WELCOME TO THE MONTHLY LEARNING WEBINAR

The presentation will begin shortly
General Housekeeping

• Use the chat box to register your name, facility represented and all participating team members.

• To prevent distractions, please mute all phones:
  – Please DO NOT put phones on hold to avoid playing background music we are unable to control.

• Use the chat box for questions during the presentation but please hold comments until the end of the session.

• All collaborative members want to learn from your wins and challenges so please share!
AIM Bundles

READINESS

RECOGNITION AND PREVENTION

RESPONSE

REPORTING/SYSTEMS LEARNING
AIM: Reduce SMM in women who have a hemorrhage by 20% by 12/2020.

Readiness
- Hemorrhage Cart and Immediate Access to Hemorrhage Medications
  - Establish a response team
  - Establish and maintain a massive transfusion protocol
  - Unit education on implicit bias, protocols and unit-based drills

Recognition
- Assessment of hemorrhage risk on admission to the unit
- Measurement of cumulative blood loss, as quantitative as possible
- Active management of 3rd Stage of Labor

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

Reporting/Systems Learning
- Multidisciplinary review of serious hemorrhages for systems issues
- Establish a culture of huddles for high-risk patients and post even debriefs to identify successes and opportunities
<table>
<thead>
<tr>
<th>Measure</th>
<th>Type</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Maternal Morbidity</td>
<td>Outcome</td>
<td>20% reduction</td>
</tr>
<tr>
<td>No. of women with severe maternal morbidities (e.g. Acute renal failure, ARDS, Pulmonary Edema, Puerperal CNS Disorder such as Seizure, DIC, Ventilation, Abruption) / No. pregnant &amp; postpartum women with postpartum hemorrhage diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>Process</td>
<td>100%</td>
</tr>
<tr>
<td>No. of women had a hemorrhage risk assessment with risk level assigned, performed at least once between admission and birth and shared among the team/ no. of women</td>
<td></td>
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<tr>
<td>Debriefs on all cases requiring ≥4 units RBCs or admission to the ICU</td>
<td>Process</td>
<td>100%</td>
</tr>
<tr>
<td>Quantified blood loss No. of women who had measurement of blood loss from birth through recovery period using quantitative and cumulative techniques/no. of women</td>
<td>Process</td>
<td>100%</td>
</tr>
</tbody>
</table>
## AIM Hemorrhage Structure Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Report Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1: Patient, Family &amp; Staff Support</td>
<td>Report Completion Date</td>
<td>Has your hospital developed OB specific resources and protocols to support patients, family and staff through major OB complications?</td>
</tr>
<tr>
<td>S2: Debriefs</td>
<td>Report Start Date</td>
<td>Has your hospital established a system in your hospital to perform regular formal debriefs after cases with major complications?</td>
</tr>
<tr>
<td>S3: Multidisciplinary Case Reviews</td>
<td>Report Start Date</td>
<td>Has your hospital established a process to perform multidisciplinary systems-level reviews on all cases of severe maternal morbidity (including women admitted to the ICU, receiving ≥4 units RBC transfusions, or diagnosed with a VTE)?</td>
</tr>
<tr>
<td>S4: Hemorrhage Cart</td>
<td></td>
<td>Does your hospital have OB hemorrhage supplies readily available, typically in a cart or mobile box?</td>
</tr>
<tr>
<td>S5: Unit Policy and Procedure</td>
<td>Report Completion Date</td>
<td>Does your hospital have an OB hemorrhage policy and procedure (reviewed and updated in the last 2-3 years) that provides a stage based management plan with checklists?</td>
</tr>
<tr>
<td>S6: EHR Integration</td>
<td>Report Completion Date</td>
<td>Were some of the recommended OB Hemorrhage bundle processes (i.e. order sets, tracking tools) integrated into your hospital’s Electronic Health Record system?</td>
</tr>
</tbody>
</table>
# AIM Hemorrhage Process Measures

<table>
<thead>
<tr>
<th>Process Measure</th>
<th>Description</th>
</tr>
</thead>
</table>
| **P1: Unit Drills**   | Unit Drills  
Has your hospital developed OB specific resources and protocols to support patients, family and staff through major OB complications? |
| **P2: Provider Education** | Provider Education  
The number of OB providers and CNMs that completed an educational program on OB hemorrhage?  
The number of OB providers and CNMs that completed an training on implicit bias? |
| **P3: Nursing Education** | Nursing Education  
The number of OB nurses that completed an education program on the OB Hemorrhage bundle elements and unit standard protocol?  
The number of OB nurses that completed training on implicit bias? |
| **P4: Risk Assessment** | Risk Assessment  
The number of mothers had a hemorrhage risk assessment with risk level assigned, performed at least once between admission and birth and shared among the team? |
| **P5: Quantified Blood Loss** | Measurement of Blood Loss  
The number of mothers that had measurement of blood loss from birth through the recovery period using quantitative and cumulative techniques? |
# Report Changes

<table>
<thead>
<tr>
<th>Process Measure</th>
<th>Description</th>
<th>Reporting time period (QUARTERLY)</th>
<th>COMMENTS (NOT REQUIRED)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P1:</strong> Civil Drill</td>
<td>Report # of drills and the drill topics</td>
<td>July 1, 2019-September 30, 2019</td>
<td></td>
</tr>
<tr>
<td>P1a: In this quarter, how many OB drills (in situ and/or SimLab) were performed on your unit for any maternal issue/topic?</td>
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<tr>
<td>P1b: In this quarter, what topics were covered in the OB drills? (Note: add more numbers for additional topics covered, as needed)</td>
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<tr>
<td><strong>P2:</strong> Provider Education</td>
<td>At the end of this quarter, how many OB physicians and midwives (numerator) have completed (within the last 2 years) an education program on Obstetric Hemorrhage? How many OB physicians and midwives does your hospital have (denominator)?</td>
<td>Reporting on P2c begins Quarter 1 2020 (January-March 2020)</td>
<td></td>
</tr>
<tr>
<td>P2a: Numerator:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>P2b: Denominator:</td>
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<tr>
<td>P2c: At the end of this quarter, how many OB physicians and midwives (numerator) have completed (within the last 2 years) an education program on Obstetric Hemorrhage bundle elements and the unit-standard protocol? How many OB physicians and midwives does your hospital have (denominator)?</td>
<td>Reporting on P2c begins Quarter 1 2020 (January-March 2020)</td>
<td></td>
<td></td>
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<tr>
<td>P2d: Numerator:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P2e: Denominator:</td>
<td></td>
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<tr>
<td><strong>P3:</strong> Nursing Education</td>
<td>At the end of this quarter, how many OB nurses (numerator) have completed (within the last 2 years) an education program on Obstetric Hemorrhage? How many OB nurses does your hospital have (denominator)?</td>
<td></td>
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</tr>
<tr>
<td>P3a: Numerator:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P3b: Denominator:</td>
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<td></td>
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</tr>
<tr>
<td>P3c: At the end of this quarter, how many OB nurses (numerator) have completed (within the last 2 years) an education program on Obstetric Hemorrhage bundle elements and the unit-standard protocol? How many OB nurses does your hospital have (denominator)?</td>
<td>Reporting on P3c begins Quarter 1 2020 (January-March 2020)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P3d: Numerator:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P3e: Denominator:</td>
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<tr>
<td><strong>P4:</strong> Risk Assessment</td>
<td>At the end of this quarter, how many mothers (numerator) had a hemorrhage risk assessment with risk-level assigned, performed at least once between admission and birth and shared among the team? How many mothers did you have this quarter (denominator)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P4a: Numerator:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P4b: Denominator:</td>
<td></td>
<td></td>
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<tr>
<td><strong>P5:</strong> Quantified Blood Loss</td>
<td>In this quarter, how many mothers (numerator) had measurement of blood loss from birth through the recovery period using quantitative and cumulative techniques? How many mothers did you have this quarter (denominator)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P5a: Numerator:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P5b: Denominator:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Implicit Bias Training Resources

• [https://implicit.harvard.edu/implicit/takeatest.html](https://implicit.harvard.edu/implicit/takeatest.html)

Future training opportunities:
• Cook Ross: Annual Meeting Presentation, Online Training and Train the Trainer Course
Conflict of Interest Statement

• No conflicts of interest to report
Learning Objectives

• Discuss why debriefing is beneficial for improving patient outcomes.
• Outline strategies and tactics for holding debriefs.
• Identify how to make debriefs more effective.
Definitions

• **Debriefing** is defined as:
  – Brief, informal exchange and feedback session
  – Occurs after an event
  – Designed to improve teamwork skills and outcomes
    • An accurate reconstruction of key events
    • Analysis of why the event occurred
    • What should/could be done differently next time
    • Identify systems issues to be addressed
Debriefing background

• Military
  – Individuals returning from a mission would discuss and describe their experiences in order to learn and to receive psychological support after traumatic events.

• Commercial aviation
  – Adopted Crew Resource Management in the late 1970’s as a way to change the culture from one of hierarchy to one of high reliability and increased safety.
Debriefing in Healthcare

Institute of Medicine, “To Err is Human”, 1999

Healthcare organizations looked to other industries for strategies to begin the journey to high reliability.

High reliability organizations (HROs) are those which have systems in place allowing them to consistently accomplish goals while avoiding potentially catastrophic error.
High Reliability: TeamSTEPPS

- 4 domains -
  - communication,
  - situation monitoring
  - mutual support
  - leadership

- Teams are provided tools and strategies to assist members in becoming more effective and highly functional.
- **Debriefing** is a key strategy within the leadership domain.
Characteristics of HROs

• Safety-oriented culture
• Operations are a team effort
• Communications are highly valued and rewarded
• Emergencies rehearsed and unexpected is practiced
• “Top brass” devotes appropriate resources to safety training
• Members always consider “what can go wrong.”
Principles Underlying HROs

According to Weick and Sutcliffe, the principles underlying the performance of highly reliable organizations are:

• Preoccupation with failure
• Reluctance to simplify
• Sensitivity to operations
• Commitment to resilience
• Deference to expertise

Managing the Unexpected
Weick and Sutcliffe (2007)
## Team STEPPS™

<table>
<thead>
<tr>
<th><strong>Barriers</strong></th>
<th><strong>Tools and Strategies</strong></th>
<th><strong>Outcomes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconsistency in team membership</td>
<td>Brief</td>
<td>Shared Mental Model</td>
</tr>
<tr>
<td>Lack of time</td>
<td>Huddle</td>
<td>Adaptability</td>
</tr>
<tr>
<td>Lack of information sharing</td>
<td>Debrief</td>
<td>Team Orientation</td>
</tr>
<tr>
<td>Hierarchy</td>
<td>STEP</td>
<td>Mutual trust</td>
</tr>
<tr>
<td>Defensiveness</td>
<td>I’M SAFE</td>
<td>Team performance</td>
</tr>
<tr>
<td>Conventional thinking</td>
<td>Cross monitoring</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>Complacency</td>
<td>Feedback</td>
<td></td>
</tr>
<tr>
<td>Varying communication styles</td>
<td>Advocacy and Assertion</td>
<td></td>
</tr>
<tr>
<td>Conflict</td>
<td>Two-challenge Rule</td>
<td></td>
</tr>
<tr>
<td>Lack of coordination and follow-up with coworkers</td>
<td>CUS</td>
<td></td>
</tr>
<tr>
<td>Distractions</td>
<td>DESC Script</td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>Collaboration</td>
<td></td>
</tr>
<tr>
<td>Workload</td>
<td>SBAR</td>
<td></td>
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<tr>
<td>Misinterpretation of cues</td>
<td>Call-out</td>
<td></td>
</tr>
<tr>
<td>Lack of role clarity</td>
<td>Check-back</td>
<td></td>
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<td></td>
<td>Handoff</td>
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<td></td>
<td>Task Assistance</td>
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</tbody>
</table>
Debriefing in Clinical Healthcare

- Debriefing can be a first step to identify critical areas of focus from front line team members involved in major events which can guide further review.
Debriefing Guidance & Pitfalls

**Key elements of good debriefing:**

- Empathetic, non-blaming, non-threatening
- Conversational
- Pair advocacy with inquiry

**Avoid:**

- When asking questions, do not grill.
  - “Don’t you know...?”
  - “Did it occur to you...?”
  - “Why didn’t you double check?”
  - Guess what I am thinking...
Debriefing Techniques

• Non-judgmental debriefing
  – The goal, but may not be possible
  – Want a way to create psychologic safety and be nonconfrontational and yet share constructive criticism

• Debriefing with good judgment
  – Understand the mental model that drove the participants actions
  – Adopt a debriefing stance that unites curiosity and respect
  – Speak in a way that combines advocacy and inquiry
Debriefing Techniques (cont)

• Plus-delta
  – What went well
  – What could have gone better

• “Sandwich technique”
  – What went well?
  – What could have gone better?
  – What are lessons learned for future?
  – Reiterate the positives
Debriefing in Obstetrics

• Who?
  – Entire interdisciplinary team (obstetrics, nursing, pediatrics, and anesthesia)
  – Social Work: most severe events

• What?
  – All deliveries vs. just certain trigger events

• When?
  – As close to an event as possible to maximize the potential for information gathering and identification of systems issues
  – Before documenting the event when possible

• Where?
  – Safe space where participants feel comfortable enough to express opinions and offer suggestions.

• Why?
  – To help the team identify opportunities for improvement in teamwork, skills, and outcomes.
  – Emotional well-being.

• How?
  – Trained debriefers
  – Use of a debriefing guide
Debriefing in Obstetrics-Triggers?

- **Maternal Events:**
  - Maternal Death
  - Unanticipated hysterectomy on nulliparous patient
  - Unanticipated admission to ICU

- **Neonatal Events:**
  - Unanticipated fetal/neonatal death
  - Neonatal significant injury
    (brain cooling/ neonatal code)

- Whenever a member of the team thinks it would be useful
Debriefing in Obstetrics-Tools

Debriefing in Obstetrics-Tools

Kilpatrick et al. Obstet Gynecol 2014
Start with what went well…

Identify what went well (Check if yes)

☐ Communication

☐ Role clarity (leader/supporting roles identified assigned)

☐ Teamwork

☐ Situational awareness

☐ Decision-making

☐ Other: ______________________
Opportunities for improvement:

Identify opportunities for improvement: “**human factors**”? (Check if yes)

☐ Communication

☐ Role clarity

☐ Teamwork

☐ Situational awareness

☐ Decision-making

☐ Human error

☐ Other: __________________________
Opportunities for improvement:

Identify opportunities for improvement: “systems issues”? (Check if yes)

☐ Equipment/supplies/accessibility
☐ Medications
☐ Blood products availability
☐ Inadequate support (in unit or other areas of the hospital)
☐ Delays in transporting the patient (within hospital or to another facility)
☐ Staffing
☐ Other: ______________________________
Debriefing in Obstetrics - Benefits

- Real time identification of opportunities for improvement in:
  - Teamwork
  - Knowledge/skills
  - Systems

- “Emotional debriefing”:
  - Team members feel empowered, supported and heard
  - Allows identification of potential “second victims”
Emotional Debriefing

Critical Incident Stress Management (CISM)

– Comprehensive package of interventions intended to:
  • mitigate impact of a traumatic event
  • facilitate recovery of individuals having normal reactions to traumatic event
  • restore adaptive function for individuals, communities, or organizations
  • identify individuals who could benefit from additional support services or referrals for further evaluation and treatment

– May take precedence over “fact-finding” debriefing after most severe events (death or serious injury)

https://www.icisf.org/a-primer-on-critical-incident-stress-management-cism/
Medicolegal Considerations

• Are debriefings legally protected?
  – Variations in state laws make this difficult to answer
• To help ensure success of debriefing please make certain that any possible protections are in place.
  – Collaborate and coordinate within existing quality and patient safety structures
  – Work closely with legal and risk management
Final Thoughts…

• Incorporating debriefing into obstetrical care has the potential to transform:
  – the way teams function
  – the way systems issues are identified and corrected
  – our care for future patients
  – our well-being as providers

• Low cost, low resource tools:
  – exist
  – can be easily incorporated
  – provide valuable data
Questions?
References

- http://teamstepp.sahrq.gov/
- Issenberg SB, McGaghie WC, Petrusa ER, Gordon DL, Scalese RJ. What are the features and uses of high-fidelity medical simulations that lead to most effective learning: a BEME systematic review. *Med Teach* 2005; 27:10-12.
References

- ACOG. Preparing for clinical emergencies in obstetrics and gynecology. *Committee Opinion 590; March 2014.*
Hemorrhage Education Plan

Webinar:
• December 3, 2019: Identification of Patient Risk and Team Communication

Regional Training:
• Clinical Simulation Drills and Debrief
Questions?