine who should be involved in clinical audits: who is involved in the delivery of care, who receives, uses, or benefits from the care or service, who has the authority to support the implementation of any identified changes (3).

Since clinical audits evaluate the effectiveness of clinical care practices and the majority of these involve multi-disciplinary teams, the involvement of representatives of all clinical and managerial practices contributing to the audit topic area is crucial. Everyone involved should be made clear of the aim of the audit and their specific role and responsibilities. An agreement for the leadership and ownership should be reached and where possible commitment for change by all involved should be ascertained (3).

The facility should establish a QIT (which will also serve as an audit team) that consists of all relevant stakeholders for the improvement of the care. It may be composed of representatives of all involved in the care provision i.e., clinicians (physician, midwife, nurse, lab, and pharmacy professionals) and unit leaders/coordinators, administration staff, and other health workforce.

The primary concerns of those receiving care might differ from those delivering care therefore the audit team should give careful thought to the possible benefits of involving service users in the clinical audit process and which methods to use if they are to be part of the audit. Service users can be directly involved in the audit or they can be indirectly involved through FGD, interviews, surveys, collecting feedback, and the likes.

Where service users are directly involved in clinical audit programs, their roles need to be clearly defined and appropriate support and guidance provided to enable the delivery of the audit (3).

Attaining the buy-in of those with authority to approve changes arising from audit recommendations is also important, especially in circumstances where the changes need a resource or have implications for other services areas (3).

Step 2: Determine the audit topic

Careful thought should be given when selecting audit topics as health centers have limited resources with which they can execute clinical audits. The audit team should do this with the view of improving the quality and safety of care. Apart from mandatory audits (national audits prioritized by MoH), all other audits should be prioritized in a way resource can be utilized efficiently (3). The following factors should be taken into account when prioritizing audit topics

- costly practice areas
- areas with a frequent patient complaint
- high-volume practice areas
- risky practice areas
- areas that show variation in clinical practice,
- have evidence of poor quality (high rate of complication and adverse outcome)
- have a reliable data source
- likely to improve process and outcome care

It is also good to consider whether there is good evidence to inform audit standards and if data can be collected in a reasonable time (3).

Audits that are part of national audits should be a top priority. The health center/ department will then prioritize the other topic areas using a scoring system taking into account the above points. It should be noted that there is also room for carrying out audits on the clinical interest of practitioners (3).

After topic selection, the audit proposal should be prepared and submitted to the QI unit/focal (annex 2: audit proposal form), QI committee approves the proposed audit after thorough review. Approved proposals should be registered using the registration form to facilitate monitoring of progress. (Annex 3)

Step 3: Planning the audit delivery

Planning the audit execution is a very crucial step for a successful audit. The following issues should be well considered in this step.

A. Set the aim/objectives of the audit

Carrying out an audit with no clear objective will bring little to no improvement. Detailed statements can be used to describe the different aspects of quality that will be measured to show how the aim of the clinical audit will be met (3).

E.g. DM

Audit topic - Diabetic Routine Care

Aim - to improve the outpatient clinical care provided to diabetic patients on follow-up

Objective -

- Ensure patients on diabetic follow-up have appropriately documented history
- Ensure pertinent physical examination is performed
- Ensure patients receive evidence-based management
- Ensure patients receive evidence-based management
- Ensure patients have optimal follow-up

Assure all team members are aware of the purpose: All Health workforce involved in the subject of the audit must understand the aim of the audit and their role in it. This needs to be clarified at the outset and may be expressed in terms of the reference document (3).

B. Equip the audit team with the necessary knowledge and skills

Involving the right people with the right skill will be a crucial aspect of the planning process ensuring the task will be accomplished effectively and efficiently. The audit team should have a great depth of understanding of clinical audit processes. Members should know the concept of clinical audit, and EPHCG utilized in clinical care. They have to be familiar with setting criteria, data collection, tools used in clinical audit (audit proposal form, chart abstraction forms....), data analysis methods, and methods for quality improvement. The QI unit/focal will be responsible for building the capacity of the QIT in the aforementioned areas; it will also provide technical support whenever necessary.

Skills required in clinical audit process (3)

- Leadership, organizational and management skills
- Clinical skills
- Project management skills
- Change management skills
- Audit methodology expertise
- Understanding of data protection requirements
- Data collection and data analysis skills
- Facilitation skills
- Communication skills
- Interpersonal skills

Adapted from A practical guide to clinical audit August 2013 Dublin

C. Providing the necessary structures

The presence of an appropriate structure that can provide the necessary support is crucial for the success of clinical audit work.

Completed proposal form along with relevant standards, audit tools, and other forms should be prepared and submitted to the QI unit/focal for approval before the audit begins. This is necessary to ensure all aspects of the audit have been considered. Resources needed to cascade the audit should be mapped and made available. This issue should be raised and communicated

through the appropriate line of governance structure. The mechanism for progress tracking, reporting to the appropriate lead, and a clear timeline in which the audit will be designed and conducted should be defined in the structures (3).

6.2. Selecting Quality Standards And Setting Criteria

For the selected national disease and condition priorities, use the audit criteria attached here (second part of the document). However, if the criteria are not available for the topic to be audited, the QIT can formulate evidence-based and relevant criteria using the guide below.

The quality standards or criteria developing process should take the internationally validated methodology and these should be included in the audit proposal for approval by the quality committee.

6.2.1. Defining standards and criteria

6.2.1.1. Standard

"An objective with guidance for its achievement given in the form of criteria sets which specify required resources, activities, and predicted outcomes" (Royal College of Nursing, 1990) (4).

6.2.1.2. Criteria

"An item or variable which enables the achievement of a standard (broad objective of care) and the evaluation of whether it has been achieved or not" (Royal College of Nursing, 1990) (4).

Within clinical audit, criteria are used to assess the quality of care provided by an individual, a team, or an organization. These criteria are explicit statements that define what is being measured and represent elements of care that can be measured objectively (5).

Criteria can be classified in to three- structure criteria, process criteria, outcome criteria (2).

6.2.1.2.1. Sturcture Criteria

Structure criteria refer to the resources required. They may include the numbers of staff and skill mix, organizational arrangements, the provision of materials, drugs, equipment, and physical space (2).

6.2.1.2.2. Process criteria

Process criteria refer to the actions and decisions taken by practitioners together with users. These actions may include communication, assessment, education, investigations, prescribing, surgical and other therapeutic interventions, evaluation, and documentation (2).

6.2.1.2.3. Outcome criteria

Outcome criteria are typically measures of the physical or behavioral response to an intervention, reported health status, and level of knowledge and satisfaction. Sometimes surrogate, a proxy, or intermediate outcome criteria are used instead. These relate to aspects of care that are closely linked to eventual outcomes but are more easily measured (2).

6.2.2. Developing valid criteria

Once a topic has been chosen, appropriate criteria that are explicit, evidence-based, measurable, and related to important aspects of care must be developed (2).

Methods for developing criteria

1. Using guidelines: criteria can easily be drawn out from recommendations of up-to-date clinical practice guidelines. A literature search of the specific journal can also be used to develop criteria when national or locally endorsed guidelines are unavailable (2).

2. Prioritizing the evidence method: start by conducting systematic reviews to identify key elements of care. Then carry out focused systematic literature reviews about each key element of care to develop, when it is justified by evidence, one or more criteria for each element of care. This is followed by prioritization of the criteria into 'must do' or 'should do' based on the strength of research evidence and impact on outcome. Present the criteria in a protocol including data collection forms, and instructions to external peer review (2).

3. RAND/UCLA appropriateness method: The method applies presenting findings of a literature review to a panel of clinicians, chosen for their clinical expertise and professional influence, who are asked to rate the appropriateness of a set of possible criteria for the particular procedure on a 9-point scale from 1 (extremely inappropriate) to 9 (extremely appropriate). The first round of ratings is undertaken without allowing any discussion between the panelists, and a second-round is undertaken after a structured panel meeting (2).

4. Criteria based on professional consensus: criteria can also be developed based on the views of professional groups, applying methods of formal consensus. However, different consensus groups are likely to produce different criteria. A checklist is useful to ensure that an explicit process is used to identify, select, and combine the evidence for the criteria and that the strength of the evidence is assessed in some way. Such criteria have the advantage of taking local factors such as the concerns of local users into account (2).

5. Involving users: Service users can also become usefully involved in developing criteria that take account of the needs of people with their particular condition, from specific age groups, or ethnic or social backgrounds. Audit teams can collaborate with users to establish their experience of the service and the important elements of care from which criteria can be developed. If the criteria selected by clinicians and those selected by users relate to different elements of care, both sets of criteria may be included. If clinicians and users have different views about the same element of care, an open approach is required to achieve consensus (2).

While developing standards or criteria it should be noted that the criteria/ standards should be in line with the SMART protocol. Each criterion should be clear, easy to understand (un- ambiguous), specific (not open to interpretation). They also should be measurable- feasible to attain the data for, achievable- of a level of acceptable performance agreed with stakeholder, Relevant (related to important aspects of care), and theoretically sound (evidence-based). Acceptable evidence-based guidelines that are going to be used to formulate the criteria should be identified ahead.

6.2.3. Setting target

Audit criteria should consist of quantifiable performance levels. These performance levels or targets: a defined level or degree of expected compliance with the audit criterion may be expressed as percentages (0% to 100%). Clinical importance, practicability, and acceptability should be taken into account and assessed when setting targets. Where a criterion is critical to the safety of service users, targets may be set at 100%. However, where clinical importance is not as significant, resources required to fulfill the target performance level should be considered and an acceptable performance level (one which is seen as both reasonable and attainable by those delivering and receiving care) should be identified. Setting an ideal target also requires identifying the best possible care that lies between the minimally acceptable level of care and the highest possible level of care (3).

6.2.4. Inclusion criteria/exclusion criteria

To make the data collection purposeful and ascertain the representativeness of the target population, it is advised to set inclusion and exclusion criteria. Inclusion criteria are statements describing the "target population to whom a clinical guideline is intended to apply", While exclusion criteria are used to "Define areas outside the remit of the clinical guideline" (3).

6.2.5. Exceptions

Refers to a group of cases within the target population for which the criterion is not applicable. There will be acceptable circumstances in which the identified sample may not comply with a specific criterion. These samples will not be included in the data analysis for that specific criterion. It should be noted that an agreement should be reached on exception before the audit commence (3).

6.3. Measuring Performance Against Standards

This stage has the following four steps: data collection, data analysis, drawing conclusions, and presentation of results (3).

6.3.1. Data Collection

This is the collection of relevant data about the current practice to facilitate comparison. Before data collection commences, a structured approach should be taken to the identification of relevant data and to ensuring that the data collection process is efficient, effective, and accurate. Details that need to be established from the outset include, the user group to be included, inclusion/exclusion criteria, the consent required to access user group information, the healthcare professionals involved in the service user's care, the period over which the criteria apply, and the analysis to be performed (2).

Points to be considered before data collection begins

- What type of data do I need to collect (quantitative and/or qualitative)?
- What data items will need to be used to show whether or not performance levels have been met for each standard?
- What data sources will be used to find the data?
- Will a data collection tool need to be designed?
- Will I need to collect data prospectively and/or retrospectively?
- What size is the target population and will I need to take a sample?
- How long will data be collected (manually and/or electronically)?
- How long will it take to collect the required amount of data?

- Who will be collecting the data?
- How will I ensure data quality?

Adapted from Ashmore, Ruthven and Hazelwood

The type of data required is dependent on the audit question and objectives. The aim of data collection is to enable comparison of current practice against the audit standard; therefore, the type of data collected must facilitate this comparison. Data types can be of categorical (nominal/ordinal) and quantitative or numerical (discrete/ continuous) (3).

6.3.1.1. Data items

Data collected must be relevant to the aims and objectives of the audit. It is equally important that each data item is adequate and not excessive for the purpose of measurement of practice against the relevant audit criteria. Collection of data which is not required for the purposes of measurement provides little or no benefit, is more time consuming and may infringe compliance with information governance requirements and practices (3).

6.3.1.2. Sources of data

The source of data for an audit should be specified and agreed by the audit team. The source specified should provide the most accurate and complete data as readily as possible. As much as possible data that is relevant and routinely collected and can be found in existing sources should be used for auditing. In times where the data in question is not documented in existing source a method of tracing the data from other far reached sources can be attempted (3).

6.3.1.3. Data collection methods:

Can be retrospective/ cross sectional/ prospective. Retrospective data is collected after the completion of care to the service use while prospective data is collected in real time during the care provision (3).

6.3.1.4. Sample selection methods

More often than not clinical audits involve the technique of sampling as it is not necessary or even feasible to take data on all target population identified. Major factor that should be taken in to account when sampling is that the sample should be representative of the target population. There are various methods of sampling but the commonly used are random sampling and convenience sampling (3).

Random sampling is a simple method of sampling where service users are selected randomly for instance every 3rd, 6th case seen (3).

Convenience sampling uses the approach of selecting the nearest and most convenient persons to act as respondents; it therefore does not produce findings that can be taken to be representative (3)

6.3.1.5. Sample size

Clinical audit is not research. It is about evaluating compliance with standards rather than creating new knowledge, therefore sample sizes for data collection are often a compromise between the statistical validity of the results and pragmatic issues around data collection i.e., time, access to data, costs. The sample should be small enough to allow for speedy data collection but large enough to be representative. In some audits the sample will be time driven and in others it will be numerical (2).

6.3.2. Data analysis

Data collection is only part of the process of measuring performance, in order to compare actual practice and performance against the agreed standards, the clinical audit data must be collated and analyzed. The basic aim of data analysis is to convert a collection of facts (data) into useful information in order identify the level of compliance with the agreed standard (3).

The basic requirement of an audit is to identify whether or not performance levels have been reached. This requires working out the percentage of cases that have met each audit criterion. In order to calculate the percentage, it is necessary to identify both the total number of applicable cases for a criterion (the denominator) and the total number within the denominator group that met the criterion (the numerator) (3).

6.3.3. Drawing conclusions

After results have been compiled and the data has been analyzed against the standards, the final step in the process (where applicable), is to identify the reasons why the standard was not met. In order to understand the reason for failure to achieve compliance with clinical audit criteria, the audit team should carefully review all findings. Individual cases where care is not consistent with criteria should be reviewed to find any cases which may still represent acceptable care. Cases of unacceptable care should then be reviewed in order for the team to: clearly identify and agree on areas for improvement identified by the clinical audit. Analyze the areas for improvement to identify what underlying, contributory or deep-rooted factors are involved (3).

There must be a clear understanding of the reasons why performance levels are not being reached to enable development of appropriate and effective solutions. There are a number of tools that can be utilized to facilitate a root cause analysis, including process mapping, the 'five whys', cause and effect diagrams (fishbone diagramming) and process mapping (2, 3).

6.3.4. Presentation of results

The aim of any presentation of results should be to maximize the impact of the clinical audit on the audience in order to generate discussion and to stimulate and support action planning. There are various methods for the presentation of clinical audit results including visual presentations, for example, posters which are useful ways of reaching as many stakeholders as possible. Data can also be presented visually using tables, charts and graphs in both written and verbal presentations (for example, through using presentation software like Microsoft PowerPoint), Written reports (annex 4) for submission to the relevant clinical lead, directorate or governance committee and Verbal presentations at relevant meetings (3).

6.3.5. Audit methodology for selected national disease priorities

The description here below illustrates the methodology that should be followed while auditing the selected topics in a health center set-up. The health center clinical audit tool measurement criteria were developed through successive consultative workshops involving experts with subject matter knowledge and programmatic experience on selected priority topic areas. National and international guidelines were used to synthesize the measurement criteria with special emphasis to EPHCG as this guideline dictates the service provision in health center setup.

6.3.5.1. Data collection methods

- The data collection source is client chart review. Registration review should be used for specific topic areas (sick child, sick young infant) and some measurement criteria in audit topic areas of TB, HIV/AIDS, and Malnutrition). The measurement criteria or brief description along the measurement criterion will guide which one to use.

- A total of 19 medical records (client chart) of the last reporting quarter should be sampled for the audit. The individual client charts can be withdrawn by systematic random sampling (total number of cases seen in the last completed quarter divided by 19 will give the Nth value, take MRN number of charts every Nth value.

- For topic areas that have a diagnosis and follow-up care components (Family planning, Malnutrition, TB, HIV, DM, HTN, Asthma, mental health illness), 19 charts should be drawn separately to assess the appropriateness of initial care and routine follow-up care. For the follow-up care, review the record of the last visit/ visits that occurred within the quarter.

- For topics under the section child health (sick young infant, sick child, and under-five malnutrition) select 19 clients from the registration (total number of clients that were seen within the last quarter divided by 19 will give you the Nth value. Select patients from the registry every nth value).

- Use the available client charts drawn for the last reporting quarter as 100% even if the number of client charts found for the reporting quarter is less than 19.

- Use the data abstraction tool and identify the data element for the audit.

- If all requirements for criteria are met, score 1 if any requirement is unmet score 0. If the criterion does not apply for the unit or specific chart, record it as NA (not applicable)

- N.B. The facility should conduct clinical audit for the following adolescent and youth services separately using the audit tools incorporated in the document. Client charts should be identified and sampled from the adolescent and youth clinic registry).
    - Comprehensive HIV testing and counseling and treatment
    - Antenatal Care including PMTCT,
    - Postnatal Care
    - Comprehensive Abortion Care
    - Family Planning Service (Contraception)
    - Adolescent Nutrition
    - Mental health

Peculiarities in sick child and sick young infant data collection from IMNCI register

- If a problem(disease) title in the IMNCI register column has a **Yes|No** choice and the provider circled/underlined No: the standard measurement criteria is considered fulfilled and the clinical auditor can skip to the next problem. If the health care provider has circled/ underline **Yes** then the health care provider is expected to circle/underline or record a symptom/sign under the identified major complaint if it is present on history or during observation. Hence, if a symptom/sign is not circled it means that the provider has not done a proper evaluation. In other words the problems

including Very Severe Disease, jaundice, HIV status, and feeding problems should be assessed and normal/negative finding listed under that category must be recorded/circled/underlined, classified & managed accordingly. Hence, if the recording on the register does not show findings stated above; it implies that the standard measurement criteria is not full filled. It is assumed that if the record shows that negative symptoms are documented/circled/underlined and the positive symptoms are not underline/ circled it indicates that the provider has checked the symptoms/signs and were not present in that particular child, and hence the standard measurement criteria is considered full filled.

NB: Sick young infant register does not have **Yes|No** at top of column except for Diarrhea. Hence, each column or problem will have a positive/negative symptom that should be assessed and classified i.e. there is a need for the health worker to document (identify) a normal finding or illness sign from the register and classify it using chart booklet.

- Once these data are collected, using the symptoms circled/underlined the auditor will have to verify the classifications using chart booklet. Chart Booklet must also be used to verify that correct treatment is given for each classification identified
- NB: Problem evaluations, classification of a problem, treatment for a problem, immunization status assessment, counseling of mothers and follow-up care (bolded items in the sick young infant and sick child section of the audit tool) are standards to be measured and graded.

6.3.5.2. Data Analysis

- The "total" on top of the table along the Y-axis denotes the total number of charts that met given criteria.
- Identify both the total number of applicable criteria (the denominator) and the total number within the denominator group that met the criteria (the numerator).
- Calculate the percentage for each measurement criteria. ("Average" at the top of the table along the Y-axis). This is calculated by dividing the total number of charts that met the criteria by the total number of charts for which the criteria apply.
- "Grand total" for each audit topic area along the x-axis denotes the total score a given chart met out of the listed measurement criteria.
- "Average" at the bottom of each table along the x-axis denotes the percentage of criteria met by a single chart. It is calculated for a single chart by dividing the total number of criteria met by the total number of measurement criteria expected to be met. (i.e., excluding NA)
- Additionally, calculate the total percentage of met criteria for a given audit area.

6.3.5.3. Drawing conclusion

- Do problem analysis using five whys and fishbone analysis and other tools.
- Identify the root cause of the gap.

6.3.5.4. Presentation of results and writing report

- Present the findings to staff and relevant stakeholders.
- Write a report (Annex 4) and submit it to the responsible body (facility manager, case team leaders, process owner, QI unit, etc.)
- Regular summary clinical audit reports, together with recommendations, should be communicated to all relevant areas of the organization. An effective audit carried out in one area of the institution may be transferable to other parts of the organization. Once a round of data collection has been completed and the data has been analyzed, the results and findings should be presented at quality meetings, for discussion, agreement of interventions, and a commitment to complete another audit cycle within a designated timeframe. The quality committee will review all summary clinical audit reports on completion.

6.4. Making improvements

The ultimate goal of conducting clinical audits is, understanding the degree to which care provided comply with the expected level of care and identify poor areas of performance to make improvements in those areas (3).

Data analysis and interpretation which lead to a conclusion will answer the question of degree of compliance thereby pointing to areas of excellence and areas of poor performance. QIT should interpret the data and discuss the findings to identify areas of poor performance that need improvement action (3).

After a thorough analysis of root causes the next step is to come up with possible changes or recommendations that can address the areas which need improvement. The audit team is expected to develop such changes and these should be presented to all relevant stakeholders where a thorough discussion regarding the feasibility, urgency, impact on clinical care and service users, and resource implication of proposed changes can be made to decide on priority actions. These actions must be documented and a detailed quality improvement plan on how the priority actions will be tested should be devised(P part of PDSA).The quality improvement plan should include a detailed task for each prioritized action, assigned responsible persons, a reasonable time scale for completing the tasks along with how and when progress will be measured(3).

6.5. Sustaining the improvement

Once proposed changes are put in place, their implementation progress should be monitored regularly to ensure they are being implemented as agreed plan and time frame(D part of PDSA). The responsible bodies that are identified in the quality improvement plan will be accountable for the execution of the changes in accord with the plan. The progress made in the implementation, the difficulties faced and actions taken to address them should be studied, documented and reported in a summarized form to the appropriate body regularly (S part of PDSA). Developing or identifying a small number of indicators to monitor the status of implementation and improvements made would make the tracking effective and help identify difficulties early. To make sure whether implemented changes have brought improvement or not, a second

audit or re-audit will be conducted making the process continuous. This cycle is repeated until the desired performance is achieved. It is important to note that documenting and disseminating successful audits is part of sustaining improvement. The QI unit/focal together with the QIT should document audits that have brought on improvement and share it with all stakeholders. Using the existing learning platforms, the knowledge obtained should be communicated to other departments and units within and outside the institution (3).

7. Audit Monitoring Process

The recommended time to complete a clinical audit is three months, but this might depend on the problems the audit team prioritized to address in one cycle. The audit team should assign an estimated time of completion of the project at the beginning of the audit. The audit team should notify the QI focal if a need for extension arises during the implementation of the clinical audit project and this should be with sufficient justification(5).

Three phases along with an estimated period are identified to help track the status of the audit and make the monitoring easy.

Phase 1 - comprises team establishment, planning the delivery of audit, and data collection. The estimated time is two weeks.

Phase 2 - comprises data analysis and interpretation, problem prioritization, root cause analysis, drawing a conclusion, developing change ideas,presentation of findings, and writing reports. The estimated time is three weeks.

Phase 3 - comprises designing and implementing QI projects, including testing change ideas (PDSA) for each prioritized problem. The remaining period from the estimated date of completion will be used for this phase. It is best to complete the phase-in seven weeks period.

Reaudit will be conducted at the end of the clinical audit project (ideally three months but could be more depending on the length of QI project implementation).

7.1. Audit status indicator definition

- On track- project is progressing according to schedule
- Delayed- project is running but falls behind schedule
- Completed- each phase is completed according to the schedule
- Abandoned- the project is not completed within the initial estimated period or the extension period allowed.

8. Roles and responsibilities

8.1. MoH

- Oversee the implementation of clinical audit
- Update the guide regularly
- Build the capacity of regions
- Ensure coordination of the audit
- Evaluate clinical audit program (annual review meeting, periodic evaluation)
- Support the regions in the mobilization of resources
- Strengthen partnership
- Ensure the regions for allocation of resources for effective implementation of clinical audit at all levels of health facility
- Plan, organize, and lead national clinical audit

8.2. Sub national (RHB, Zonal, district)

- Monitor the implementation of clinical audit
- Build the capacity of health facility
- Ensure coordination of the audit
- Evaluate clinical audit program (bi-annual review meeting)
- Mobilization and allocate budget for implementation of clinical audit
- Strengthen partnership

8.3. Health facility

- Establish audit committee
- Monitor the implementation of audits regularly
- Integrate clinical audit as a regular activity
- Ensure change is achieved as per the action plan
- Ensure capacity building of their respective staff
- Ensure availability of guidelines, protocols, and audit tools to service delivery unit

8.4. Healthcare Providers

- Involve actively in clinical audit
- Perform regular audit with the audit team
- Recording and documentation of audit
- Identify topics for clinical audit
- Maintain client privacy and confidentiality

8.5. Quality Improvement team

- Plan for clinical audit
- Support the quality unit in the coordination of clinical audit
- Ensure the audit guideline is implemented
- Undertake analysis, interpretation of clinical audit
- Design the implementation of change as per the audit finding (support linkage of audit activity with quality improvement activity)

- Ensure clinical audit is implemented by a multidisciplinary team
- Ensure presentation (dissemination) of clinical audit finding
- Monitor and evaluate the performance of clinical audit

8.6. Quality unit/focal/directorate

- Support clinical audit team in planning clinical audit
- Support clinical audit team in the coordination of clinical audit and support for overall quality improvement
- Makes approval of audit projects
- Register clinical audit projects and follow the execution as per the schedule
- Facilitate in the dissemination of audit findings using different platform
- Coordinate in analysis, interpretation of clinical audit
- Support the implementation of change as per the audit finding (support linkage of audit activity with quality improvement activity)
- Facilitate clinical audit to be implemented by a multidisciplinary team
- Support in monitoring and evaluating clinical audit performance

8.7. Partners

- Support (financially &/or technically) the implementation of clinical audit at all level

9. REFERENCES

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PART TWO

CLINICAL AUDIT TOOLS FOR NATIONAL PRIORITY CONDITIONS

Clinical Care Audit Tool: Maternal And Adolescent Youth Health

Audit Tool: ANC

Facility name	
Audit topic	Chart audit for ANC
Objective	Ensure all pregnant women coming for ANC follow up receive appropriate care according to national guidelines
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	History on present pregnancy, LMP, GA, Complaints including intimate partner violence taken																				
3.	Past obstetric history as per the national guideline, Integrated client card (ANC, Delivery and PNC) taken																				
4.	Medical History for DM, renal disease, cardiac disease, and chronic hypertension taken																				
5.	History on Mental health problem taken																				
6.	History on substance use (drugs and other substance use such as alcohol, Khat, tobacco) taken																				
7.	Blood pressure taken at each visit																				
8.	Weight measured at each visit																				
9.	Fundal height measured every visit from 12 weeks																				
10.	Fetal heartbeat counted (Every visit from 20 weeks)																				
11.	Fetal lie and presentation determined after 36 weeks																				

12.	Mid upper arm Circumference measured (MUAC < 23cm: except for TB, HIV and mothers on malnutrition treatment)																				
13.	Ultrasound done before 24 weeks																				
14.	Essential laboratory tests were performed ■ Hemoglobin/hematocrit ■ Blood group and RH ■ VDRL/RPR ■ Urine for protein, microscopy ■ Rapid HIV test ■ HBsAg																				
15.	HIV viral load tested at first visit if HIV positive; on ART: 3 months, then 6 monthly																				

16.	Proper advice and counseling provided ■ Nutrition including iodine salt, calcium, and iron rich foods ■ Rest, hygiene, safe sex practice ■ Family planning ■ Breast feeding ■ partner HIV testing ■ Birth Preparedness and complication readiness (Danger signs of pregnancy, place of birth, emergency fund and transport) ■ Provide HIV test result with posttest counseling ■ Safe sex practices and encouraged repeat testing after three months, if test result is negative.																				
17.	Advised on Malaria prevention, sleeping under an ITN																				

18.	Advised on Living positively, adherence to treatment, risk reduction, partner testing and exclusive breastfeeding if test result is positive																				
19.	Mother properly managed ■ Identified problems (mental health risk, HIV, malaria, preeclampsia, etc.) managed accordingly ■ Oral iron and folate supplemented according to the protocol ■ Deworming (single dose after 16 wks of gestation) ■ Scheduled a date for the next visit according to findings and recommended 8 antenatal visits ■ Birth plan developed																				

20.	TT vaccine provided ■ If up to date, given 1 dose of tetanus vaccine at 27-36 weeks gestation ■ If not up to date/unknown, given 3 doses of tetanus vaccine: at first visit, then after 1 month and then after 6 months.																				
21.	Referred timely to hospital for specialized care if a woman experienced complications or problems																				
	Grand Total																				
	Average (%)																				

Audit Tool: Labour And Delivery

Facility name	
Audit topic	Chart audit for delivery
Objective	Ensure all pregnant women coming for delivery receive appropriate care according to national guidelines(Obstetric management protocol for health center 2021)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	Appropriate history, physical examination performed																				

3.	Urinalysis and hematocrit updated (if not done in two weeks)																				
4.	HIV test done if she was not tested during ANC																				
5.	Maternal and fetal condition monitored as the Health center protocol if she is admitted in latent phase of labor																				
6.	Partograph used and completed for active stage of labor ■ Identification part of the partograph filled properly ■ Fetal condition monitored (FHB, Moldings, Caput, liquor status) ■ Labor progress monitored (uterine contraction, cervicograph, descent) ■ Maternal condition monitored as per the standard (BP, PR,Temp)																				
7.	Abnormal maternal, fetal and labor findings from the partograph interpreted and managed accordingly																				
8.	She had companion during labor and delivery(see SCBL)																				

9.	She was provided pain relief (pharmacologic or non-pharmacologic																				
During second stage																					
10.	FHR monitored ■ every 15 min (low risk) ■ every 5 min (after each contraction (high risk)																				
11.	Progress of labor monitored																				
12.	Delivery summary properly documented on partograph and delivery summary sheet																				
13.	Safe childbirth checklist used and filled completely																				

Management of third stage of labor																					
14.	Uterotonics given with in 1 minute of delivery of the baby																				
15.	The placenta is delivered with controlled cord traction																				
16.	The tone of uterus checked every 15 min for 2 hrs after delivery																				
17.	Postpartum family planning counseling and service provided																				
	Grand Total																				
	Average (%)																				

Audit Tool: PNC

Facility name	
Audit topic	Chart audit for PNC
Objective	Ensure all women coming for PNC receive appropriate care according to national guidelines(Obstetric management protocol for health center)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	The mother and newborn stayed for 24 hours in the health center per the PNC guideline																				
3.	Initiated breast feeding immediately (<1hr)																				
4.	BP, PR, Temp measured and Uterine tone checked every 30min with in the first 2hrs of delivery																				
5.	The mother monitored for vaginal bleeding and for other complication until discharge																				
6.	The mother was counseled on danger signs (maternal and neonatal), family planning, early ambulation, nutrition, and breast feeding upon discharge																				
7.	The mother received postnatal care within 72 hrs, 7 days and 6 weeks after delivery																				
8.	The mother assessed for her wellbeing (mental health) and complications at each visit																				
	Grand Total																				
	Average (%)																				

Audit Tool: Postpartum Hemorrhage

Facility name	
Audit topic	Clinical audit record for PPH
Objective	Ensure women with post-partum hemorrhage promptly receive appropriate care according to up-to-date National clinical protocols(Obstetric management protocol for health center and EPHCG)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Two IV line opened, and crystalloids infused																				
3.	The uterus massaged																				
4.	Oxytocics (oxytocin, ergometine and misoprostol) was given according to the guideline																				
5.	Checked if placenta has been expelled and complete																				
6.	Genital tract exploration performed																				
7.	Maternal vital signs and urine out monitored during and after PPH management																				
8.	Blood taken for hemoglobin (Hg)/ hematocrit (Hct), Blood group and RH																				

9.	Specific management provided for the identified cause (atonic, tear, retained placenta)																				
10.	Tranexamic acid given for PPH with in 3 hrs of birth																				
11.	NASG applied																				
12.	Bimanual and aortic compression performed																				
13.	Urgent referral made to higher level facility if PPH is not controlled																				
	Grand Total																				
	Average (%)																				

Audit Tool: Severe Preeclampsia

Facility name	
Audit topic	Chart audit for severe preeclampsia and convulsion
Objective	Ensure women with severe preeclampsia and convulsion promptly receive appropriate care according to up-to-date National clinical protocols (Obestatric management protocol for health center and EPHCG)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Appropriate History and physical examination done																				
3.	The mother was given supportive care (ABC, positioning, oxygen)																				
4.	Magnesium Sulphate loading dose given according to the guideline																				
5.	Hydralazine given if BP≥160/110mmHg																				
6.	The mother was referred urgently																				
	Grand Total																				
	Average (%)																				

Audit Tool: Fever With Child Birth

Facility name	
Audit topic	Chart audit for fever with childbirth
Objective	Ensure women with Fever during child birth receive appropriate care according to up-to-date National clinical protocols (Obstetric management protocol for health center and EPHCG)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Appropriate History and physical examination done																				
4.	Essential laboratory test done (CBC, B/F, U/A)																				
5.	Appropriate combination of antibiotics administered according to the guideline																				
	Grand Total																				
	Average (%)																				

Chart Audit For: Comerhenisve Abortion Care

Facility name	
Audit topic	Comprehensive abortion care
Objective	Ensure clients promptly receive appropriate care according to up-to-date National CAC protocols for safe abortion services (National obstetric management protocol, Technical and procedural guideline for abortion care ,EPHCG)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Proper history and physical examination performed																			
3.	The size of the uterus determined by bimanual examination or ultrasound																			
4.	Written informed consent taken before the procedure																			
5.	Options of management offered to the client if she is eligible for both (MVA, Medical abortion)																			
6.	The client was given pain medication before the MVA procedure (Ibuprofen)																			
7.	Prophylactic antibiotic given before MVA procedure-STI																			
8.	Signs of completeness of the procedure confirmed																			
9.	The client was given discharge instructions (danger sign)																			
10.	Post procedure counseling provided (Family planning, STI, HIV testing, cervical cancer screening, psychosocial support)																			
	Grand Total																			
	Average (%)																			

Audit Tool: Family Planning

Facility name	
Audit topic	Chart audit for family planning
Objective	Ensure women visiting facility for family planning services receive appropriate care according to up-to-date national protocols (EPHCG, national family planning guideline, family planning-A global hand book for providers 2018 edition)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Proper history taken and documented ■ On chronic diseases such as HPN, DM, epilepsy, HIV/AIDS, TB ■ Smoking ■ Vaginal bleeding ■ Other medication such as ART drugs, rifampicin, phenytoin ■ Symptoms of STI ■ LMP																				
3.	Weight and BMI measured																				
4.	BP is checked																				
5.	Checked for pregnancy																				
6.	Breast is checked																				
7.	HIV test done																				
8.	Cervical cancer screening done ■ For a client who is greater than 30years and HIV negative ■ For a client who is HIV positive regardless of age																				

9.	If IUCD (Bimanual and speculum examination done to determine size, position, and mobility of uterus and adenexia and state of cervix)																				
10.	Comprehensive and correct information on all methods provided																				
11.	Client medical eligibility confirmed																				
12.	Informed consent obtained and documented on client chart																				
13.	Provided the method of FP chosen (except for clients with contraindications)																				
14.	IUCD inserted appropriately ■ Uterine depth and position measured ■ Aseptic technique used ■ Pain managed ■ Presence or absence of any complication documented ■ Presence or absence of difficulties documented																				

15.	Implants placed appropriately ■ Marked and local anesthesia given ■ Aseptic technique used ■ Confirmed the end of implant is towards the shoulder ■ Pressured dressing applied																				
16.	Information on method provided documented on pt chart and/or FP registry logbook ■ Type of method ■ Expiry date for IUCD and implant ■ Site of insertion for IUCD and implant																				
17.	Method based advice is provided for client																				

18.	Advised to disclose the family planning method upon contact with clinician for medical check up																				
19.	Appropriate appointment given to the client																				
20.	Proper documentation of referral made ■ Referral diagnosis documented on client card ■ Pre referral management documented on client card ■ Reason for referral																				
	Grand Total																				
	Average (%)																				

Facility name	
Audit topic	Chart audit for family planning
Objective	Ensure women visiting facility for family planning services receive appropriate care according to up-to-date national protocols (EPHCG, national family planning guideline, family planning-A global hand book for providers 2018 edition)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
Routine care/follow up																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Proper history taken and documented ■ Vaginal bleeding ■ HIV status ■ Other medication such as ART drugs, rifampicin, phenytoin ■ Symptoms of STI ■ Adherence to FP ■ Contraceptive Side effects ■ Risky sexual behavior ■ LNMP																				
3.	Weight measured																				
4.	BP is checked if client is on Pill or injectable																				
5.	Checked for pregnancy for client on OCP or IUCD and missed period																				
6.	HIV test done if not done in the intial visit																				
7.	Appropriate managemet provided according to identififed diagnosis(STI, sexual prolems, HIV status, BP,side effects, adeherence,other medications)																				
8.	Method based advice is provided for client																				

9.	Appropriate appointment given to the client																				
10.	Proper documentation of referral made ■ Referral diagnosis documented on client card ■ Pre referral management documented on client card ■ Reason for referral																				
11.	IUD removed with aseptic technique																				
12.	Implant removed appropriately ■ Marked and local anesthesia given ■ Aseptic technique used ■ Small incision made on the insertion site ■ Forceps used to remove the implant ■ Pressured dressing applied																				
	Grand Total																				
	Average (%)																				

Audit Tool: Emergency Contraception

Facility name	
Audit topic	Chart audit for emergency cotraception
Objective	Ensure client coming for emergency contraception receive appropriate care according to National clinical protocols (EPHCG, national family planning guideline, WHO 2014 contraceptive service recommendation)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Proper history taken and documented ■ Time of sexual contact ■ Type of contact(assult or consensual) ■ Medication history (ART, Rimfampcin, phentyoin) ■ Hep B and HIV exposure																				
3.	Emergency contraception provided, if patient had unprotected sex in past 5 days and does not want pregnancy (adhere to the EPHCG protocol).																				
4.	If client vomited within 2hours of taking , dose repeated or copper intrauterine devise offered																				
5.	Client on ART, Rimfampcin or phentyoin is given 3mg levonorgestre or offered IUCD																				
6.	Client offered Contraceptive same day of visit																				
7.	Counseling on next pregnancy plan provided																				
	Grand Total																				
	Average (%)																				

Clinical Care Audit Tool: Child Health

Audit Tool: Esssential Newborn Care

Facility name	
Audit topic	Chart audit for essential newborn care
Objective	Ensure neonates born within the facility receive appropriate essential newborn care
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
Essential Newborn care and Asphyxia																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Weight , height/length, recorded																				
3.	Temperature measured																				
4.	Chief complaint recorded																				
5.	Dried baby with dry and warm towel																				
6.	Young Infant's breathing observed																				
7.	Breathing counted																				
8.	Gestational age checked																				
9.	Initiated Skin to Skin contact																				
10.	Initiated Breast feeding within 1 hour																				
11.	Applied TTC																				
12.	Applied Chlorhexidin																				

13.	Gave Vitamin K																				
14.	Nutritional status classified correctly																				
15.	Birth weight Measured																				
16.	Correctly classified the young infant for Birth Asphyxia																				
17.	Treated Birth Asphyxia as per the classification																				
18.	Correctly classified Birth Weight and Gestational age																				
19.	Treated Birth weight and gestational age as per the classification																				
	Grand Total																				
	Average (%)																				

Audit Tool: Sick Young Infant (0- 2 month)

Facility name	
Audit topic	Clinical Records Audit for IMNCI sick young infant register
Objective	Ensure sick young infants receive appropriate care according to national guidelines(IMNCI)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Weight , height/length, recorded																			
3.	**Checked for Very Severe disease and local bacterial infection**																			
	RR counted and documented																			
	Severe Chest In drawing																			
	Infant has convulsion																			
	Infant has feeding difficulty																			
	Temperature measured and >37.5 or 35.5-36.4 or <35.5																			
	Umbilicus: red/pus draining																			
	Skin pustules																			
	Infant movement with stimulation																			
4.	**Correctly classified the young infant for Very severe disease**																			
5.	**Treated Very severe disease as per the classification**																			
6.	**Checked Jaundice**																			
	Yellow on skin, palms and soles or no discoloring																			
7.	**Treated Jaundice as per the classification**																			

8.	**Assessed Diarrhea in the young infant(Yes or No)**																			
	Asked presence of diarrhea																			
	Checked duration of diarrhea																			
	Checked presence of blood in diarrhea																			
	Checked for sunken eyes																			
	Checked Skin pinch																			
9.	**Correctly classified diarrhea in the young infant**																			
10.	**Treated Diarrhea in the young infant as per the classification**																			
11.	**Assessed HIV**																			
	Checked for HIV status of the mother(pos/Neg/Unkn)																			
	HIV status of the young infant checked(DNA/PCR)																			
12.	**Classification of HIV status done correctly**																			
13.	**Correctly managed HIV status as per the classification**																			

14.	**Assessed Feeding problem for Breastfeeding**																			
	Checked for feeding difficulty																			
	Checked whether breast feeding is <8 breast feeds in 24hrs																			
	Checked mother is Switching breast frequently																			
	Checked mother is Not increasing BF during illness																			
	Checked whether child Receives other foods/drinks																			
	Checked whether child is Underweight (Wt/age)																			
	Checked whether child has Mouth ulcers/thrush																			
	Checked Positioning of infant																			
	Checked attachment of infant																			
	Checked child's Suckling																			
15.	**Correctly classified the young infant for feeding problem or underweight**																			

16.	**Correctly treated the young infant as per the classification**																				
17.	**Assessed feeding problem or underweight for non- breast feed infant**																				
	Checked Incorrectly/ Unhygienically prepared milk																				
	Checked about Inappropriate replacement feed																				
	Checked whether replacement feeds are insufficient																				
	Checked Mixing breast milk & other feeds is practiced																				
	Checked whether there is Bottle feeding																				
	Checked child is Underweight(Wt/age)																				
	Checked presence of Mouth ulcers / thrush																				
18.	**Correctly classified the young infant for feeding problem or underweight**																				

19.	**Correctly treated the young infant as per the classification**																			
20.	**Assessed immunization status of the child**																			
21.	**Provided immunization intervention accordingly**																			
22.	**Provided proper Counseling of Mothers**																			
	Mother was counseled on Breast Feeding																			
	Mother advised how to Keeping Warm the young infant																			
	Mother counseled on When to return																			
23.	**Infants condition assessed and documented at follow-up**																			
24.	**Infant managed according to follow-up assessment**																			
	Grand Total																			
	Average (%)																			

Audit Tool: Sick Child (2 month- 5 years)

Facility name	
Audit topic	Clinical Records Audit for IMNCI sick child register
Objective	Ensure sick children receive appropriate care according to up-to-date national guidleines (IMNCI)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Weight , height/length, temperature recorded																				
3.	Chief complaint recorded																				
4.	**The child who has initial visit; checked and assessed for General Danger signs:** **YES | NO**																				
	Checked for the ability to drink or breastfeed																				
	Checked for the presence of vomit everything																				
	Checked for the history of convulsions																				
	Looked for lethargy or consciousness																				
	Looked for convulsion at the time of the visit.																				
5.	**A child with general danger signs properly classified according to national protocol**																				
6.	**A child with general danger signs properly managed according to national protocol**																				

7.	**Assesed child for cough or difficult breathing** **YES | NO**																			
	Asked for the duration of cough or difficult breathing																			
	Respiratory rate was counted in one minute																			
	Observed for Chest In drawing																			
	Looked and listened for stridor.																			
	Looked and listened for wheezing.																			
8.	**The child with cough/difficulty in breathing classified according to national protocol**																			
9.	**The child with cough/difficulty in breathing managed according to national protocol**																			
10.	**Assessed the child for diarrhea** **YES | NO**																			
	Checked for the duration																			
	Checked for the presence of blood in the stool																			
	Looked for general condition (Lethargic or unconscious, Restless and irritable)																			
	The child with diarrhea assessed for hydration status																			

11.	**The child with dehydration classified according to national protocol**																			
12.	**The child with dehydration managed according to national protocol**																			
13.	**The child with prolonged diarrhea classified according to national protocol**																			
14.	**The child with prolonged diarrhea managed according to national protocol**																			
15.	**The child with bloody diarrhea classified according to national protocol**																			
16.	**The child with bloody diarrhea managed according to national protocol**																			
17.	**Assesed child with for fever** **YES | NO**																			
	Checked presence of Fever																			
	Assessed for the duration of fever																			
	Assessed for the pattern of fever (If it is for more than 7 days, was it been present every day)																			
	Assessed for the occurrence of measles within the last 3 months																			
	Looked for stiff neck and runny nose.																			
	Looked for any bacterial cause of fever.																			

	Looked for signs of MEASLES (Generalized rash and One of these: cough, runny nose, or red eyes).																			
	Checked for a malaria test and risk of malaria																			
18.	**A child with fever properly classified according to the national protocol**																			
19.	**A child with fever properly managed according to the national protocol**																			
20.	**Assessed the child for ear problem** **YES | NO**																			
	Checked for ear pain																			
	Checked for ear discharge and duration of the discharge																			
	Looked for pus draining from the ear.																			
	Feel for tender swelling behind the ear.																			
21.	**The child with ear problem classified according to national protocol**																			
22.	**The child with ear problem managed according to national protocol**																			
23.	**Checked for anemia**																			
	Severe pallor																			
	Some pallor																			
	No pallor																			

24.	**The child with anemia classified according to national protocol**																			
25.	**The child with anemia managed according to national protocol**																			
26.	**Checked and classified immunization status (complete, Up-to-date, not-up-to-date, defaulted, not started**																			
27.	**Planned according to immunization status findings**																			
28.	**Checked for VITAMIN A status**																			
29.	**Provided VIT A management according to assessment**																			
30.	**Checked deworming status**																			
31.	**Provided appropriate deworming intervention according to finding**																			
32.	**Assessed HIV Exposure and infection**																			
	Checked mother's HIV status																			
	Checked for HIV antibody test result of the child																			
	Checked for DNA/PCR test result of the child																			

	Check breast feeding status of the child in the past 6 weeks																				
33.	**Correctly classified the child for HIV**																				
34.	**Provided correct treatment for the child's classification**																				
35.	**Assessed the child for tuberculosis**																				
	Checked Fever and night Sweats																				
	Checked Close contact History with known TB patient																				
	Checked contact with MDR TB																				
	Checked for swelling/discharging wound																				
	Checked for signs of acute malnutrition																				
36.	**Correctly classified the sick child for Presumptive tuberculosis and further workup**																				
	Grand Total																				
	Average (%)																				

Audit Tool: Child Malnutrition

Facility name	
Audit topic	Clinical Record Audit tool for under five children with malnutrition
Objective	Ensure children with malnutrition receive appropriate evaluation amd management according to up-to date national protocols (IMNCI)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Nutritional History taken																				
3.	Anthropometric measurements done ■ Weight and Height Measured, ■ Determine WFH/WFL Z- Score using reference chart ■ MUAC measured ■ Checked BMI for age																				
4.	PR,RR, Temperature taken																				
5.	Checked for medical signs of complication ■ Checked for Convulsion, ■ Assessed level of consciousness ■ Checked for Dehydration (watery diarrhea with recent sunken eye balls.) ■ Checked for Hypoglycemia ■ Checked for Sever anemia (sever palmar pallor) ■ Checked for Jaundice Checked for Dermatosis+++ ■ Checked for presence of edema of both feet ■ Checked for signs of Corneal clouding or ulceration ■ Checked for signs of Measles (now or with eye/mouth complications)																				

6.	Appetite test Conducted																				
7.	Correctly Classified nutritional status of the child according to the National protocol																				
8.	Correctly Managed according to the National protocol																				
9.	Every variable on follow-up chart assessed and recorded																				
	Grand Total																				
	Average (%)																				

Audit Tool: Children 5-15 Years (For Children Visiting Outpatient Department With Any Symptom)

Facility name	
Audit topic	Chart audit for child 5-15 years with _____Symptom
Objective	Ensure children aged 5-15 visiting OPD receive appropriate care according to up-to-date national guidelines
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	Chief compliant recorded																				

3.	Presence or absence of urgent symptoms and signs documented																				
4.	Appropriate management was given and referred for a child with urgent signs and symptoms																				
5.	Diagnosis was identified as per EPHCG																				
6.	Appropriate investigations were done as per EPHCG																				
7.	Appropriate routine care was given as per EPHCG																				
8.	Appropriate counseling was provided as per EPHCG																				
	Grand Total																				
	Average (%)																				

Clinical Care Audit Tool: Malnutrition (age >15)

Facility name	
Audit topic	Clinical Record audit for Malnutrition management
Objective	Ensure patients with malnutrition receive appropriate evaluation and management according to up-to-date national guidelines(EPHCG and National malnutrition guideline)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
1.	Diagnosis is made using the appropriate criteria (as per EPHCG)																				
2.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

3.	Urgent signs excluded (Respiratory rate ≥ 30, BP < 90/60, Jaundice, Extensive skin lesions, Very weak, lethargic or unconscious, seizures)																			
4.	Nutrition (dietary) history taken																			
5.	Assessed for bilateral pitting edema																			
6.	Weight, height and BMI measured																			
7.	MUAC measured																			
8.	Nutritional status classified correctly																			
9.	Checked for signs of medical complication ■ Assessed for presence of fever or hypothermia ■ Assessed for dehydration(history of intractable vomiting and diarrhea, sunken eyes, dry mouth) ■ Assessed for severe skin lesions ■ Assessed for eye signs of vitamin A deficiency ■ Assessed for lower respiratory tract infection ■ Assessed for severe anemia (severe palmor pallor) ■ Assessed for hypoglycemia(RBS measured)																			

10.	Assessed for TB																			
11.	Tested for HIV																			
12.	Patient with urgent sign and symptom is resuscitated with normal saline and referred urgently																			
13.	Signs and symptoms of medical complications managed, if present																			
14.	Patient whose TB screening is positive is managed accordingly																			
15.	Patient with posititve HIV test is managed accordingly																			
16.	Nutritional advise provided																			
17.	Dewormed with single dose Mebendazole 500mg po or Albendazole 400mg																			
18.	RUTF 2 100g sachet three times a day provided																			
19.	Patient is given appropriate appointment																			
20.	Patient who is not getting at least two meals per day or eating a balanced diet is referred to nutrition support program																			

21.	Patient with complication is referrerd ■ Who has swelling of face, hands or feet ■ Who is not gaining weight or is losing weight ■ Patient who has severe anemia																				
22.	Referral form is completed (patient ID, date, diagnosis and investigation done, pre-referral treatment given, reason for referral recorded)																				
CINuS register																					
23.	Date recorded accurately																				
24.	All data elements recorded																				
	Grand Total																				
	Average (%)																				

Facility name																					
Audit topic		Clinical Record audit for Malnutrition management																			
Objective		Ensure patients with malnutrition receive appropriate evaluation and management according to up-to-date national guidelines(EPHCG and National malnutrition guideline)																			
Period of Audit																					
Exclusion criteria (where applicable)																					
If all are completed give '1' if not give '0'																					
S.N.	**Measurement criteria**	**Chart 1**	**Chart 2**	**Chart 3**	**Chart 4**	**Chart 5**	**Chart 6**	**Chart 7**	**Chart 8**	**Chart 9**	**Chart 10**	**Chart 11**	**Chart 12**	**Chart 13**	**Chart 14**	**Chart 15**	**Chart 16**	**Chart 17**	**Chart 18**	**Chart 19**	**Total/ Average**
Routine care																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Urgent signs excluded (Respiratory rate ≥ 30, BP < 90/60, Jaundice, Extensive skin lesions, Very weak, lethargic or unconscious, seizures)																				
3.	Assessed for bilateral pitting edema																				
4.	Weight, height and BMI measured																				
5.	MUAC measured																				
6.	Nutritional status classified correctly																				
7.	Checked for signs of medical complication ■ Assessed for presence of fever or hypothermia ■ Assessed for dehydration(history of intractable vomiting and diarrhea ,sunken eyes, dry mouth) ■ Assessed for severe skin lesions ■ Assessed for eye signs of vitamin A deficiency ■ Assessed for lower respiratory tract infection																				
8.	Assessed for TB																				
9.	Patient with urgent sign and symptom is resuscitated with normal saline and referred urgently																				

10.	Signs and symptoms of medical complications managed, if present																				
11.	Patient whose TB screening is positive is managed accordingly																				
12.	Nutritional counseling provided																				
13.	RUTF 2 100g sachet three times a day provided																				
14.	Patient is discharged when BMI is >17.5																				
15.	Pregnant or breast feeding mother is discharged when MUAC is >23																				
16.	Patient is given appropriate appointment																				
17.	Patient who is not getting at least two meals per day or eating a balanced diet is referred to nutrition support program																				
18.	Patient with complication is referrerd ■ Who has swelling of face, hands or feet ■ Who is not gaining weight or is losing weight ■ Patient who has severe anemia																				
19.	Referral form is completed (patient ID, date, diagnosis and investigation done, pre-referral treatment given, reason for referral recorded)																				

CINuS register																					
20.	Date recorded accurately																				
21.	All data elements recorded																				
	Grand Total																				
	Average (%)																				

Clinical Care Audit Tool: General Adult OPD

Facility name	
Audit topic	Chart audit for Adults (>15years with)_____Symptom
Objective	Ensure patients Adult patients visiting OPD with any symptom receive appropriate evaluation and management according to EPHCG
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	Chief compliant recorded																				

3.	Presence or absence of urgent symptoms and signs documented																				
4.	Appropriate management was given and referred for a patient with urgent signs and symptoms																				
5.	Diagnosis was identified as per PHCG																				
6.	Appropriate investigations were done as per EPHCG																				
7.	Appropriate routine care was given as per EPHCG																				
8.	Appropriate counseling was provided as per EPHCG																				
	Grand Total																				
	Average (%)																				

Clinical Care Audit Tool: Communicable Diseases

Audit Tool: Tuberculosis

Facility name	
Audit topic	Clinical Record Audit tool for patients with TB
Objective	Ensure patients with symptoms of TB, diagnosis of presumed TB and Definitive TB receive appropriate care according to EPHCG
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
TB: Diagnosis																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

2.	Pertinent history taken including screening for symptoms and signs needing urgent attention according to the guideline																				
3.	Pertinent physical examination done (vital sign, oral mucosa, conjunctiva, scelra, lymphograndualr system, chest examination, abdominal examination)																				
4.	Patient with one or more sign and symptoms or urgency is managed promptly according to EPHCG and referred in the same day ■ respiratory rate >30, ■ breathless at rest or talking, ■ confusion or agitation , ■ coughs >1 tablespoon of fresh blood)																				
5.	Patient with presumed TB is assessed for risk factors of DRTB																				
6.	Pt with presumed TB is screened for HIV																				
7.	Appropriate sputum investigation is done for pt with presumed TB																				
8.	Patient with presumed TB is appropriately classified in to the categories of TB diagnosis																				

9.	Referral is made for patient with diagnosis of complicated TB ■ Extra pulmonary TB or ■ Drug resistance TB																				
Patient diagnosed with DS-TB																					
10.	Weight ,BMI and MUAC measured																				
11.	RBS measured																				
12.	Tracing, screening and management of contacts done																				
13.	Contraceptive needs assessed and managed accordingly																				
14.	Pt assessed for substance abuse																				
15.	Management of substance abuse provided for patient with positive history of substance abuse																				
16.	Pt with maluntrirtion is managed appropriately																				

17.	Patient is advised on ■ medication adherence and dangers of resistance, ■ medication side effects, ■ the time to be infectious, ■ to avoid use of alcohol, khat and other illegal and over the counter (drugs which are taken without prescription) medications																				
18.	Correct regiment is initiated (including supplemental drugs)																				
19.	Patient is given appropriate appointment																				
	Grand Total																				
	Average (%)																				

Facility name	
Audit topic	Clinical Record Audit tool for patients with TB
Objective	Ensure patients with diagnosis Definitive TB receive appropriate care according to EPHCG
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
Routine care for Patient diagnosed with DS-TB or smear –vet TB																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	Pt is assessed at two weeks and then once a month throughout treatment																				

3.	Pertinent progress history taken ■ Worsening of symptoms ■ Drug adherence ■ Drug side effects ■ Contraceptive needs ■ Symptomatic contacts ■ HIV status																				
4.	Physical examination is done ■ Respiratory rate ■ Chest examination ■ Metal status ■ Weight																				
5.	MUAC measurement done at week eight																				
6.	Sputum smear for AFB is done at the appropriate time (end of 2, 5 & 6 months of initiating therapy) for smear +vet patient																				
7.	Sputum specimen for Xpert MTB/RIF done at the appropriate time (end of 2,5 & 6 months of initiating therapy) for HIVpositive or smear -ve patient																				
8.	Patient with symptoms needing urgent attention managed accordingly																				
9.	Patient is managed according to the sputum examination result at the end of each phase (2,5 & 6 months)																				

10.	ART initiation is done at the appropriate time for HIV positive patient																				
11.	Appropriate contraceptive provision conducted																				
12.	Malnourished patient managed appropriately																				
13.	Tracing, screening and management of contacts done																				
14.	Pt experiencing drug side effects is managed appropriately																				
15.	Defaulter patient is managed appropriately																				
16.	Referral is made for patient with complication ■ Pt Whose symptoms worsen or don't improve after one month of treatment or ■ Patient Constantly losing weight or ■ Develops drug resistance while on treatment or ■ Develops Treatment failure																				

17.	Proper advise provided for patient ■ medication adherence and dangers of resistance, ■ medication side effects, ■ the time to be infectious, ■ to avoid use of alcohol, khat and ■ other illegal and over the counter (drugs which are taken without prescription) medications																				
18.	Patient is given appropriate appointment																				
19.	At the end of treatment, Treatment outcome is assessed and recorded																				
	Grand Total																				
	Average (%)																				

Audit Tool: Malaria

Facility name	
Audit topic	Chart audit for malaria
Objective	Ensure patients with the diagnosis of malaria receive appropriate care according to national guidelines(EPHCG and National malaria guidelines)
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	Pertinent history and physical examination guided to diagnosis is documented																				
3.	All symptoms needed to rule in or rule out other causes of fever are elicited																				

4.	All symptoms which need urgent attention are elicited from the history and physical examination																				
5.	All essential laboratories to diagnose malaria is done (B/F or RDT																				
6.	Diagnosis is labeled either as uncomplicated or complicated malaria documented including malaria species																				
7.	All lab tests to rule in or rule out complications are done as per national guideline																				
8.	management is outlined for uncomplicated or complicated malaria per the guideline																				
9.	follow up plan was outlined as per recommendation																				
	Grand total																				
	Average (%)																				

Audit Tool: HIV/AIDS

Facility name	
Audit topic	Clinical Record Audit tool for HIV/AIDS patients
Objective	Ensure patients with the diagnosis of HIV/AIIDS receive appropriate care according to national guidelines(EPHCG and National comprehensive HIV care and treatment guideline)
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
Counseling and Testing and diagnosis																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ date of visit ■ MRN																				

2.	Risk assessment and management done according to guidelines (National comprehensive HIV care and treatment guideline) ■ screening Tool for HIV is utilized ■ HIV testing and counseling done ■ positive persons linked to care and treatment services ■ HIV negative people to linked to prevention services																				
3.	Eligibility criteria was used before subjecting clients to HIV testing using PITC approach (see RST tool)																				
4.	Retesting on Newly diagnosed HIV positive clients was done before initiating ART																				
5.	Partner & Family Based Index Case Testing HIV testing was done (see the ART Register for the specific patient chart)																				
6.	CVD risk assessment is done and managed accordingly																				
7.	Before treatment initiation retesting and recency testing done acc to the guideline (National comprehensive HIV care and treatment guideline)																				
8.	Complete clinical assessment (history taking, complete physical examination) performed																				
9.	Relevant lab tests were done (see EPHCG)																				

10.	Appropriate clinical staging done																				
11.	Screening and management of opportunistic infections and was conducted																				
12.	Assisted partner notification provided and recorded(see register)																				
13.	Sexual health assessment and risk reduction counseling provided and recorded																				
14.	Screened for TB is done and managed accordingly																				
15.	Screened for mental health problems and substance use is done on every visit and managed accordingly																				
16.	Nutritional assessment (weight, BMI, MUAC) is conducted and managed accordingly																				
17.	Screening for other STI conducted																				
18.	Syndromic treatment approach was implemented and documented for patients with genital symptoms																				
19.	screening of cervical cancer was conducted and documented																				
20.	family planning and contraception use is assessed and managed accordingly																				
21.	Pregnancy status assessed																				
22.	eMTCT provided for pregnant mother																				
23.	Patient is documented on HIV + tracking register, pre-ART register and ART register																				

24.	Adherence counseling provided during ART initiation																				
25.	patients were initiated on timely and optimized ART regimen as per the EPHCG																				
26.	Cotrimoxazole was prescribed if the patient is eligible based on EPHCG																				
27.	Patient is given appropriate appointment																				
28.	If patient is referred: The referral form (patient ID, date, diagnosis and investigation done, pre-referral treatment given, reason for referral) recorded and return referral completed and attached to the chart.																				
	Grand total																				
	Average (%)																				

Facility name	
Audit topic	Clinical Record Audit tool for HIV/AIDS patients
Objective	Ensure patients with the diagnosis of HIV/AIIDS receive appropriate care according to national guidelines(EPHCG and National comprehensive HIV care and treatment guideline)
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
Routine care																					
1.	Demographic and identification information recorded ▪ Name ▪ Age ▪ Sex ▪ Address ▪ date of visit ▪ MRN																				
2.	Complete clinical assessment (history taking, complete physical examination) performed																				
3.	Relevant lab tests according to schedule was done (see EPHCG)																				
4.	Appropriate clinical staging done																				
5.	Screening and management of opportunistic infections and was conducted																				

6.	Assisted partner notification provided and recorded(see register)																				
7.	Sexual health assessment and risk reduction counseling provided and recorded																				
8.	Screening for TB is done and managed accordingly																				
9.	Screening for mental health problems and substance use is done and managed accordingly																				
10.	Adherence to medication assessed ■ Patient asked if he/she is taking medicines regularly ■ Pill count made																				
11.	Adherence counseling and support provided and documented																				
12.	Nutritional assessment (weight, BMI, MUAC) is conducted on every visit and managed accordingly																				
13.	Screening for other STI is done																				
14.	Syndromic treatment approach is implemented and documented for patients with genital symptoms																				
15.	screening of cervical cancer is conducted and documented																				
16.	Assessment and management of pain and symptoms is conducted and documented																				
17.	family planning and contraception use is assessed and managed accordingly																				

18.	Pregnancy status is assessed																			
19.	eMTCT provided for pregnant mother																			
20.	Patient is documented on HIV + tracking register, pre-ART register and ART register																			
21.	Viral load testing is done and result documented at 6th months, 12th months and 12th months																			
22.	Enhanced adherence counseling (EAC) provided for patient with high viral load																			
23.	Patient with viral load > 1000 copies/mL for 2nd time is referred to Hospital																			
24.	Patient is initiated on timely and optimized ART regimen as per the EPHCG																			
25.	Patient is monitored for drug toxicity as per the national guideline																			
26.	Cotrimoxazole is prescribed if the patient is eligible based on EPHCG																			
27.	CD4 and/or viral load testing (either on-site or by referral) is done to monitor for treatment failure																			
28.	Patient is given appropriate appointment																			

29.	If patient is referred: The referral form (patient ID, date, diagnosis and investigation done, pre-referral treatment given, reason for referral) recorded and return referral completed and attached to the chart.																					
30.	Identification and tracking conducted and evidence of brought back into care documented if patient defaulted (see ART register for the particular patient)																					
	Grand total																					
	Average (%)																					

Clinical Care Audit Tool: NCD

Audit Tool: Diabetes

Facility name	
Audit topic	Chart audit for diabetic care
Objective	Ensure patient with diabetes receive appropriate interventions according to up-to-date National clinical protocols (EPHCG).
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
Diabetic: diagnosis and initial care																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	RBS testing is used to screen unwell and symptomatic patients																				
3.	FBS (after 8hours of fasting) testing is used to screen stable patients																				
4.	Patient with RBS/FBS of >200mg/dl is assessed for urgent symptoms																				

5.	Patient with sign and symptoms of DKA is resuscitated and urgently referred																				
6.	Confirmatory testing in one week period is done for pts with FBG level of >126mg/dl																				
7.	Patient with confirmed Diagnosis of DM is classified according to EPHCG																				
8.	Pertinent history (dietary habit, smoking, chest pain, leg pain, wound, urinary complaints, visual impairments, symptoms of hypoglycemia, medication adherence) is taken																				
9.	BP, Waist circumference ,BMI measured																				
10.	Eyes assessed for presence of retinopathy and cataract																				
11.	Comprehensive Foot Exam done																				
12.	Urine protein, GFR are assessed																				
13.	Baseline Cholesterol level measurement done if patient is <40yrs or CVD risk<20%																				
14.	Patient started on Aspirin if CVD risk >30% or established CVD																				
15.	Patient who qualifies for Simvastatin is started on it																				
16.	Patient with risk of renal disease is started on enalaprin																				
17.	Patient is started on appropriate hypoglycemic agents																				

18.	Proper advise provided for patient ■ Meal and dose of meal, ■ acute and chronic complication, ■ regular foot care, ■ Medication adherence ■ life style modifications, ■ insulin storage and injection technique, ■ Symptoms of hyper and hypoglycemia.																				
19.	Patient is given appropriate appointment																				
20.	Referral is made for patient with complications ■ If pt has retinopathy or cataract or ■ GFR <60ml/min/1.73m² or ■ If pt is pregnant or ■ if pt has severe foot infection																				
	Grand Total																				
	Average (%)																				

Facility name	
Audit topic	Chart audit for diabetic care
Objective	Ensure patient with diabetes receive appropriate interventions according to up-to-date National clinical protocols (EPHCG).
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
Diabetes routine care																					
1.	Demographic and identification information recorded ▪ Name ▪ Age ▪ Sex ▪ Address ▪ Date of visit ▪ MRN																				
2.	The diabetic patient is actively assessed for presence of urgent sign and symptoms																				
3.	Pertinent history (dietary habit, smoking, chest pain, leg pain, wound, urinary complaints, visual impairments, symptoms of hypoglycemia, medication adherence) is taken																				

4.	Patient is screened for the presence of CVD risk yearly																				
5.	BP, Waist circumference measured																				
6.	visual feet examination done																				
7.	BMI and Comprehensive Foot Exam done Annually																				
8.	Vision , urine protein, GFR are assessed yearly																				
9.	Cholesterol level measurement done three months after starting simvastatin																				
10.	Random blood glucose done for DM patients when symptomatic or during adjustments of glucose lowering medications																				
11.	Updated diagnosis of the patient is identified ■ Controlled or uncontrolled ■ Other co morbidities																				
12.	Patient with urgent sign and symptoms is managed accordingly																				
13.	Patient is started on Aspirin if CVD risk >30% or established CVD																				
14.	Patient who qualifies for simvastatin is taking simvastatin																				
15.	Patient with risk of renal disease is taking enalaprin																				
16.	Appropriate dosage adjustments and medication switching is done based on updated diagnosis																				

17.	Patient is monitored for possible drug side effects																				
18.	Proper advise provided for patient ■ Meal and dose of meal ■ acute and chronic complication ■ regular foot care ■ Medication adherence ■ life style modifications ■ insulin storage and injection technique ■ Symptoms of hyper and hypoglycemia																				
19.	Referral is made for patient with complication ■ If pt has retinopathy or cataract or ■ GFR <60ml/min/1.73m² or ■ If pt is pregnant or ■ If pt has severe foot infection or ■ If pt has uncontrolled cholesterol																				
20.	Patient is given appropriate appointment																				
21.	Referral is made for a Type 1 DM pt who needs more than 30IU of insulin or has repeated measurement of RBS of >180mg/dl after three month																				
	Grand Total																				
	Average (%)																				

Audit Tool: HTN

Facility name	
Audit topic	Chart audit for hypertensive care
Objective	Ensure patients with hypertension receive appropriate care according to up-to-date National clinical protocols (EPHCG).
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
Hypertension: diagnosis and initial care																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ date of visit ■ MRN																				
2.	V/S(BP,PR, RR and T) recorded																				
3.	At least two BP measurements taken five minutes apart are used to make the diagnosis of hypertension																				
4.	Immediate action taken if BP>180/110																				
5.	Female patient with high BP reading is screened for pregnancy																				

6.	Pt diagnosed with HTN(initial encounter) is assessed for signs of complications ■ CVD risk ■ Blood glucose level ■ Urine dipstick ■ eGFR																				
7.	Pertinent Hx eliciting symptoms needing urgent attention, ischemic heart disease, heart failure and stroke/ TIA are taken																				
8.	Pt. qualifying for simvastatin is started on simvastatin																				
9.	Pt. qualifying for aspirin is started on aspirin																				
10.	Pt is started with anti-hypertensive according to the guideline																				
11.	Proper advise provided for patient ■ live style modification(salt restriction, weight reduction and smoking cessation), ■ medications to avoid ■ complications of HTN																				
12.	Patient given appropriate appointment																				
13.	Referral is made for a newly diagnosed HTN with complications ■ BP 200/120 or ■ BP> 180/110 and urgent symptoms or ■ With indication of secondary hypertension(Age <40)																				
	Grand total																				
	Average (%)																				

Facility name	
Audit topic	Chart audit for hypertensive care
Objective	Ensure patients with hypertension receive appropriate care according to up-to-date National clinical protocols (EPHCG).
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
HTN: Routine care																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	V/S(BP,PR, RR and T) recorded																				
3.	Immediate action taken if BP>180/110																				
4.	Pertinent Hx eliciting symptoms needing urgent attention, ischemic heart disease, heart failure and stroke/ TIA are taken																				
5.	Pregnancy plan is assessed for female patient																				
6.	Two separate BP readings are taken on every visit																				

7.	Pt is assessed yearly for signs of chronic complications ■ Eye retinopathy ■ Blood glucose level ■ Urine dipstick ■ eGFR																				
8.	CVD risk assessment done ■ Yearly for a pt with <10% risk ■ Six monthly for 10-20% risk																				
9.	Cholesterol level measurement done three months after starting simvastatin for Pt with CVD and DM																				
10.	Updated diagnosis of the patient is identified ■ Controlled or uncontrolled ■ other comorbidities																				
11.	Pt. qualifying for simvastatin is receiving it																				
12.	Pt. qualifying for aspirin is receiving aspirin																				
13.	Pt is treated with anti-hypertensive according to the guideline																				

14.	Proper advise provided for patient ■ live style modification(salt restriction, weight reduction and smoking cessation), ■ medications to avoid ■ complications of HTN																					
15.	Patient given a proper appointment																					
16.	Referral made for patient with complications (see EPHCG)																					
	Grand total																					
	Average (%)																					

Audit Tool: Asthma

Facility name	
Audit topic	Chart audit for Asthma care
Objective	Ensure patients with Asthma receive appropriate care according to up-to-date National clinical protocols (EPHCG).
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
Asthma diagnosis and initial care																					
1.	Demographic and identification information recorded ▪ Name ▪ Age ▪ Sex ▪ Address ▪ Date of visit ▪ MRN																				
2.	Pertinent history that elicits symptoms and risk factors pertaining to B.Asthma and rule out other differentials is taken																				
3.	Pertinent physical examination performed(vital sign, oxygen saturation, , chest examination, mental status)																				

4.	Patient is started on appropriate medications																				
5.	Prednisolone is started for pt who has received prednisolone or hydrocortisone for an acute exacerbation																				
6.	Antibiotics treatment is given for pts with acute exacerbation and symptoms of fever, thick yellow/green sputum																				
7.	Patient is assessed for the presence of other associated conditions allergic rhinitis, dyspepsia																				
8.	Patient with associated conditions is managed properly ■ Allergic Rhinitis ■ Dyspepsia																				
9.	Proper advise provided for patient ■ smoking ■ to rinse and gargle after each dose of beclomethasone, ■ avoid allergens that worsen/trigger asthma (animals, dust, chemicals, pollen, grass, aspirin, NSAIDS, beta blockers) ■ return before next appointment if no better or symptoms worsen (see EPHCG)																				
10.	Patient is given appropriate appointment																				
	Grand total																				
	Average (%)																				

Facility name	
Audit topic	Chart audit for Asthma care
Objective	Ensure patients with Asthma receive appropriate care according to up-to-date National clinical protocols (EPHCG).
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
Asthma routine care																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	Patient is evaluated for symptoms indicating acute exacerbation and uncontrolled asthma																				
3.	Patient is assessed for medication adherence & correct spacer/inhaler use																				
4.	Patient is assessed for associated symptoms(allergic rhinitis, dyspepsia and oral Candida)																				

5.	Pertinent physical examination performed(vital sign, oxygen saturation, , chest examination, mental status)																				
6.	Updated diagnosis is identified ■ Controlled or Uncontrolled ■ Associated conditions																				
7.	Pt with signs and symptoms of acute exacerbations is managed accordingly																				
8.	Prednisolone is started for pt who has received prednisolone or hydrocortisone for an acute exacerbation																				
9.	Antibiotics treatment is given for pts with acute exacerbation and symptoms of fever or thick yellow/green sputum																				
10.	Patient with associated conditions is managed properly ■ Allergic Rhinitis ■ Dyspepsia ■ Oral candiidasis																				
11.	Patient with poor adherence or incorrect inhaler use is referred for health extension worker support																				
12.	Step up of treatment is made for patients with acute exacerbation and uncontrolled symptoms																				
13.	Stepping down of treatment is made for pts in whom symptoms are controlled and no exacerbation is seen for ≥ 6month																				

14.	Proper advise provided for patient ■ smoking ■ to rinse and gargle after each dose of beclomethasone, ■ avoid allergens that worsen/trigger asthma (animals, dust, chemicals, pollen, grass, aspirin, NSAIDS, beta blockers) ■ return before next appointment if no better or symptoms worsen (see EPHCG)																					
15.	Patient is given appropriate appointment																					
16.	Referral is made for pt with complication ■ Beclomethasone is planned to be initiated but not available or ■ In whom symptoms are uncontrolled one month after being on maximum treatment or ■ Acute exacerbations occurred while being on maximum treatment or ■ Took >2 courses of predinsolone in the past six month																					
	Grand total																					
	Average (%)																					

Clinical care audit tool: Mental health

Audit Tool: Depression/Anxiety

Facility name	
Audit topic	Chart audit for depressive and anxiety disorders
Objective	Ensure patients with depressive and anxiety disorders receive appropriate care according to up-to-date National clinical protocols (EPHCG)
Period of Audit	
Exclusion criteria (where applicable)	
If all are completed give '1' if not give '0'	

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
Diagnosis and initial care																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	V/S(BP,PR, RR and T) recorded																				

3.	Core and additional symptoms/ signs of depression identified																				
4.	Assessment for anxiety symptoms done (see routine care page for anxiety diagnosis)																				
5.	Medication taken for medical condition considered as possible cause																				
6.	Assessment done for ■ anemia, ■ substance dependence ■ bipolar disorder ■ psychosis																				
7.	Antidepressant prescribed																				
8.	Medication started with the lowest possible dose																				
9.	Information on the illness and the treatment is provided for the patient/ care takers																				
10.	Proper advise provided for the patient ■ on what to do and not to do when thought of self harm occurs ■ on adherence ■ on self relaxation and activation and socialization																				

11.	Patient is given appropriate appointment																				
12.	Referral offered when indicated ■ The patient is anemic or ■ The disorder is caused by medication given for medical problem or ■ Has psychotic symptoms or ■ patient is pregnant or ■ patient is breast feeding																				
	Grand Total																				
	Average (%)																				

Facility name	
Audit topic	Chart audit for depressive and anxiety disorders
Objective	Ensure patients with depressive and anxiety disorders receive appropriate care according to up-to-date National clinical protocols (EPHCG)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total**
Diagnosis and initial care																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	V/S(BP,PR, RR and T) recorded																				

3.	Complete assessment is done ■ Symptoms of depression and anxiety ■ Suicidality ■ Side effect of medication ■ Mania ■ Substance abuse ■ Stressors																				
4.	Updated diagnosis identified(symptoms control, associated conditions)																				
5.	Medication dose adjusted according to symptom control																				
6.	Patient with associated conditions(Mania, self-harm, stressors, substance abuse) is managed accordingly																				
7.	Patient with medication side effects is managed accordingly																				
8.	Information on the illness and the treatment is provided for the patient/ care takers																				
9.	Proper advise provided for the patient ■ on what to do and not to do when thought of self harm occurs ■ on medication adherence ■ on self relaxation and activation and socialization																				

10.	Patient is given appropriate appointment																				
11.	Referral offered when indicated ■ No response seen after 8 weeks trial with medication or ■ patient is pregnant or ■ patient is breast feeding																				
	Grand Total																				
	Average (%)																				

Audit Tool: Psychosis

Facility name	
Audit topic	Chart audit for psychosis
Objective	Ensure patients with psychosis receive appropriate interventions according to up-to-date National clinical protocols (EPHCG)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total / Average
Diagnosis and initial care																					
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	V/S(BP,PR, RR and T) recorded																				
3.	Symptoms and signs of psychosis identified																				

4.	Complete assessment done ■ Assessment for aggression/violence ■ Assessment for self-harm ■ Assessment for stressors ■ Assessment for substance ■ Family planning ■ Medication intake for other illness																				
5.	BMI measured																				
6.	Screened for HIV and syphilis																				
7.	Diagnosis identified																				
8.	Antipsychotic prescribed																				
9.	One medication started with the lowest possible dose																				
10.	CVD risk management is provided for patient with BMI>25																				
11.	Patient with associated conditions (aggressiveness, delirium, self-harm, stressors, substance abuse) is managed accordingly																				

12.	Proper advise provided ■ Advise to the care taker provided ■ Advise on avoiding substance of abuse provided ■ Advise on the need of adherence given																				
13.	Patient is given appropriate appointment																				
14.	Referral offered when indicated ■ Unsure of the diagnosis or ■ Is on other medication that can cause psychosis or ■ HIV test or syphilis test is positive or ■ If patient is pregnant or planning pregnancy or ■ If patient is breast feeding																				
	Grand Total																				
	Average (%)																				

Facility name	
Audit topic	Chart audit for psychosis
Objective	Ensure patients with psychosis receive appropriate interventions according to up-to-date National clinical protocols (EPHCG)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
Routine care																					
1.	Demographic and identification information recorded ▪ Name ▪ Age ▪ Sex ▪ Address ▪ Date of visit ▪ MRN																				
2.	V/S(BP,PR, RR and T) recorded																				
3.	Symptoms and signs of psychosis identified																				

4.	Complete assessment done ■ Symptoms control ■ for aggression/violence ■ for self-harm ■ for stressors ■ for substance abuse ■ Family planning ■ Medication intake for other reasons ■ Medication adherence ■ Medication side effects																				
5.	BMI measured																				
6.	Updated diagnosis identified(symptoms control, associated conditions)																				
7.	Medication dose adjusted according to symptom control																				
8.	CVD risk management is provided for patient with BMI>25																				
9.	Patient with associated conditions (aggressiveness, delirium, self-harm, stressors, substance abuse) is managed accordingly																				
10.	Patient with adherence problem is managed accordingly																				

11.	Patient with medication side effects is managed accordingly																				
12.	Proper advise provided ■ Advise to the care taker provided ■ Advise on avoiding substance of abuse provided ■ Advise on the need of adherence given																				
13.	Patient is given appropriate appointment																				
14.	Referral offered when indicated ■ Unsure of the diagnosis or ■ Is on medication that can cause psychosis or ■ more than typical effective dose is required or ■ if patient is pregnant or planning pregnancy or ■ if patient is breast feeding																				
	Grand Total																				
	Average (%)																				

Clinical Care Audit Tool: Surgical Services

Facility name	
Audit topic	Chart audit for surgical services
Audit lead	
Objective	Ensure patients with the need for surgical services receives appropriate care as per national protocol/guideline for surgical services
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	**Total/ Average**
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				

Pre-operative																						
2.	Pre-operative patient assessment done ■ Physical preparation ■ Psychological preparation ■ Preoperative teaching ■ Surgical site preparation																					
3.	Pre-operative screening test assessment done Laboratory:- CBC Imaging :- U/S, x-ray																					
4.	Pre-operative anesthesia evaluation conducted ■ Evaluation form used and completed																					
5.	Informed consent taken ■ Informed about clinical condition, treatment plan, and possible outcome ■ Explanation of the procedure, risks and benefits ■ Alternative treatments and the risks and benefits of doing ■ Patient and / or attendant's informed about clinical condition, surgical finding and prognosis																					
6.	Safety checklist attached and completed ■ attached ■ completed																					

Intra-operative																					
7.	Intra-operative anesthesia care assessment completed ■ Anesthesia sheet attached ■ Anesthesia sheet Completed																				
8.	OR note completed ■ Date & time of procedure ■ Name of operating professional, assistant professional & anesthetist ■ Name of the procedure, with the incision made ■ Operative diagnosis and the findings ■ Complication & any additional procedures performed ■ Detailed of closure techniques, estimated blood loss ■ Antibiotics ■ Detailed post-operative care instructions																				

Post-operative																					
9.	Post-anesthesia care assessment done																				
10.	Post-operation order given																				
13.	Progress note completed																				
14.	Discharge summary completeness assessment ■ Counseling on behavioral adjustment ■ Counseling on dietary modification ■ Counseling on medication adherence ■ Counseling on wound care ■ Counseling on physical activity ■ Follow-up appointment																				
	Grand Total																				
	Average (%)																				

Clinical Care Audit Tool: Emergency Services

Facility name	
Audit topic	Chart audit for Emergency care
Objective	Ensure patients with emergency conditions receive appropriate care according to up-to-date National clinical protocols(EPHCG)
Period of Audit	
Exclusion criteria (where applicable)	

If all are completed give '1' if not give '0'

S.N.	Measurement criteria	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	Chart 6	Chart 7	Chart 8	Chart 9	Chart 10	Chart 11	Chart 12	Chart 13	Chart 14	Chart 15	Chart 16	Chart 17	Chart 18	Chart 19	Total/ Average
1.	Demographic and identification information recorded ■ Name ■ Age ■ Sex ■ Address ■ Date of visit ■ MRN																				
2.	V/S(BP,PR, RR and T) recorded																				
3.	Patient triaged at emergency room by a completed triage form																				

4.	**Airway** assessed as per the PHCG ■ snoring, ■ gurgling, ■ noisy breathing																				
5.	If air way obstructed, managed as per the PHCG ■ applied appropriate maneuver, head tilt ■ chin-lift ■ jaw-thrust																				
6.	**Breathing** assessed as per the PHCG **check** ■ Saturation/capillary refill/ ■ distant breath sounds, ■ difficulty of breathing																				
7.	If difficulty of breathing was detected, it is managed as per the PHCG ■ Ventilation with bag, ■ valve mask, ■ oxygen administration																				

8.	**Circulation** assessed as per the PHCG ■ Pulse rate ■ blood pressure																				
9.	If abnormality in circulation is detected, it is managed as per the PHCG ■ IV access and fluid resuscitation, ■ Bleeding control mechanism applied																				
10.	Disability is assessed ■ Level of consciousness assessed as per the PHCG Glasgow. Coma.Score documented). ■ **AVPU** (Alert,Verbal, Pinch pain, unconscious)																				
11.	Unconscious patient assessed as per the PHCG ■ Pupillary size reaction, ■ temperature ■ blood glucose level																				
12.	Unconscious patient managed according to PHCG.																				
13.	Appropriate lab investigation done and documented (RBS, Blood Film)																				

14.	Frequent Vital sign monitored as per the PHCG Temperature , Pulse rate ■ Respiratory rate ■ Blood pressure ■ Pain																				
15.	Additional and pertinent patient history was taken.																				
16.	Additional appropriate physical examination was conducted and finding was documented.																				
17.	The final diagnosis is clearly and visibly recorded.																				
18.	Appropriate treatment or management plan as per the guideline (EPHCG).																				
11.	Appropriate prescription prescribed as per the PHCG dose, ■ dosage form ■ regimen, ■ treatment duration ■ route																				

12.	If the patient referred to the next level facility, referral form with complete information is attached in the patient chart ■ receiving institution name, ■ Patient personal information, ■ Diagnosis ■ lab investigation result ■ Treatment given, ■ Reason for Referral ■ Referring person name and signature)																				
21.	The patient given a proper appointment																				
22.	Discharge advises ■ Physical activity, ■ Diet, ■ Wound care																				
23.	If patient died, specific cause of death identified and recorded																				
	Grand Total																				
	Average (%)																				

Annex

Annex 1 - List of Contributors

Name	Institution
Area Of Contribution- Clinical Audit Guide	
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Area Of Contribution- NCD Audit Tool	
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Area Of Contribution- Audit Tool Piloting	
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Mr. Solomon Mamo	Semen Health Center
Mr. Cheru Demissse	Semen Health Center
Mrs. Lemlem Tesfaye	Semen Health Center

Annex 2 - Clinical Audit Proposal Template

Department _____

Audit Lead _____

Position _____ **Tel** _____

E-mail Address:_____

New audit: ☐

Re-audit: ☐

Uses MoH developed audit criteria(if audit topic is national priority)

Evidence Base/Reference standards used to develop criteria (for audit topics out of national priority)_____

Audit Title:_____

Aim_____

Objectives:_____

_____

_____

Why are you proposing to conduct this audit? How is the topic chosen or prioritized

What standards will you be auditing against? Please attach a copy of the relevant standard(s) to the submission

Is this a re-audit?

Yes ☐ No ☐

If Yes, have previous audit's actions been implemented?

Audit Start Date... (Dd/mm/yy) .....

Data collection to be completed by (Dd/mm/yy).....

Planned presentation at QIT Meeting date (Dd/mm/yy).....

Planned presentation and quality committee Meeting date (Dd/mm/yy).....

Audit completion date (not including any action plan dates) (Dd/mm/yy).....

Audit sample size: _____

Time period to be assessed: From: _____ To: _____

Describe the audit tool you intend to use? Please attach a copy of the audit tool to the submission

Public and Patient Involvement

Applicable: ☐ Not applicable: ☐

If applicable indicate the patient group to whom the audit standards apply to:_____

Please indicate how patients and/or relatives/caregivers are to be involved in the audit:

Identification of audit topic ☐ Review/Dissemination of results ☐

Audit design ☐ Assistance with carrying out the audit ☐

Input into Action Plan ☐ Evaluation of audit findings ☐

If this audit affects anyone outside your specialty/department, please list those affected below and attach all relevant supporting correspondence.

INTERNAL (within the facility)	EXTERNAL (outside the facility)

Multi-disciplinary audit team/stakeholders (All participants must be listed)			
Name	Job title	Team/division	Telephone and email

Confidentiality: The use of clinical audit data should follow . code of practice for undertaking scientific research or studies using patient's information. Yes ☐

Resource Implications

Please indicate below the assistance you require from the QI unit

- Assistance with audit topic prioritization
- Assistance with development of criteria
- Assistance with capacity building of QIT members
- Assistance with data analysis relevant to the clinical audit
- Assistance with problem prioritization for intervention
- Assistance with designing interventions

Please tick (maybe more than one)

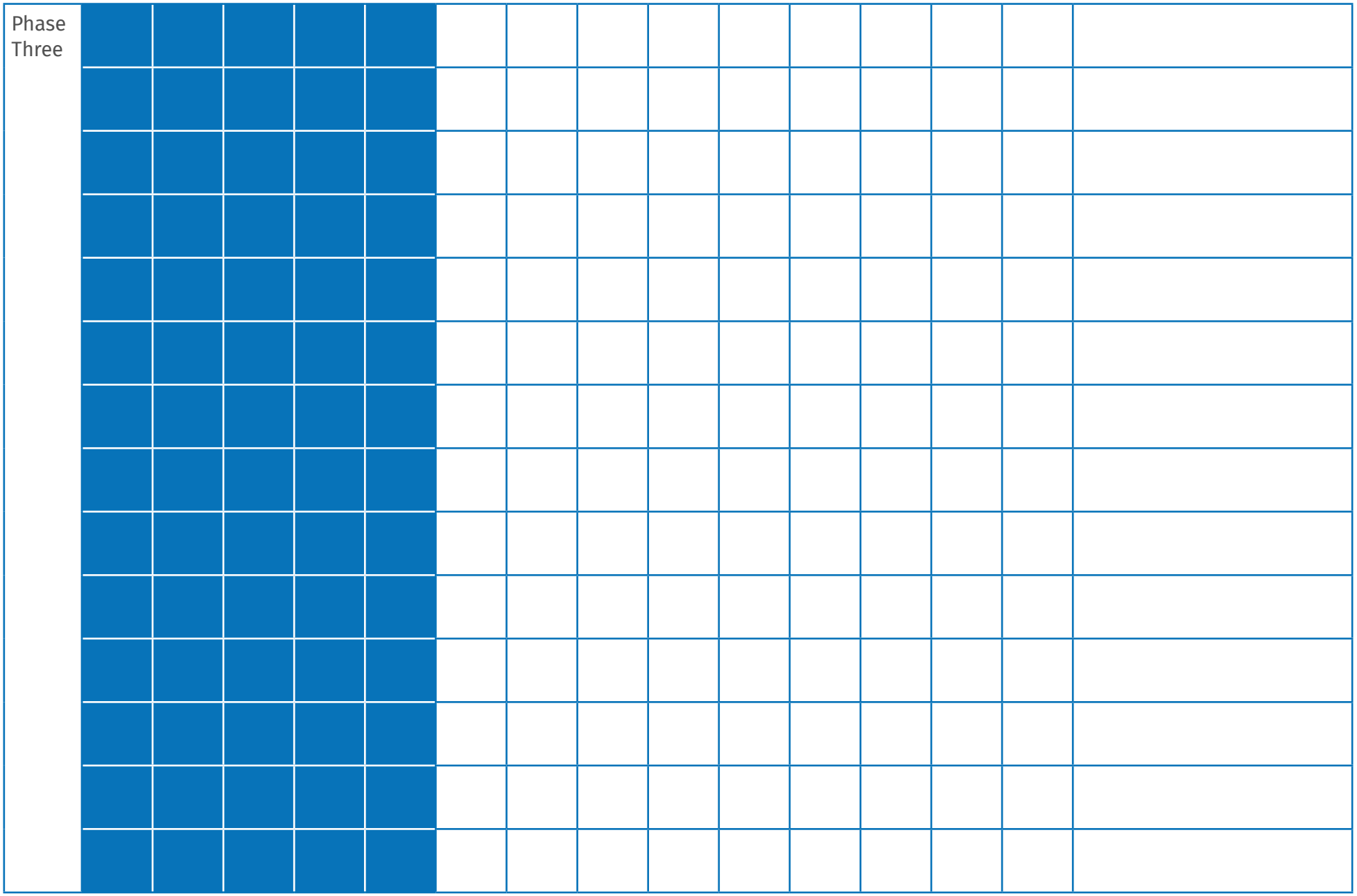
Is this audit linked to a risk to the facility, patient, staff, or visitor	Yes ☐	No ☐
Is this audit a result of a previous or potential complaint	Yes ☐	No ☐
Is the audit linked to high mortality and/or morbidity	Yes ☐	No ☐
Does the audit have a resource implication	Yes ☐	No ☐

Please tick if this audit links to any /all Outcomes as below(maybe more than one) Domain 1. Preventing people from dying prematurely Domain 2. Enhancing quality of life for people with long term conditions Domain 3. Helping people to recover from episodes of ill health or following injury Domain 4. Ensuring that people have a positive experience of care. Domain 5. Treating and caring for people in a safe environment and protecting them. them from avoidable harm
The departmental head must sign below confirming that the Head of Department is aware of, and supports this audit proposal. SIGNED: _____ PRINT NAME: _____Date_____

Annex 3 - Clinical Audit Registration And Monitoring Template

T-On track, D- Delayed, C- completed, A-Abandoned

Date audit proposal submitted														
Expected date of audit completion														
Audit Status (T, D, C, A)														
Audit lead														
	wk1	wk 2	wk 3	wk4	wk5	wk 6	wk 7	wk8	wk9	wk10	wk11	wk12	wk13	wk14	Support provided by the QI focal
Phase One															
Phase Two															


Phase
Three

Annex 4: Clinical Audit Finding Reporting Template

Title of the audit		
Date of report		
Department/specialty		Re audit date
Audit lead	Name	Job title
Key stakeholders	Names	Department
Background & aim: Say why the audit was done. Perhaps a problem had been identified? Statement of what the project is trying to achieve:		

Standard	
Methodology: State ■ Chosen population ■ How to sample selected ■ Retrospective or prospective ■ Sample size ■ Describe tool used	
Results: (State the results. Start with total number (n=)) Data may be presented visually (graphs, tables)	

Conclusion: (List key points that flow from results)	
Recommendation: (bullet point prioritiezed problems and change ideas/ interventions to be tested)	

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MINISTRY OF HEALTH-ETHIOPIA
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unicef

Health Center Clinical Audit Guide And Tools

November 2021