Creating Culture of Safety: Physician and Staff Buy In!

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System Clinical Nurse Specialist, Perinatal

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Provide the WHY!!

Educate

Motivate

Empower

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Standardization

- PATIENT SAFETY
- RISK REDUCTION
- SAFE CLINICAL OUTCOMES

Processes

- ORDER SETS
- PROTOCOLS
- EDUCATION, PATIENT TEACHING

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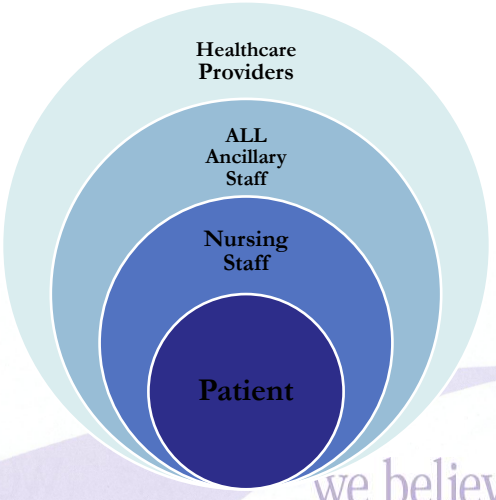
Educate!



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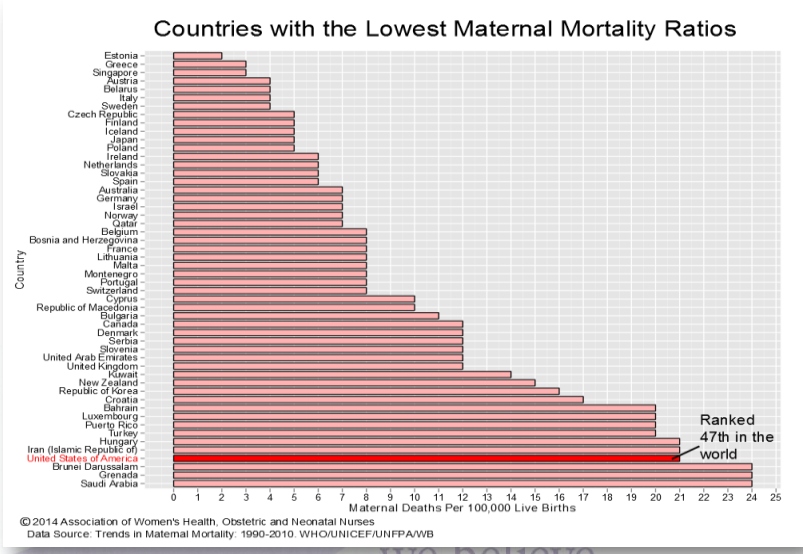

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Show

JOGNN

IN FOCUS

Maternal Death from Obstetric Hemorrhage

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Keywords
maternal mortality
maternal morbidity
obstetric hemorrhage
quality improvement
state-wide maternal mortality reviews

ABSTRACT

Obstetric hemorrhage remains the leading cause of maternal death in the United States, and 54% to 93% of these deaths may have been preventable. Leaders must honor the lives of women who die from obstetric hemorrhage by reviewing their deaths and sharing lessons learned. Shortening the current 3 to 7 year data gap will allow for timely initiation of quality improvement efforts. Designated leaders and researchers from the Association of Women's Health, Obstetric, and Neonatal Nurses are ideally positioned to lead these quality initiatives.

JOGNN, 41, 531-539; 2012. DOI: 10.1111/j.1552-6909.2012.01372.x

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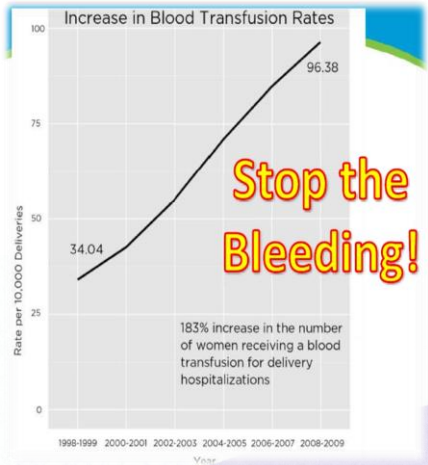
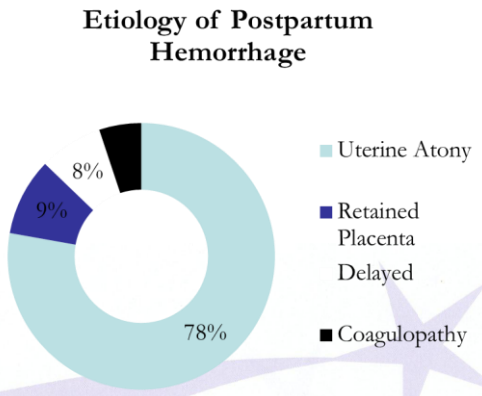
Here Lies the Problem…





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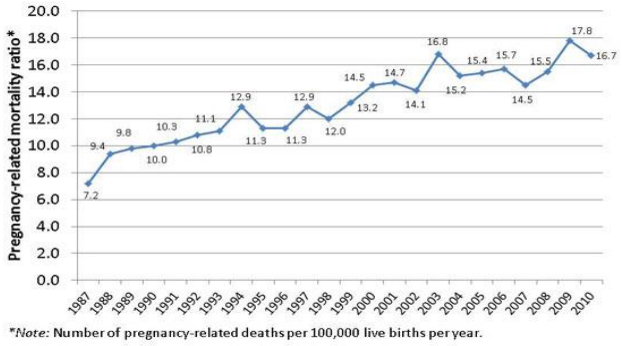
Trends in pregnancy-related mortality in the United States: 1987–2010



*Note: Number of pregnancy-related deaths per 100,000 live births per year.

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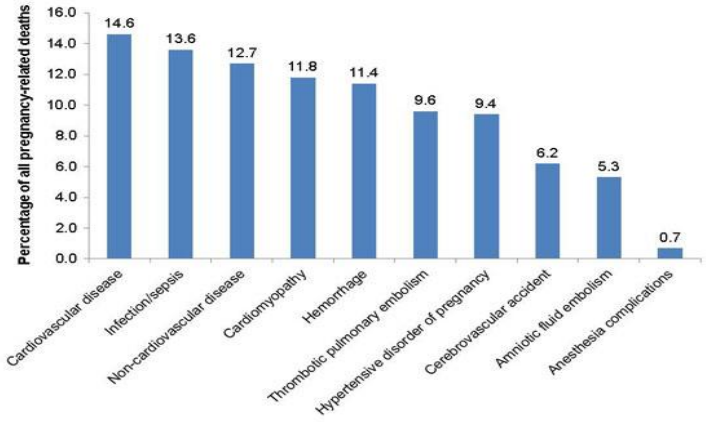
Causes of pregnancy-related death in the United States: 2006–2010



Note: The cause of death is unknown for 4.7% of all pregnancy-related deaths.

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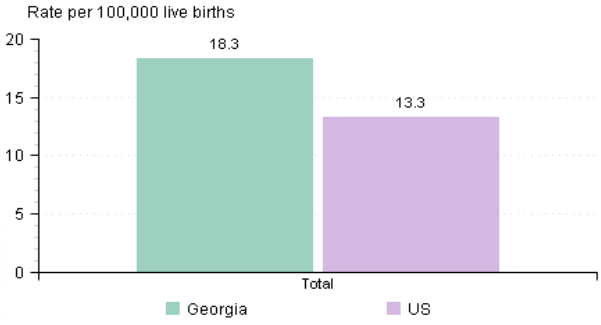
Maternal mortality rates

Georgia and US, 2003-2007 Average

- Georgia (GA) 20.5 per 100,000 Ranks 50th
- 88 Birthing Hospitals



Footnotes available in notes section.
Source: National Center for Health Statistics, final mortality data; National Center for Health Statistics, final natality data. Retrieved January 29, 2014, from www.marchofdimes.com/peristats.

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The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

AWHONN
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

The Joint Commission

Society for Maternal-Fetal Medicine

January 28, 2015

Severe Maternal Morbidity: Clarification of the New Joint Commission Sentinel Event Policy

In January 2015, the Joint Commission issued a revised definition for a sentinel event, expanding the concept for all specialties to include "a patient safety event (**not primarily related to the natural course of the patient's illness or underlying condition**) that reaches a patient and **results in any of the following: death, permanent harm, or severe temporary harm**" (1). For obstetrics, the new definition for severe temporary harm focused on severe maternal morbidity defined as receiving 4 or more units of blood products (subsequently revised to 4 or more units of RBCs) and/or ICU admission (2,3). Although this revision brought

Revised definition of a sentinel event

Severe Maternal Morbidity : receiving greater than 4 or more units of blood products and or ICU admission

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H.R. 4216

Maternal Health Accountability Act of 2014

- Pregnancy related ratio in the US as measured by CDC and Prevention Pregnancy Mortality Surveillance System
- State based maternal death reviews and maternal quality collaborative
- African-American women are 3 to 4 more likely to die
- Healthy People 2010, set a goal reducing maternal mortality and it was not met
- Near miss or severe maternal morbidity has increased by 75% and 114% for postpartum hospitalizations

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GA MMRCC 2013 cases

- The Georgia MMRC identified 32 deaths ***pregnancy-related*** . Cardiomyopathy was leading cause of pregnancy related deaths. These deaths occurred 43 to 364 days postpartum they were cardiomyopathy/cardiovascular (16%)
- Second leading cause : Hemorrhage (16%) and Embolism (16%)
  - Causes of embolism were unique to pregnancy such as: gestational diabetes, hyperemesis, liver disease of pregnancy

GA MMRC 2013 Cases

- Cardiac Disorders: Cardiomyopathy
  - Women were unaware of their risk and/or warning sings of cardiac diseases
  - Providers did not screen, educate, and or refer women at risk for cardiomyopathy
- Embolism:
  - Obese patients placed on prolonged bed rest fostering a thrombotic event
  - Lack of prophylaxis to prevent thrombosis

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GA MMRC 2013 cases

- Hemorrhage
  - Delayed recognition and treatment of hemorrhage in post-partum women by both clinicians and patients.
- Anxiety /Depression
  - Inadequate screening of pregnant and postpartum women for depression and other mental health issues.
  - Possible lack of access to mental health services
  - Potential lack of awareness by patients or providers of benefits and safety of antidepressant therapy during pregnancy and postpartum.

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National Partnership for Maternal Safety Goals

1. To reduce maternal morbidity and mortality in the US by 50%
2. To reduce racial and ethnic maternal health disparities

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"What every birthing facility in the U.S. should have..."

Obstetric Hemorrhage
Preeclampsia/ Hypertension
Prevention of VTE in Pregnancy

*Note: The bundles represent outlines of highly recommended protocols and materials important to safe care **BUT** the specific contents and protocols should be individualized to meet local capabilities.*

These bundles are being released from the Council on Patient Safety in Women's Health Care

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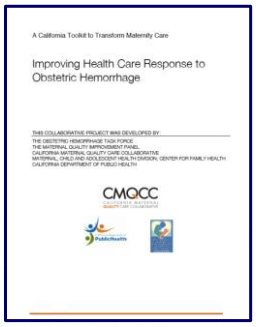
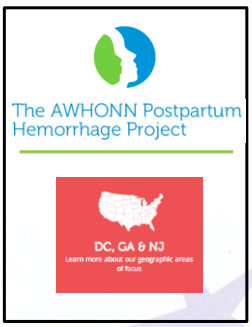
Key OB Hemorrhage QI Toolkits: Full of Resources



www.CMQCC.org
v2.0 available soon



www.pphproject.org

www.safehealthcareforeverywoman.org

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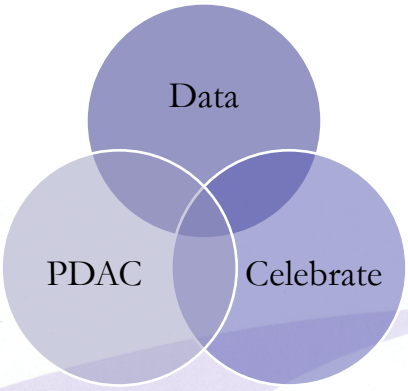
Motivate



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4 Domains: OB Hemorrhage Patient Safety Bundle

- Improve **readiness** to hemorrhage by identifying standardized protocols (general and massive)
- Improve **recognition** of OB hemorrhage by performing on-going objective quantification of actual blood loss
- Improve **response** to hemorrhage by utilizing unit-standard, stage-based, obstetric hemorrhage emergency management plans with checklists
- Improve **reporting/systems learning** of OB hemorrhage by performing regular on-site multi-professional hemorrhage drills

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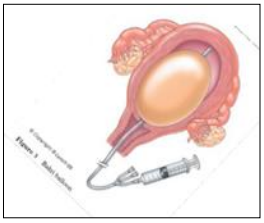
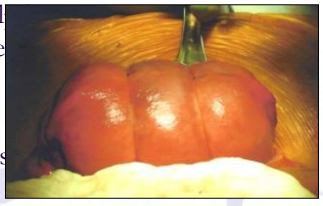
Obstetric Hemorrhage Key Elements

Readiness - Every Unit



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



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Obstetric Hemorrhage Key Elements

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Recognition - Every Patient

5. Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
6. Measurement of cumulative blood loss (formal, as quantitative as possible)
7. Active management of the 3rd stage of labor (routine use of oxytocin)

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Obstetric Hemorrhage Key Elements

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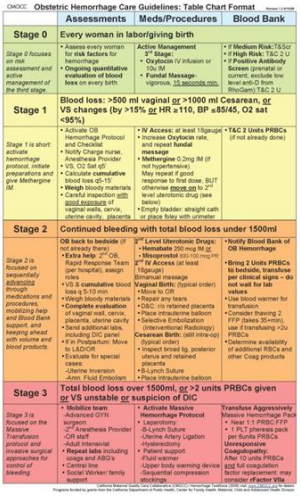
Response - Every Hemorrhage

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



CMQCC Obstetric Hemorrhage Care Guidelines: Table Chart Format

	Assessments	Meds/Procedures	Blood Bank
Stage 0	**Every woman in labor/giving birth**		
Stage 0 focuses on risk assessment and active management of the third stage.	• Assess every woman for **risk factors** for hemorrhage • **Ongoing quantitative evaluation of blood loss** on every birth	**Active Management 3rd Stage:** • **Oxytocin** IV infusion or 10u IM • **Fundal Massage**- vigorous, 15 seconds min.	• If **Medium Risk:** T&Sc/ • If **High Risk:** T&C 2 U • If **Positive Antibody Screen** (prenatal or current, exclude low level anti-D from RhoGam) T&C 2 U
Stage 1	**Blood loss: >500 ml vaginal or >1000 ml Cesarean, or VS changes (by >15% or HR ≥110, BP ≤85/45, O2 sat <95%)**		
Stage 1 is short: activate hemorrhage protocol, initiate preparations and give Methergine IM.	• Activate OB Hemorrhage Protocol and Checklist • Notify Charge nurse, Anesthesia Provider • VS, O2 Sat q5' • Calculate **cumulative** blood loss q5-15' • **Weigh** bloody materials • Careful inspection with good exposure of vaginal walls, cervix, uterine cavity, placenta	• **IV Access:** at least 18gauge • Increase **Oxytocin** rate, and repeat **fundal massage** • **Methergine** 0.2mg IM (if not hypertensive) May repeat if good response to first dose, BUT otherwise move on to 2nd level uterotonic drug (see below) • Empty bladder: straight cath or place foley with urimeter	• **T&C 2 Units PRBCs** (if not already done)
Stage 2	**Continued bleeding with total blood loss under 1500ml**		
Stage 2 is focused on sequentially advancing through medications and procedures, mobilizing help and Blood Bank support, and keeping ahead with volume and blood products.	**OB back to bedside** (if not already there) • **Extra help**: 2nd OB, Rapid Response Team (per hospital), assign roles • VS & **cumulative** blood loss q 5-10 min •Weigh bloody materials • **Complete evaluation** of vaginal wall, cervix, placenta, uterine cavity • Send additional labs, including DIC panel • If in Postpartum: Move to L&D/OR • Evaluate for special cases: -Uterine Inversion -Amn. Fluid Embolism	**2nd Level Uterotonic Drugs:** • **Hemabate** 250 mcg IM or • **Misoprostol** 800-1000 mcg PR **2nd IV Access** (at least 18gauge) Bimanual massage **Vaginal Birth:** (typical order) • Move to OR • Repair any tears • D&C, rlo retained placenta • Place intrauterine balloon • Selective Embolization (Interventional Radiology) **Cesarean Birth:** (still intra-op) (typical order) • Inspect broad lig, posterior uterus and retained placenta • B-Lynch Suture • Place intrauterine balloon	• **Notify Blood Bank of OB Hemorrhage** • **Bring 2 Units PRBCs to bedside, transfuse per clinical signs – do not wait for lab values** • Use blood warmer for transfusion • Consider thawing 2 FFP (takes 35+min), use if transfusing >2u PRBCs •Determine availability of additional RBCs and other Coag products
Stage 3	**Total blood loss over 1500ml, or >2 units PRBCs given or VS unstable or suspicion of DIC**		
Stage 3 is focused on the Massive Transfusion protocol and invasive surgical approaches for control of bleeding.	• **Mobilize team** -Advanced GYN surgeon -2nd Anesthesia Provider -OR staff -Adult Intensivist • **Repeat labs** including coags and ABG's • Central line • Social Worker/ family support	• **Activate Massive Hemorrhage Protocol** • Laparotomy: -B-Lynch Suture -Uterine Artery Ligation -Hysterectomy • Patient support -Fluid warmer -Upper body warming device -Sequential compression stockings	**Transfuse Aggressively** Massive Hemorrhage Pack • Near 1:1 PRBC:FFP • 1 PLT pheresis pack per 6units PRBCs **Unresponsive Coagulopathy:** After 10 units PRBCs and full coagulation factor replacement: may consider **rFactor VIIa**

California Maternal Quality Care Collaborative (CMQCC) Hemorrhage Taskforce (2009) Visit www.cmqcc.org for details
Programs funded by grants from the California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division

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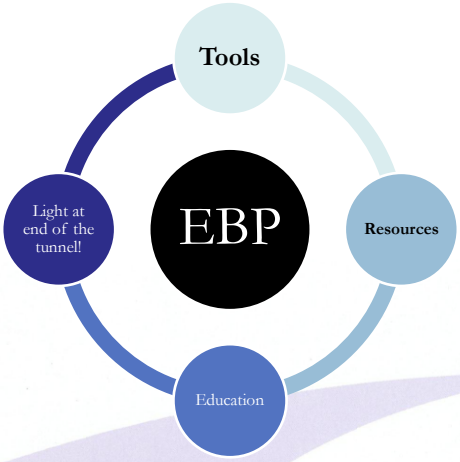
Empower!



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Use all Avenues for Buy In!

- OB department meetings
- Staff meetings
- Hospital news letters
- Signage
- Email
- Huddles
- In-services
- Impromptu

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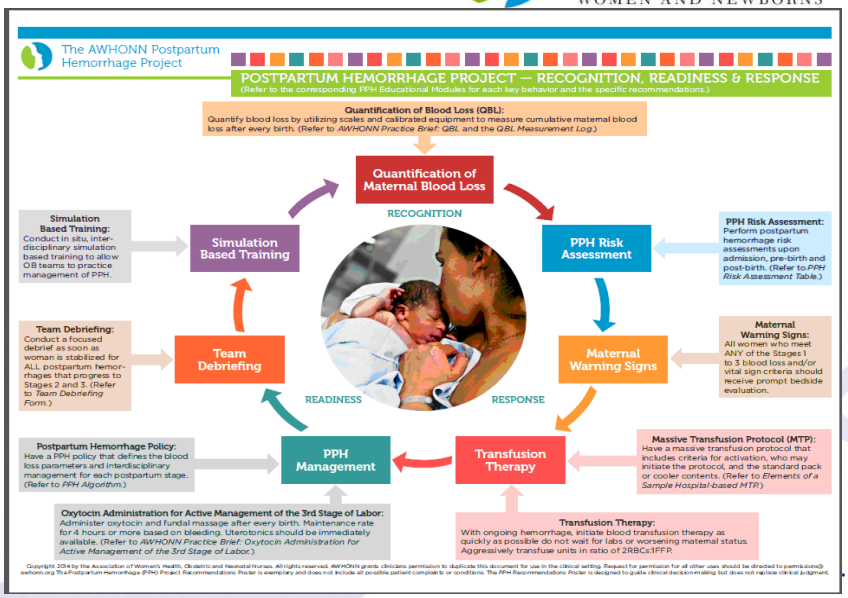

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Practice Brief Quantification of Blood Loss (QBL)


AWHONN
PRACTICE BRIEF
CLINICAL MANAGEMENT GUIDELINES FOR WOMEN'S HEALTH AND PERINATAL NURSES
NUMBER 1, MAY 2014
Quantification of Blood Loss
Recommendation:
Magnitude of the Problem
Inaccuracy of Visual Estimation of Obstetric-Related Blood Loss or Estimated Blood Loss (EBL)
Implications of Inaccurate Evaluation of Blood Loss

Suggested Equipment

- Calibrated under-buttocks drapes to measure blood loss
- Dry weight card, laminated and attached to all scales, for measurement of items that may become blood-soaked when a woman is in labor or after giving birth
- Scales to weigh blood-soaked items, ideally in every labor and operating room and on the postpartum unit; save costs by using the scales used to weigh newborns
- Formulas inserted into the electronic charting system that automatically deduct dry weights from wet weights of standard supplies such as chux and peri-pads

https://www.youtube.com/watch?v=F_ac-aCbEn0&list=UUPrOhL3Od7ZeFDq27ycS00g

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Celebrate Your WINS!!!!

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