Southern California Patient Safety Collaborative
Fast Facts

Patient Safety First...
a California Partnership for Health

April 10, 2012–Track III: Perinatal Safety

On April 10th, 80 attendees representing 30 hospitals learned about:

Quantitative Progress- Reaching For Our Goal!

Julia Slininger, RN, BS, CPHQ, Hospital Association of Southern California

Attendees were thanked for participation and data submission. Our collaborative goal is for each hospital to reduce early elective deliveries to <= 5% of all deliveries between 37 and 38+6 weeks. 43 of our 55 hospitals have at least 2 data points. Of these 43, 15 were already meeting this goal at baseline, 27 achieved/maintained the goal at their most current data point, and 16 are not yet at goal but several have reduced the gap between baseline and goal by (a range of) 32%-97%. **In sum, 27 of 55 (49%) have met the goal, 51% to go!**

"Delivering Babies: It's Not Over When the Baby's Out!"

Larry Veltman, M.D., FACOG Risk Management & Patient Safety Institute

Attendees learned how the perinatal team, including the Obstetrician, should remain involved in the baby's care after delivery. New recommendations for age-old practices were also reviewed, ie: the cord should not be cut immediately, but only after the total placental blood volume has been transferred to the baby, taking approximately 1 minute if the baby is held slightly below the level of the delivery bed/table, or up to 3 minutes if the baby is up on the mother's chest.

Focus on the Newborn: Preventing Falls and Other Misadventures

Linda Helsley, RN, MSN, CNS, Director of Regional Newborn Services-Oregon, Providence Health & Services

Attendees learned how to assess the environment in the delivery room, and in the post partum room, to identify risks for babies to fall or be dropped. Disasters (head injuries) are rare, but do still occur. Examples include a father holding the baby in the delivery room, sitting on a low stool, who fainted and dropped the baby. Post partum beds with separate side rails (head section and foot section), can create a fall "chute" for the baby to slide from the bed to the floor when the head of the bed is upright for feeding the baby, and the mother's arms relax if she falls asleep.

OB Documentation - Knowing the Write Information

Mary Ellen Filbey, RN, BSN, JD, CPHRM, Clinical Risk Management and Patient Safety Specialist

Attendees reviewed the purpose of medical record documentation, how to keep a "team" approach" (not blaming each other or covering one's own assessment or actions to the point of implicating another), and generally include all the necessary information while avoiding increased risk of malpractice claims. Incomplete documentation regarding shoulder dystocia is one of the more common contributing factors to liability with adverse outcomes.

Changing our World- Roadmap to the Finish Line

Julia Slininger, VP, Quality & Patient Safety, HASC

The Collaborative goal was reviewed, and determined to be within reach. A video of a mother whose baby was delivered early and had a 3 week stay in NICU subsequently, summarized her experience by saying: "I wish someone had told me" (not to follow her OBMD's recommendation to schedule delivery in the 38th week). There are many things in our world that command our attention, horrible things and ridiculous things, over which have little or no power/ability to change (the front page of the Sunday LA Times dated April 1st was referenced), but we *can* stop early elective deliveries, and save babies and families from the potential for adverse outcomes. We should treat this like a campaign, with passion and purpose, and we are nearing the tipping point. Awards and rewards are planned for all teams who meet the goal by year's end.

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