Southern California Patient Safety Collaborative
Fast Facts

Patient Safety First...
a California Partnership for Health

April 7th, 2011—Track III: Perinatal Safety

How National and International Evidence Define Sate Practice in Obstetrics —Carol Curran RNC, MS, OGNP, President, Clinical Specialists Consulting, Inc.

- OB Centers of Excellence have a culture of offensive rather than defensive practice standards, placing the primary focus on increasing quality and safety instead of (as was historically common) on decreasing risk. Including a proactive and non-punitive evaluation of "near misses" is key.
- Managerial components of OB Centers of Excellence include a participative management style, innovative incentives, dedicated systems/process improvement teams to implement revised practices, and simplified/standardized communications.
- To become an OB Center of Excellence, consider a 4 phase approach; Research and Development (select best practices and integrate them into P&Ps), Education (multidisciplinary education including competency evaluation), Rollout and Review (progressive site implementation with a data collection and analysis plan) and Maintenance (including outcomes analysis, updates and revisions as necessary).
- Review of current practice standards:
  - Decision to Incision = 30 minutes
  - 1:2 nurse/patient ratio for the Induction or Augmentation of Oxytocin
  - VBAC requires immediately available OR/OB staff – *immediate!*
  - Admission assessment complete within 24 hours
  - 2:1 nurse/patient ratio at Delivery

Disruptive and Intimidating Behavior: A Safety Issue—Larry Veltman, MD, FACOG, Collaborative Faculty Co-Chairman, Risk Management & Patient Safety Institute

- Rude and disruptive behavior has been so the "norm" that every person in the room stood when asked who had ever experienced: verbal attacks, angry outbursts, intimidation, sexual harassment, or willful non-compliance with existing clinical policies and procedures. In the literature, some 97% of nurses report the same. Sometimes the disruptive behavior is nurse to nurse, not always involving a physician
- A new culture of non-tolerance is becoming more common since clear linkages have been made between disruptive behavior, unsafe environments, and untoward events/medical errors. The rationale for the lack of "speaking up" is becoming more understood, which gives the healthcare community to ability to combat it. One helpful publication is the book "Silence Kills: Speaking Out and Saving Lives.
- The cost of lagging in this trend- maintaining a disruptive status quo, is in the $$$ millions, even for individual hospitals averaging 500 bed-size.
- Eliminating the problem in your facility will require:
  - A Zero Tolerance position supported by Administration and Medical Staff Leadership, even for highest admitters
  - Broad Based Education to all medical, nursing and ancillary staff, with clearly defined consequences
  - Revisions to Medical Staff Bylaws and Policies requiring the practice of harmonious working skills
  - A Disruptive Behavior Policy defining boundaries and options for actions to be taken/ chain of command
  - Training for Intervention, incorporating scripts, tools, techniques, focusing on the *behavior*, not on the person.

Addressing Preventable Maternal Death through the CMQCC OB Hemorrhage Collaborative—L'Tanya M. Simein-Robnett, RN, PHN, MSN, St. Francis Medical Center

- The CMQCC Collaborative focuses on improving readiness, recognition, response, and reporting of obstetric hemorrhage by establishing protocols to guide multidisciplinary training.
- Key to success is to spread assignments among the team members, sharing accountability, and enhancing the team dynamics at every juncture. Component assignments include attention to:
  - Supplies
  - Forms and documentation
  - Communication tools including quantification of ebl during delivery and recovery, and an SBAR handoff
  - P&Ps and protocols, review and revision ie: "OB Hemorrhage Protocol"
  - Education, Drills, and Audits. Ongoing drills and audits are key to success and sustained improvement.

- Typical challenges include getting the MDs to do the necessary documentation, quantifying the ebl, including the entire team in the debrief once the situation stabilizes, new blood procurement practices- consider a blood freezer in L&D

Achieving a 5% rate of <39 week elective deliveries—Rhonda Mulvehill, RN, Director Maternal/Child Services, San Antonio Community Hospital

- Effort started with presentation of the new ACOG criteria to OB Committee in 3/09, along with the NQF perinatal measures from TJC and the March of Dimes campaign information about the last weeks of pregnancy, championed by our Perinatologist. With the Department meeting only every other month, discussion ensued until 11/09, and "kickoff" followed in 1/10 with education to all OBMDs, Pediatricians, and their office staffs. The Office Staff breakfast meeting was key
- OB staff receiving calls from offices began using the approved formula to calculate dates, rather than just taking the Office/MD word that the mother was at or beyond 39 weeks. Main reason for earlier induction seems to be family or MD convenience- wanting a certain OBMD in a group, or working around family time schedules.
    - In the interactive discussion, other hospital representatives indicated that the poster depicting brain development in the last 4 weeks has been the single most effective educational piece for the families.
    - Continued and strict adherence is key. Even the Chief of Service tried to schedule some at 38.5 or 38.6
- In the first remeasurement, the rate of elective deliveries between 37 and 39 weeks dropped from 30% to 15%, by June 2010 and dropped further to about 4% by the end of 2010.
- Recommendations for success: Engage an internal Obstetrician or Perinatologist Champion, use ACOG as a reference, encourage the Medical staff they can be trendsetters or (later) followers, be ready to negotiate to achieve initial priorities (ie: Bishop scores are not yet required, but are slated for reconsideration).

Non-Discoverable Discussion Forum —Rory Jaffe, MD, MBA, Executive Director, CHPSO

- The Genesis of Patient Safety Organizations (PSOs) was described, which began with federal legislation in 2005. CHPSO is dedicated to eliminating preventable harm and improving the quality of health care delivery in California Hospitals
- All hospital members of the California Hospital Association are invited to be CHPSO members, which requires NO new data collection, and allows the members to report, discuss, analyze, and learn from errors and near misses with the protection of non-discoverability.
- Ground rules for today's discussion were set, to include the caveat that individuals must NOT be named, and while problems and strategies can be discussed back at one's own hospital, the names of the facilities sharing information today must not be divulged.
- A lively, open, and helpful discussion ensued.

The Importance of Teams in the High Risk area of Labor and Delivery—David Marshall, C.O.O. Safer Healthcare

- In Healthcare Units where high risk is a problem, high reliability is the solution. High Reliability is all about increasing the predictability of quality and eliminating errors. A High Reliability Organization (HRO) is one that has succeeded in avoiding catastrophies in an environment where a small percentage of accidents and sentinel events is considered "normal" due to risk factors and complexity.
- Common root causes of sentinel events over the last three years have remained relatively consistent: Communication, Human Factors, Leadership, Assessment, Information Management, and the Physical Environment
- A focus on repairing breakdowns in communication and on halting the "normalization" of deviance is needed to become an HRO
- Teamwork is the key, with the members working toward the same stated goals, employing principles of crew resource management, supported by top leadership, and incorporating standardized communications and operations. Debriefing after difficult situations, near misses, or drills is also key to enhancing the learning, and improving critical systems.
- To nurture a Patient Safety Culture remember: "it is easier to ACT your way to a new way of thinking than to THINK your way to a new way of acting"!

Presentations and additional materials from this meeting are available at www.HASC.org