GaPQC
GEORGIA PERINATAL QUALITY COLLABORATIVE

AIM OB Hemorrhage What's next?

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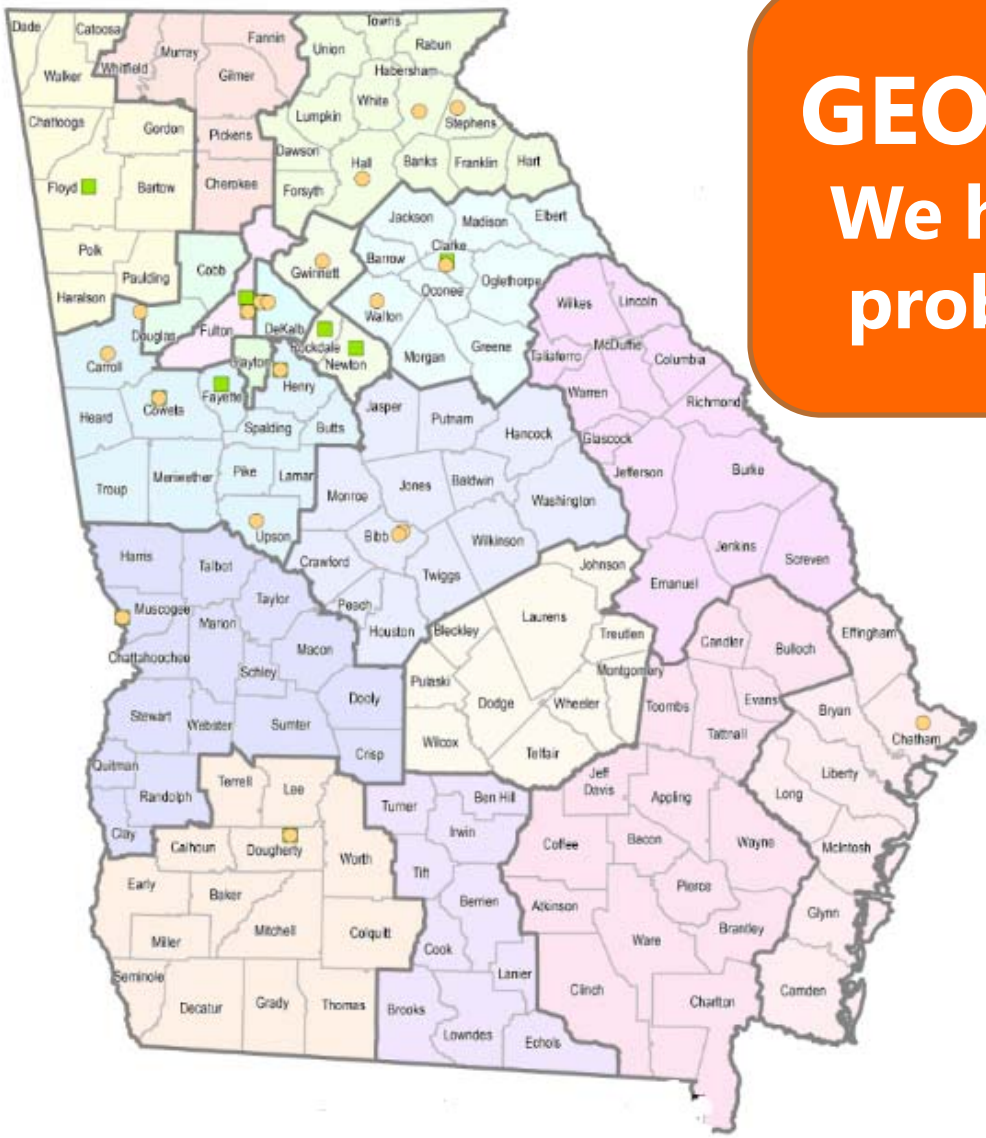
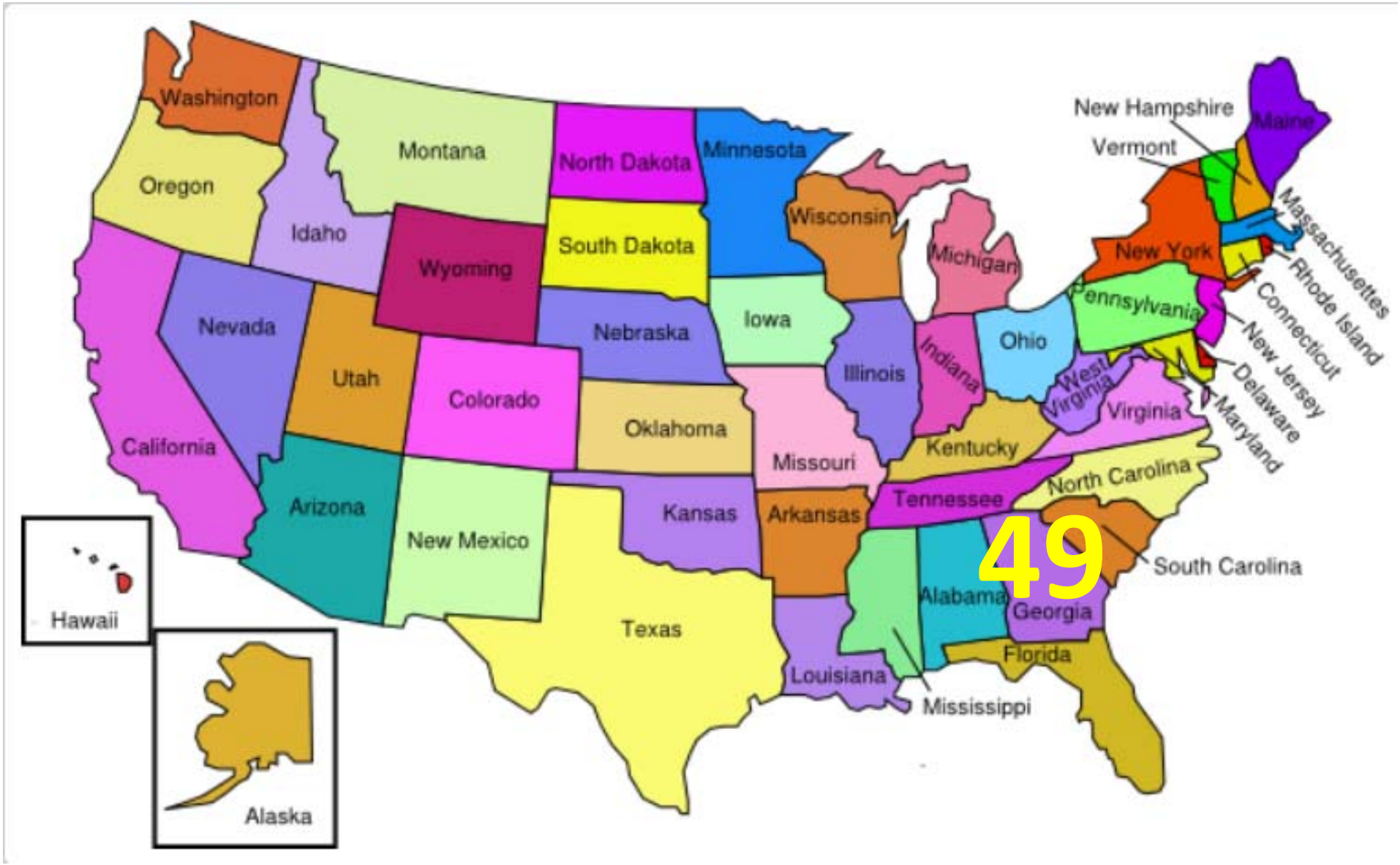
YOU ROCK!

- Innovators
- Best practice
  - Sharing practices, protocols, educational tools
- Holistic Care involvement
  - OB providers
  - RNs and allied professionals
  - Patients



GEORGIA

We have a problem!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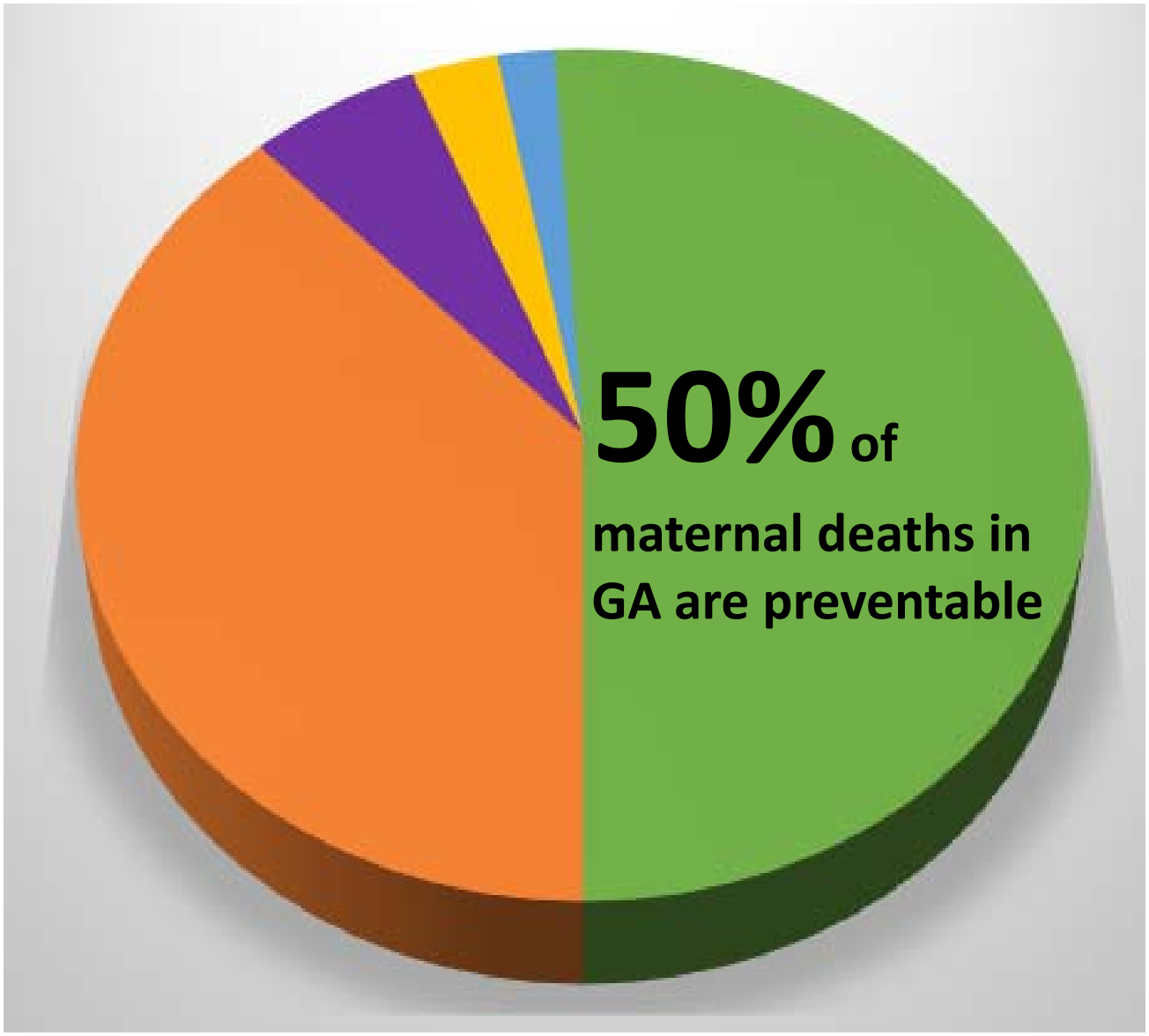
THE IMPACT OF SAFETY BUNDLES IN GA

- The maternal death rate is growing nationally, but GA is more than three times the national rate

- Maternal deaths in Georgia increased from 35 per 100,000 live births in 2013 to 57.8 per 100,000 live births in 2015

* Ref: DPH (2017). Reducing Maternal Mortality In Georgia 2013 Case Review



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WHY OBSTETRICAL HEMORRHAGE BUNDLE?

- Hemorrhage is one of the leading causes of pregnancy-related deaths in Georgia
- Experience from previous initiatives
  - Processes already in place
  - Provides opportunity to build on previous work
  - Strengthens sustainability
  - Enables L&D facilities the opportunity to share experience, knowledge and protocols

WHY OBSTETRICAL HEMORRHAGE BUNDLE?

- Narrows the scope of focus for implementation of the AIM initiative
- Provides GapQC with direction of how to best support participating hospitals, and implement any required changes for future cohorts

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

READINESS

Every unit

- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION

Every patient

- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE

Every hemorrhage

- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

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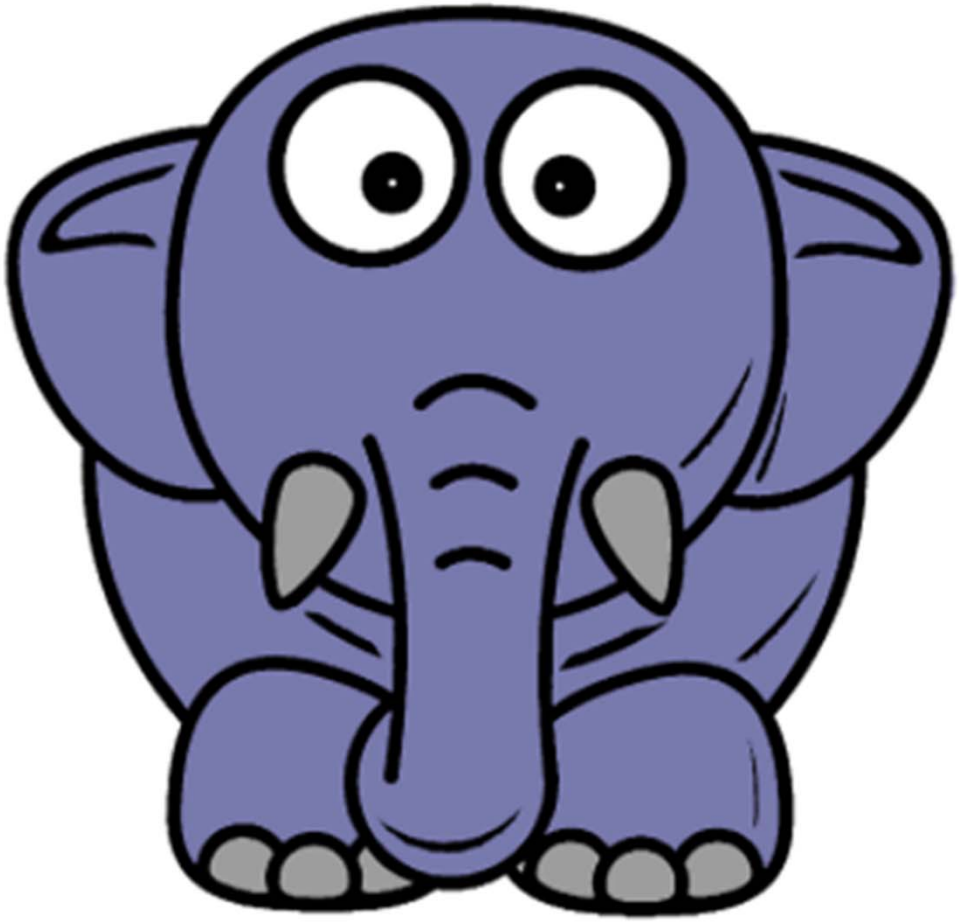
SO....HOW CAN WE DO THIS?



MOVING FROM HERE… TO THERE

- Start small - with the most important first
  - crash cart
  - hemorrhage cart
  - protocols
  - staff education
- Risk Assessments
- Maternal Early Warning System (MEWS)
- QBL, CBL practices
- Massive transfusion protocols

SUPPORT SYSTEMS

- Many facilities are already implementing several of these standards
- Standardization of processes
- Sharing/shamelessly stealing best practice
- Staff involvement
- Patient education

POSSIBLE CHALLENGES

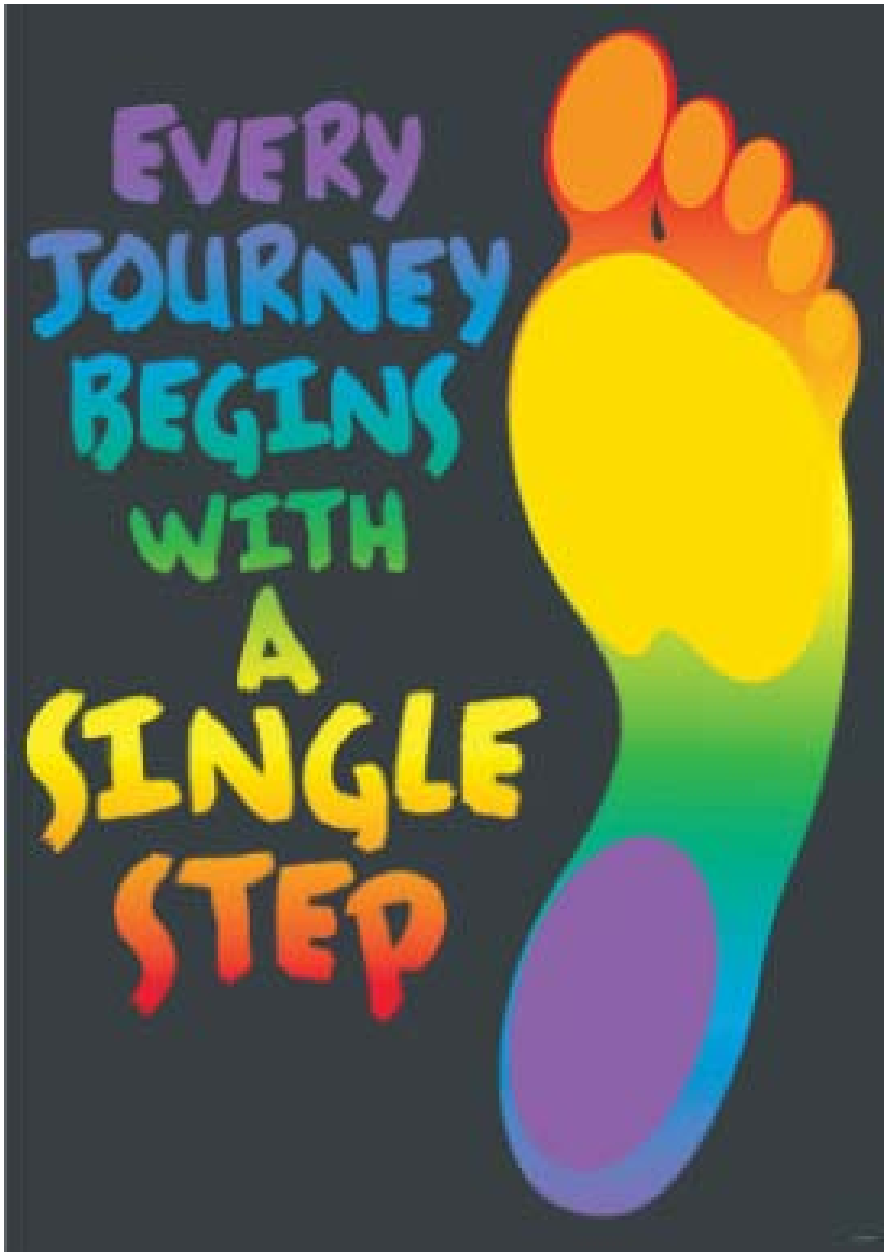
- Staff buy in
- Change processes
- Understanding what, why, how and who
- QI/Data collection
- Resources to implement
  - Human
  - Time
  - Knowledge/expertise

GaPQC SUPPORT

- Monthly “Touch Base” calls with individual hospitals
- Data analysis
- GaPQC would welcome sharing of processes and protocols sharing success stories

GaPQC SUPPORT

- Education Opportunities
  - Monthly Webinars for Learning/Collaboration
  - QI methodology training
  - Clinical support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