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!
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

50% of maternal deaths in GA are preventable

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
**READYNESS**

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
READINESS

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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
Every journey begins with a single step.