

Patient Safety in Perinatal Services Varied Approach to Achieve Common Goal

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Disclosure

Heather Gocke currently serves on the Board of Directors for the National Certification Corporation, an elected position.

Objectives

- Identify top nationwide claims trends
- Name high risk themes that continually surface in perinatal liability
- Learn three strategies to raise awareness and promote patient safety in the perinatal setting
- Understand different methods to achieve a common goal

Why Perinatal Services?



Perinatal Claims

- Hospitals:
 - 5% of all claims
 - 25% - 40% of dollars
 - 2X more expensive than other departments
- Physicians:
 - 2.6 claims per career
 - NPDB: 8% of all reported claims
 - Average indemnity: \$509,280
- Hospitals and Physicians
 - 5.6 years to resolve
 - \$2.5 million - median award

PIAA Statistics

Historically	2008 Only
<ul style="list-style-type: none">• OBGYN rank #1 of all 28 specialties in indemnity paid	<ul style="list-style-type: none">• 340 paid claims in 2008 by OBGYN
<ul style="list-style-type: none">• Largest number of paid claims for any specialty (32.4%)	<ul style="list-style-type: none">• Largest Indemnity paid \$163.5 million
<ul style="list-style-type: none">• Largest OBGYN payment was 13 Million (2008)	<ul style="list-style-type: none">• 39.2% more than overall average for all physicians
	<ul style="list-style-type: none">• Average indemnity paid \$481,077
	<ul style="list-style-type: none">• PIAA Report 2009



PIAA Claims Conditions

- 1995-2008: Pregnancy and Brain Damaged Infant
- Claim of Brain Damage Infant
 - (49% of time resulted in payout)
- Brain Damaged Infant – highest average payment (\$567,236)
- Both remain leading conditions in 2008

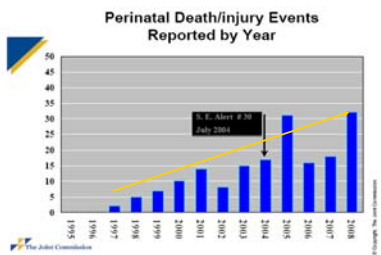


Trends and Patterns

- Communication
 - Documentation
 - Culture
- Electronic Fetal Monitoring
 - Competency
 - Interpretation Common Language
- Induction/Augmentation
 - CDC: 20% increase in 34-36 weeks gestation
 - Infant health repercussions
 - Tachysystole
 - Drug Utilization, Dosing Protocols
- Second-Stage Labor Management
 - C-Sections
 - Vacuum
 - Shoulder Dystocia



2008 Sentinel Event Statistics





TJC Recommendations

Sentinel Event Alert #30 July 2004

- Develop clear guidelines for fetal monitoring of potential high-risk patients and nursing protocols for interpretation of FHR tracings.
- Educate nurses, residents, nurse midwives and physicians to **use standardized terminology** to communicate abnormal FHR tracings



The Joint Commission Sentinel Events Statistics: 2008

2008 Top 10 Sentinel Events by Type

Event	# reviewed in 2008
Wrong-site surgery	116
Suicide	102
Delay in treatment	82
Unintended retention of foreign body**	71
Patient fall	60
Op/post-op complication	63
Medication error	46
Assault/rape/homicide	41
Perinatal death/loss of function	32
Medical equipment-related	23

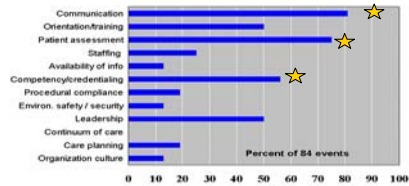
The Joint Commission

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TJC Perinatal "Stars of the Show"

Root Causes of Perinatal Deaths & Injuries (1995-2004)



JCAHO Website, 2005



The High Reliability Unit



- **Definition of a High Reliability Organization:**
 - "operate highly complex and technological systems essentially without mistakes over long periods of time."
- **Characteristics:**
 - Safety is the trademark of the organizational culture
 - *Teams function together* rather than individually
 - Team interactions are collegial rather than hierarchical
 - *Communication is highly valued*
 - *Emergencies are rehearsed* and the unexpected practiced
 - Their operations are viewed as potentially dangerous

Simpson, Knox, JHRM, 1999



Strategic Systems Approach

- Engage Leadership
 - Incentives
- Address Culture
- Create a Shared Philosophy
 - Evidenced-based
 - Common Language
 - Unit-based patient safety
- Promote Competence and Learning
 - Fetal Monitoring
 - Education Programs
- Pursue Excellence
 - Measure Progress



The Path Forward



"Let there be light" ...



- Focus on the Culture of Safety
 - Bryan Sexton, PhD
 - Safety Attitudes Questionnaire
- Scientifically validated survey instrument measures staff attitudes and behaviors
- Developed at University of Texas
- Used across the Country and abroad
- A targeted unit specific measure
- Now a Joint Commission Standard

"And there was light..."



- *An ah-ha moment!*
- What we know
 - We have a **problem**
 - Hard to change culture – the intangible
 - Data speaks volumes
 - Interim measures are needed
 - It takes time

"Let there be light..."



- 2005 Baseline Survey
- Measured caregiver attitudes in 6 domains*
 - Job satisfaction
 - **Teamwork climate**
 - **Safety climate**
 - Perception of management
 - Stress recognition
 - Working conditions
- Distributed to predetermined disciplines
- Response rate of 60% to remain statistically valid
- Scores of **80%** or higher indicate organizational safety



SAQ Focus: Climate of Safety Questions

- Medical **errors** are handled appropriately in this clinical area.
- I would **feel safe** being a treated here as a patient.
- I receive appropriate feedback about my performance.
- In this clinical area, it is **difficult to discuss errors**.
- I am encouraged by my colleagues to report any **patient safety concerns** I may have.
- The culture in this clinical area makes it **easy to learn** from the errors of others.
- I know the proper channels to direct questions regarding **patient safety** in this clinical area.



Articulate Path to Improvement

- System leadership and Board commitment
 - System wide **SMART** goal
 - Specific, Measurable, Achievable, Relevant, Time Bound
- Facility leadership buy-in
- Kickoff meeting
 - Multidisciplinary audience
 - Expert faculty answered the "Why"
 - Vision for Future
 - Toolkit (standardized policy templates)



Lay the Foundation

- Raise awareness through stories(*The Why*)
 - Videos (Josie King, Peter Pronovost)
 - Lessons from Losses
 - Event trends
 - Claims trends
 - Quality data
 - National trends
 - Interdisciplinary education



Build Trust

- Executive WalkRounds™
 - A structured approach to solicit staff observations of patient safety concerns

"How will the next patient be harmed in your area?"

"How does the environment fail you?"

"The last patient who was hurt as a result of how we delivered care - what happened?"

Many other possible questions...



Executive WalkRounds™

Format:

- Not a discussion "about your day"
- Regularly scheduled, occur monthly, accompanied by scribe
- Concerns voiced are recorded
- Information flows to unit-specific Patient Safety Team
- Accountability assigned
- Feedback mechanism
- Study trends



Team Engagement

- Perinatal Patient Safety Team
 - Formed under quality committee structure
 - Multidisciplinary:
 - Medical staff member(s)
 - All levels
 - Ancillary departments
 - Meet monthly
 - Discuss data, trends, events, EWR data
 - Share current literature
 - Ensure all policies/practice align with best demonstrated practice
 - Rapid Cycle Testing



Communication

- SBAR: Situation Background Assessment Recommendation
 - Telephone outline
 - Posters in break room
 - Paper format on charts
 - Coach and observe
- Standardized Terminology
 - Pocket cards
 - Posters in rooms: Screen shots
 - IT enhancements
 - Document review
- Education reinforced through visual cues



Competency

- Raise the Bar:
 - Assess competency
 - Reinforce common terminology
- Certification of all staff in Electronic Fetal Monitoring
 - National Certification Corporation
 - Medical staff highly encouraged
 - Residents required
 - Nurse midwives required
 - 1200+ staff sat the EFM exam (~75% passed)
 - Subspecialty certification C-EFM designation
 - Prepare with AWHONN classes
 - Certification maintenance required
 - 15 CE every 3 years in EFM



Burns, B. (2009) Continuing Competency: What's Ahead? Journal Perinatal Neonatal Nursing 23: 3 218-227.



Teamwork and Collaboration

- MedTeams ®/Team Steps
- Crew Resource Management training
 - Borne out of Dept of Defense – translated to commercial airline flight safety
 - Formal communication technique utilized in high-stakes environment
 - Teamwork focus

Sax, H. et al. Can Aviation-Based Team Training Elicit Sustainable Behavioral Change? Archives Surgery. 144:12 1133-1137.

Crew Resource Management: MedTeams®/TeamSteps

Key behaviors:

- Cross-monitoring
- Call-outs
- Check-backs
- Situational Awareness





Team Training

- Train the trainer methodology
- MD/nurse trainers returned to facilities
- 5000+ clinicians trained
- Hardwire
 - Observe, monitor, coach
 - Skills Day
 - Daily Rounds
 - Simulation*



Perinatal Safety Improvement Coalition

- Goal – Promote spread
- 15 teams: MD/CNE sponsor
- Interdisciplinary
- Monthly meetings
- Hemorrhage – Preterm Labor - NPSG
 - CMQCC
 - March of Dimes
 - Perinatologists
- Coalition served as expert group

Successes

- Culture scores increased
 - Triple those who scored 60% or higher
- Teamwork scores showed statistically significant improvement
 - Triple increase in those scoring 60% or greater
- Awareness was raised
- Momentum and commitment to pursue best practice
- Standardized processes improved reliability
- Some facilities noted documentation/practice was more defensible
- Claims payout decreased by 50% system wide

A Professional Liability Carrier's Ap



- Largest writer of malpractice coverage in CA
- Risk Retention Group
- ~100 hospitals -- ~9900 beds
- 32 perinatal units
- Over 50,000 births*
- From critical access to large academic centers
- BETA Healthcare Group Philosophy:
** Sound risk management practices improve patient safety*

*2008 BHG statistics

San Jose Mercury News

"Jury returned a \$38 million verdict against San Jose Medical Group, finding that delayed care in the delivery room led to serious brain damage for a local baby." 6/03

Los Angeles Times

November 10th, 2009

"A California University Medical Center settled a 2004 birth injury lawsuit brought by the family of a 4-year-old boy with cerebral palsy for \$6 million. The plaintiffs' attorney alleged the boy's injuries were the result of the failure by medical personnel to recognize the signs of "fetal distress" and perform a cesarean section. Plaintiff received \$1.75 million up front and another \$4 million in annuities that are expected to pay for his medical and assistive care, as well as future lost earnings. His parents waived any future wrongful death claims for \$250,000 in settlement. The total settlement is the largest amount the university has ever agreed to pay to settle a medical malpractice case."

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BETA Healthcare Group
Call to Action
"No Preventable Birth Injuries"



BETA Healthcare Group

BETA Phase I: OB Initiative

BHGH: Serious about Patient Safety!

- Risk management resource funds
- Risk assessment of perinatal services conducted at all member hospitals
- Vaginal Birth after Cesarean (VBAC) initiative
 - Required all safety measures in place or no coverage
- Introduction to web based learning and competency through APS
- Provide education and training to staff on risk management issues

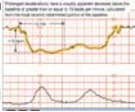
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BETA Phase II and III: OB Initiative

- Policy requiring standardized nomenclature (NICHD) and OB privileging criteria
 - OB Committee, MEC, Board approved
- NICHD nomenclature for interpretation of EFM
 - As evidenced by chart review monitored across disciplines
- Competency in EFM interpretation- AWHONN / ACOG approved course
 - Physicians, Family Practice, Residents, Allied Health, Nurses
- Multidisciplinary EFM strip review quarterly
 - Systematic process with criteria and sign-in sheets
 - 4/yr/staff member
 - Includes all disciplines
- *Members meeting all criteria will receive a contribution credit of 5%*

Adopt Standardized Nomenclature


- Purpose:
 - Communicate effectively
 - Document accordingly
- ACOG/AWHONN unite to endorse comm (July 2009)
- Out with old "hyperstimulation" and...
- In with the new "tachysystole"
- Category I, Category II, Category III defin
 - Fetal heart rate variability a big focus



Improve Competency: Online Learning

- BETA partnered with our 32 member facilities (perinatal services)
 - Covered 50% of cost of 10 perinatal modules*
- Participant in California Collaborative: APS Online Learning
- Content developed by expert faculty
- Reinforce common language
- Physicians, Family Practice, Allied Health, Nurses, Residents
- 71% participation rate – majority completed all 10 modules [4 members did not purchase]
- Modules offer CME/CEU credit

*Modules include Perinatal Safety Bundle (1-7) and Shoulder Dystocia, Operative Vaginal Delivery & SBAR-R

Monthly Multidisciplinary Strip 

- Team endeavor: Physician attendance
- Attend 4 per year
- Best Practice: Natividad Medical Center
 - At shift report
 - Nurse presents strip (with physician input)
 - Real time (improves situational awareness)
- Selection
 - Unusual (not limited to poor outcomes)
- Stimulates a culture of learning


Monthly OB Webinars 

- Lunch and Learn
- Conducted in partnership with APS
- Taught by expert faculty
- Stored on BETA Extranet for member access
- *Registration and attendance doubled during first three months!*

ARE YOU PREPARED TO MANAGE YOUR NEXT SHOULDER DYSTOCIA CASE...?



This presentation describes the mechanics and potential outcomes of shoulder dystocia and identifies recognized risk factors. In addition, common maneuvers used for delivery management will be discussed, as well as the importance of a team-based approach, documentation tools, training and drill programs.

Future Topics for OB Webinars 

Obstetrical Webinars

Worst Year OB 10

2010 Topics:


- Management of Obvious Shoulder Dystocia: Review Regimes
- Second Stage of Labor: Management & Instrumental Delivery
- Complications, Treatment and Prevention
- Obstetric Perineometry & Obstetric Bulky
- Maternal Safety in Obstetrics
- "The Top Five" Risk Management Issues in OB
- Medical Emergencies
- Resuscitating IMC and Maternal Hypertension
- Management of Post-term Labor
- Obstetrical In Progress
- Genetic Risk and Genetic Testing in Obstetrics
- Cesarean in Pregnancy
- Management of postpartum hemorrhage
- Management of postpartum infection
- Management of postpartum depression

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 BETA Healthcare Group

To complement our efforts

- Focus on Obstetrical Hemorrhage
- Adding APS module to course offerings
- Ongoing competency assessments sent monthly through email
- Toolkits developed to align with content areas
- Lessons from closed claims and near miss events

POSTPARTUM HEMORRHAGE


Every hour results a million-fold increase in postpartum hemorrhage and the health of those deaths are preventable. Postpartum hemorrhage is leading for emergency medical, but the steps we need to manage it are quite simple. The challenge is in:

- Recognizing signs
- Thinking clearly and efficiently
- Taking quick action.

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Looking Ahead! FY2011

Goal: No preventable birth injuries!



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Critical Event Team Training in Action



- Rehearse maternal fetal emergencies
- Multidisciplinary
- Utilize computerized models & videotaping
- Maintain use of pre and post procedural briefings



CETT at work

- Insert video



The future looks bright!




- Institute for Healthcare Improvement Teams
- Maintain ongoing competency
- Medication safety
- Continued partnership with members and physicians through perinatal team meetings
- Perinatal Symposium 2010
 - Celebrate achievements of our members
 - Bundles introduced






When all else fails...



Video



Questions?

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