



# Supervisor's Checklist for Inpatient Care

Health Facility: \_\_\_\_\_

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

Name Supervisor: \_\_\_\_\_

Adapted from WHO, 2002. *Training Course on the Management of Severe Malnutrition*. Geneva: WHO.

MONITORING	OBSERVE:	YES	NO	COMMENTS
<b>FOOD PREPARATIONS</b>	Are ingredients for the recipe available?			
	Is the correct recipe used for the ingredients that are available?			
	Are ingredients stored appropriately and discarded at appropriate times?			
	Are containers and utensils kept clean?			
	Do kitchen staff (and those preparing feeds) wash their hands with soap before preparing food?			
	Are the recipes for F-75 and F-100 followed exactly? (If changes are made due to lack of ingredients, are these changes appropriate?)			
	Are measurements made exactly with proper measuring utensils (e.g., correct scoops)?			
	Are ingredients thoroughly mixed (and cooked, if necessary)?			
	Is the appropriate amount of oil remixed in (i.e., not left stuck in the measuring container)?			
	Is CMV mix added correctly?			
	Is correct amount of water added to make up a litre of formula with the recipe? (Staff should <i>not</i> add a litre of cooled boiled water, but just enough to make a litre of formula.) Is correct amount of water added to make formula with the commercial packages? (Staff should add the package to one or two litres of cooled boiled water. Staff should verify the instructions on the package.)			
	Is food served at an appropriate temperature?			
	Is the food consistently mixed when served (i.e., oil is mixed in, not separated)?			
	Are correct amounts put in the dish for each child?			
	Is leftover prepared food discarded promptly?			
Other				
<b>WARD PROCEDURES: FEEDING</b>	Are correct feeds served in correct amounts?			
	Are feeds given at the prescribed times, even on nights and weekends?			
	Are children held and encouraged to eat (never left alone to feed)?			
	Are children fed with a cup and saucer (never a bottle)?			
	Is food intake (and any vomiting/diarrhoea) recorded correctly after each feed?			
	Are leftovers recorded accurately?			
	Are amounts of F-75 kept the same throughout the initial phase, even if weight is lost?			
	Is RUTF appetite tested as soon as appetite returns and medical complications are resolving, and is RUTF offered in the transition phase?			
	Is RUTF administered correctly?			
	Is drinking water provided with RUTF intake?			
Is child consuming 75% or more of the required daily intake of RUTF before referral to Outpatient Care?				

<b>MONITORING</b>	<b>OBSERVE:</b>	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
	For cases who remain in Inpatient Care on F-100 in rehabilitation phase, are amounts of F-100 given freely and increased as the child gains weight?			
<b>WARD PROCEDURES: WARMING</b>	Is the room kept between 25° C and 30° C (to the extent possible)?			
	Are blankets provided and children kept covered at night?			
	Are safe measures used for re-warming children?			
	Are temperatures taken and recorded correctly?			
<b>WARD PROCEDURES: WEIGHING</b>	Are scales functioning correctly?			
	Are scales standardised weekly?			
	Are children weighed at about the same time each day, 1 hour before or after a feed (to the extent possible)?			
	Do staff adjust the scale to zero before weighing?			
	Are children consistently weighed without clothes?			
	Do staff correctly read weight to the correct degree of precision?			
	Do staff immediately record weights on the child's Inpatient Management Record?			
	Are weights correctly plotted on the Weight Chart?			
<b>WARD PROCEDURES: GIVING ANTIBIOTICS AND OTHER MEDICATIONS AND SUPPLEMENTS</b>	Are antibiotics given as prescribed (correct dose[s] at correct time[s])?			
	When antibiotics are given, do staff immediately make a notation on the Inpatient Management Record?			
	Is folic acid given daily and recorded on the Inpatient Management Record?			
	Is vitamin A given according to schedule?			
	For children who are on F-100 for 2 days, is the correct dose of iron given daily and recorded on the Inpatient Management Record?			
<b>WARD PROCEDURES: WARD ENVIRONMENT</b>	Are surroundings welcoming and cheerful?			
	Are mothers/caregivers offered a place to sit and sleep?			
	Are mothers/caregivers taught/encouraged to be involved in care?			
	Are staff consistently courteous?			
	As children recover, are they stimulated and encouraged to move and play?			
<b>HYGIENE: HAND-WASHING</b>	Are there working hand-washing facilities in the ward?			
	Do staff consistently wash their hands thoroughly with soap?			
	Are their nails clean?			
	Do they wash their hands before handling food?			
	Do they wash their hands between patient visits?			
<b>HYGIENE: MOTHERS'/ CAREGIVERS' CLEANLINESS</b>	Do mothers/caregivers have a place to bathe, and do they use it?			
	Do mothers/caregivers wash their hands with soap after using the toilet or changing nappies (diapers)?			
	Do mothers/caregivers wash their hands before feeding children?			

<b>MONITORING</b>	<b>OBSERVE:</b>	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
<b>HYGIENE: BEDDING AND LAUNDRY</b>	Is bedding changed every day or when soiled/wet?			
	Are nappies, soiled towels and rags, etc. stored in bag, then washed or disposed of properly?			
	Is there a place for mothers/caregivers to do laundry?			
	Is laundry done in hot water?			
<b>HYGIENE: GENERAL MAINTENANCE</b>	Are floors swept?			
	Is trash disposed of properly?			
	Is the ward kept as free as possible of insects and rodents?			
<b>HYGIENE: FOOD STORAGE</b>	Are ingredients and food kept covered and stored at the proper temperature?			
	Are leftovers discarded?			
	Is all therapeutic food stored in a hygienic manner?			
<b>HYGIENE: DISHWASHING</b>	Are dishes washed after each meal?			
	Are they washed in hot water with soap?			
<b>HYGIENE: TOYS</b>	Are toys washable?			
	Are toys washed regularly, and after each child uses them?			





## Inpatient Care Quality Improvement Checklist

Step  (Hospital)	Current Status  (What do we know)	Changes to be introduced  (New things we must do)	Who will organise changes?		New resources needed	Who will organise resources?	
			Who?	When?		Who?	When?
<p><b>Malnourished children need care that is <u>different</u> from the care provided to other children.</b></p> <p>Prioritise severe wasting or oedema in the outpatient department (OPD) queue.</p> <p>Have a separate room or corner for SAM.</p>							
<b>Step 1. Prevent or treat hypoglycaemia</b>							
<p><b>PREVENT</b></p> <p>Admit quickly from OPD to the ward.</p> <p>Feed straightaway.</p> <p>Feed every 2 hours day and night. Feed on time.</p> <p>Staff know warning signs:            - low temperature            - lethargy, limpness, loss of consciousness, drowsy            - retraction of eyelids</p>							
<p><b>TREAT</b></p> <p><u>If hypoglycaemic,</u>            - give bolus 10% glucose or sucrose solution.            - feed straightaway</p> <p><u>If unconscious,</u>            - give bolus 10% sterile glucose IV</p>							
<b>Step 2. Prevent or treat hypothermia</b>							
<p><b>PREVENT</b></p> <p>Feed straightaway</p> <p>Feed every 2 hours day and night. Feed on time.</p> <p>Keep child warm: Use kangaroo technique; cover with a blanket</p> <p>Keep room warm:            use heater, exclude draughts</p> <p>Change wet clothes and bedding; Have 24-hour linen supply</p>							
<p><b>TREAT</b></p> <p>Feed straightaway .</p> <p>Re-warm with heater or lamp or kangaroo method.</p> <p>Feed 2-hourly.</p>							

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<b>Step 3. Prevent or treat dehydration</b>							
<b>PREVENT</b>							
Give ReSoMal after each watery stool, orally.							
Staff know:							
- how to prepare ReSoMal							
- how much to give and how often							
- how to record volume given, and time.							
Staff know warning signs of over-hydration.							
<b>TREAT</b>							
Give ReSoMal 5ml/kg every 30 minutes for 2 hours orally, except if in shock.							
Monitor pulse and respirations at least hourly during oral rehydration.							
Stop ReSoMal when there are signs of hydration. Staff know signs of dehydration, hydration and over-hydration.							
<i>If in shock:</i>							
- give oxygen							
- give 10% glucose by IV							
- give IV fluids							
- keep child warm							
- monitor pulse and respirations every 5–10 min.							
- give antibiotics							
<b>Step 4. Correct electrolyte imbalance</b>							
<b>PREVENT</b>							
Give F75 (and rehydrate with ReSoMal) in stabilisation phase as these are low in sodium and contain adequate amounts of micronutrients.							
Do not give diuretics for oedema.							
<b>TREAT</b>							
Give F75 (and rehydrate with ReSoMal) in stabilisation phase as these are low in sodium and contain adequate amounts of micronutrients.							
If clinical signs of hypokalemia: give extra potassium.							
If clinical signs of hypomagnesium: give extra magnesium.							

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<b>Step 5. Prevent or treat infections and infestations</b>							
<b>PREVENT</b>							
Keep children with SAM in a separate ward.							
Reduce overcrowding							
Provide good nursing care and prevent cross infections: ➤ Give drugs in time. ➤ Monitor vital signs. ➤ Wash hands before preparing feeds, after use of bathroom, after change of nappies, before and after handling the child. ➤ Ensure good hygiene in the ward; Discard left over of feeds.							
Give first-line antibiotics, even if no clinical signs.							
Give antihelminth after one week in treatment to children > 1 year.							
Give measles vaccine to unimmunised children >6 months old.							
Protect broken skin, use for example paraffin gauze, and bandage hands if scratching.							
<b>TREAT</b>							
Give Antibiotic.							
Know when to give first line antibiotic if SAM without medical complications, and first-line, second-line, third-line antibiotic if SAM with medical complications, and correct dose.							
Give antibiotics on time.							
Give antihelminth immediately in case of severe parasitic worm infestation.							
Treat other infections and infestations according to the national IMNCI protocol.							
Give paracetamol in case of high fever.							

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<b>Step 6. Correct micronutrient deficiencies</b>							
Give vitamin A after 4 weeks or upon discharge.							
Give folic acid, single dose on day 1.							
Give iron sulphate after 2 days in transition phase and only when on F-100.							
Staff know that vitamin A, folic acid, zinc and copper are already in the commercial therapeutic foods, or in the locally prepared foods when CMV is being used.							
<b>Step 7. Start cautious feeding</b>							
<b>Stabilisation phase:</b>							
Give F-75 therapeutic milk 130 ml/kg/day and divide into 2- to 3-hourly feeds.							
If the child has severe oedema (+++), reduce the volume to 100 ml/kg/day.							
Give 2-hourly feeds in the first 24 hours, then change to 3-hourly feeds according to the condition of the child.							
If the child has poor appetite, encourage the mother to support the child finishing the feed.							
Use an NGT, if the child takes < 80% of the amount offered for two consecutive feeds.							
Keep a 24-Hour Food Intake Chart for each child. Measure feeds carefully.							
If the child is breastfed, always offer breastfeeding before giving F-75.							
Weigh daily and plot weight.							
When appetite returns, move the child to transition phase.							
<b>Transition phase:</b>							
<i>Introduce RUTF:</i> Test the appetite with RUTF. Offer plenty of clean water to drink. If the child takes the RUTF (passes the appetite test), continue all feeds with RUTF, based on 150 kcal/kg/day. Complete the feed with F-100 if necessary. If the child does not take RUTF, give F-100 but repeat the appetite test at every feed.							

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<p><i>If RUTF is not available:</i> Continue feeding the child with F-100 130-150 ml/kg/day and divide in 5-6 hourly feeds. If the child is breastfed, encourage continued breastfeeding. Weigh daily and plot weight. (The child should not gain more than 5 g/kg/day.)</p>							
<p>Observe the child for 24 hours to ensure he/she is able to eat the daily amount of RUTF, and refer the child to Outpatient Care for continuing treatment if the child is clinically well and alert and the oedema is reducing and the medical complication resolving.</p>							
<b>Step 8. Increase feeding to recover weight: "Catch-up growth" (for the exceptional cases who stay in Inpatient Care for rehabilitation)</b>							
<p>Give RUTF in correct amounts. Offer plenty of water to drink.</p>							
<p>If RUTF is not available, continue free feeding on F-100 150-220 ml/kg/day. Offer extra amounts of F-100, if the child finishes the amount prescribed.</p>							
<p>If the child is breastfed, encourage continued breastfeeding.</p>							
<p>Weigh daily and plot weight. (The child should start gaining weight, i.e., more than 10 g/kg/day).</p>							
<p>Gradually introduce home foods after the child reaches the discharge criteria.</p>							
<b>Step 9. Stimulate emotional and sensorial development</b>							
<p>Provide tender loving care.</p>							
<p>Help and encourage mothers to comfort, feed and play with their children.</p>							
<p>Give structured play when the child is well enough, that improve development</p>							
<b>Step 10. Prepare for referral and follow-up in Outpatient Care</b>							
<p>Fill in the Outcome page of the Inpatient Management Record.</p>							
<p>Inform the mother of the closest Outpatient Care site to her home and give the mother a weekly ration of RUTF to continue treatment at home.</p>							
<p>Send for immunisation update.</p>							
<p>Establish a link with community health workers for home follow-up in Outpatient Care.</p>							
<p>Write a clinical summary on the referral form for the health care providers in Outpatient Care.</p>							

