GaPQC

GEORGIA PERINATAL QUALITY COLLABORATIVE

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

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

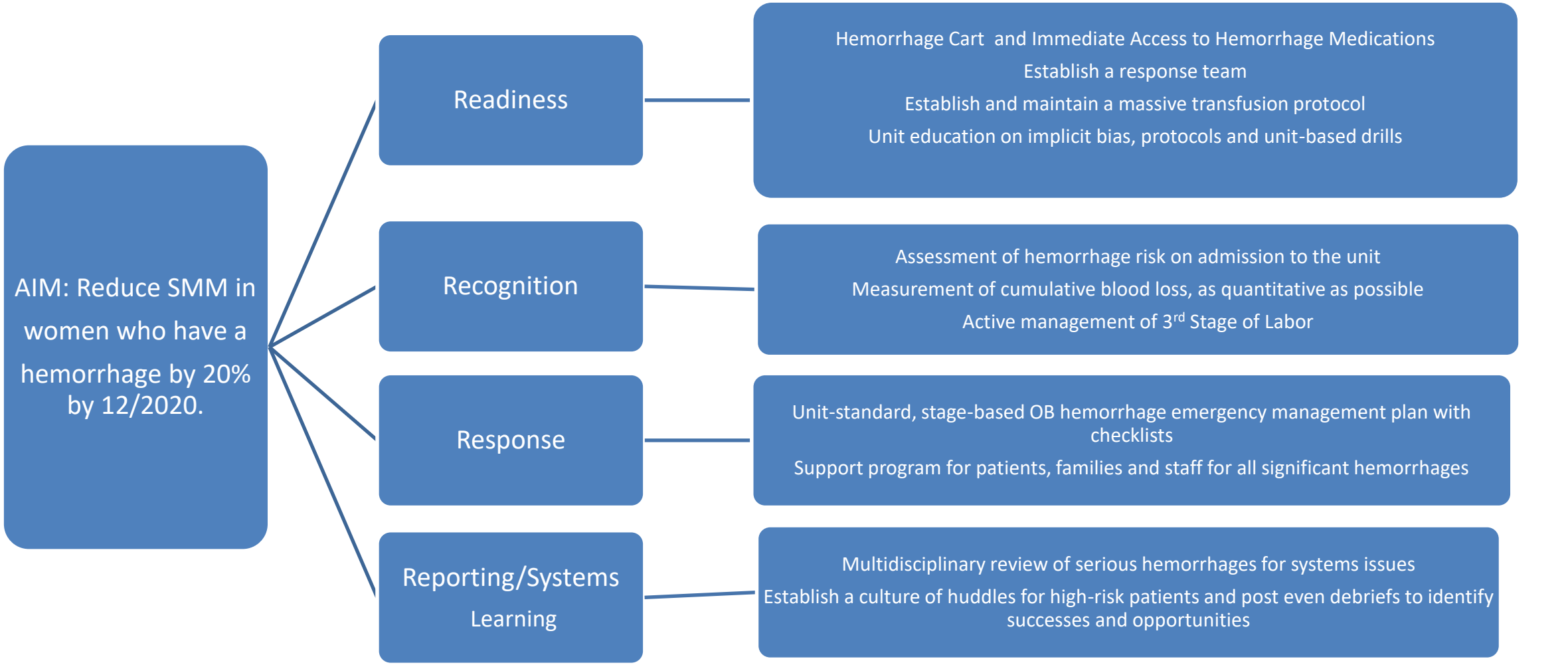
READINESS

RECOGNITION AND PREVENTION

RESPONSE

REPORTING/SYSTEMS LEARNING

Hemorrhage Driver Diagram



GaPQC Hemorrhage Goals by 12/2021

Measure	Type	Goal
Severe Maternal Morbidity 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 & postpartum women with postpartum hemorrhage diagnosis	Outcome	20% reduction
Risk Assessment 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	Process	100%
Debriefs on all cases requiring ≥4 units RBCs or admission to the ICU	Process	100%
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	Process	100%

AIM Hemorrhage Structure Measures

S1: Patient, Family & Staff Support	Report Completion Date Has your hospital developed OB specific resources and protocols to support patients, family and staff through major OB complications?
S2: Debriefs	Report Start Date Has your hospital established a system in your hospital to perform regular formal debriefs after cases with major complications?
S3: Multidisciplinary Case Reviews	Report Start Date 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)?
S4: Hemorrhage Cart	Does your hospital have OB hemorrhage supplies readily available, typically in a cart or mobile box?
S5: Unit Policy and Procedure	Report Completion Date 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?
S6: EHR Integration	Report Completion Date Were some of the recommended OB Hemorrhage bundle processes (i.e. order sets, tracking tools) integrated into your hospital's Electronic Health Record system?

AIM Hemorrhage Process Measures

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

Process Measures (P)	Description	Reporting time period (QUARTERLY): July 1, 2019-September 30, 2019		COMMENTS (NOT REQUIRED)
P1: Unit Drills	**Report # of Drills and the drill topics** **P1a:** In this quarter, how many OB drills (In Situ and/or Sim Lab) were performed on your unit for any maternal safety topic?	P1a:		
	P1b: In this quarter, what topics were covered in the OB drills? (**Note:** add more numbers for additional topics covered, as needed)	P1b:	1. 2. 3. 4. 5.	
P2: Provider Education	**P2a**: 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)?	P2a:	**Numerator**: **Denominator**:	
	P2b: At the end of this quarter, how many **OB physicians and midwives** (numerator) have completed (within the last 2 years) an education program on the **Obstetric Hemorrhage bundle elements and the unit-standard protocol**? How many OB physicans and midwives does your hospital have (denominator)?	P2b:	**Numerator**: **Denominator**:	
	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 Implicit Bias? How many OB physicans and midwives does your hospital have (denominator)?	P2c:	**Numerator**: **Denominator**:	***Reporting on P2c begins Quarter 1 2020 (January-March 2020)***
P3: Nursing Education	**P3a**: 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)?	P3a:	**Numerator**: **Denominator**:	
	P3b: At the end of this quarter, how many **OB nurses** (numerator) have completed (within the last 2 years) an education program on the **Obstetric Hemorrhage bundle elements and the unit-standard protocol**? How many OB nurses does your hospital have (denominator)?	P3b:	**Numerator**: **Denominator**:	
	P3c: At the end of this quarter, how many **OB nurses** (numerator) have completed (within the last 2 years) an education program on Implicit Bias? How many OB nurses does your hospital have (denominator)?	P3c:	**Numerator**: **Denominator**:	***Reporting on P3c begins Quarter 1 2020 (January-March 2020)***
P4: Risk Assessment	**P4**: 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)?	P4:	**Numerator**: **Denominator**:	
P5: Quantified Blood Loss	**P5**: 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)?	P5:	**Numerator**: **Denominator**:	

Implicit Bias Training Resources

- https://implicit.harvard.edu/implicit/takeatest.html
- https://www.traliant.com/implicit-bias-training-unconscious-bias-training

Future training opportunities:

- Cook Ross: Annual Meeting Presentation, Online Training and Train the Trainer Course

Strategies for Improving Debriefing as a Team

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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

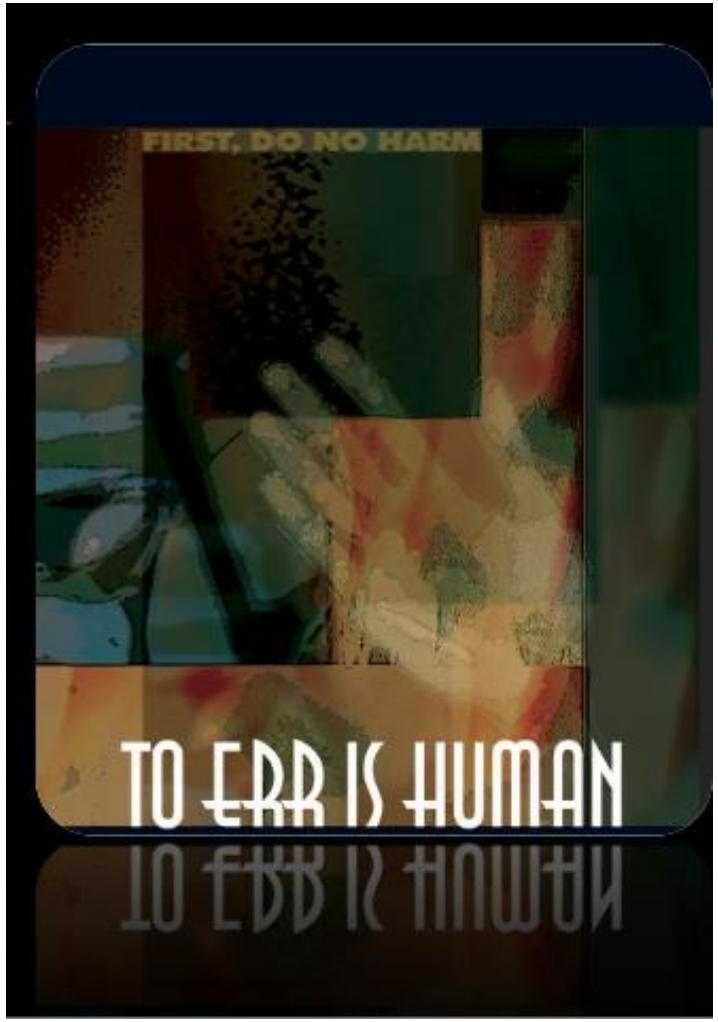
- Military
  - Individuals returning from a mission would discuss and describe their experiences in order to learn and to receive psychological support after traumatic events.
- Commercial aviation
  - Adopted Crew Resource Management in the late 1970's as a way to change the culture from one of hierarchy 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.

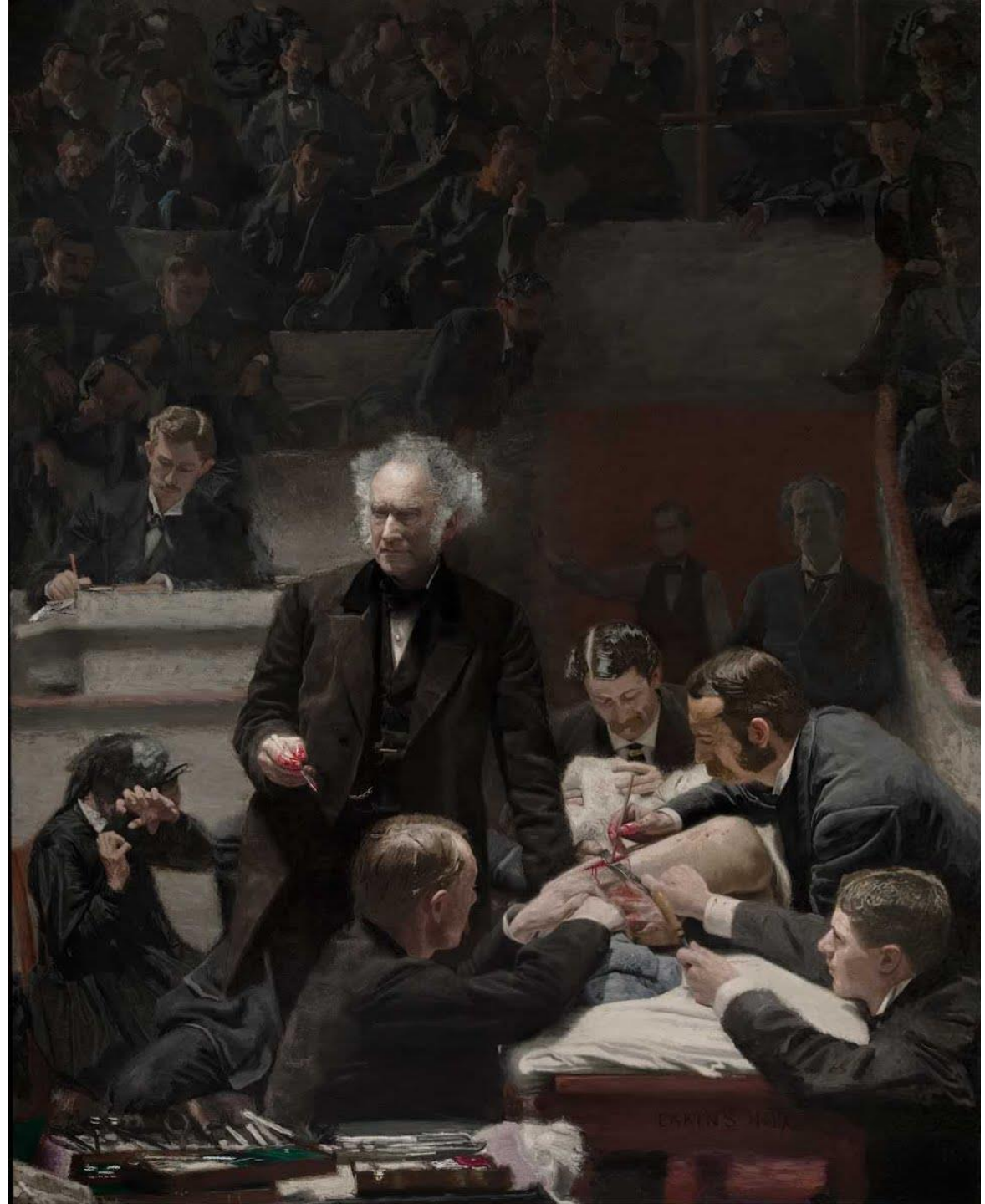
<u>High reliability organizations</u> (HROs) are those which have systems in place allowing them to consistently accomplish goals while avoiding potentially catastrophic error.

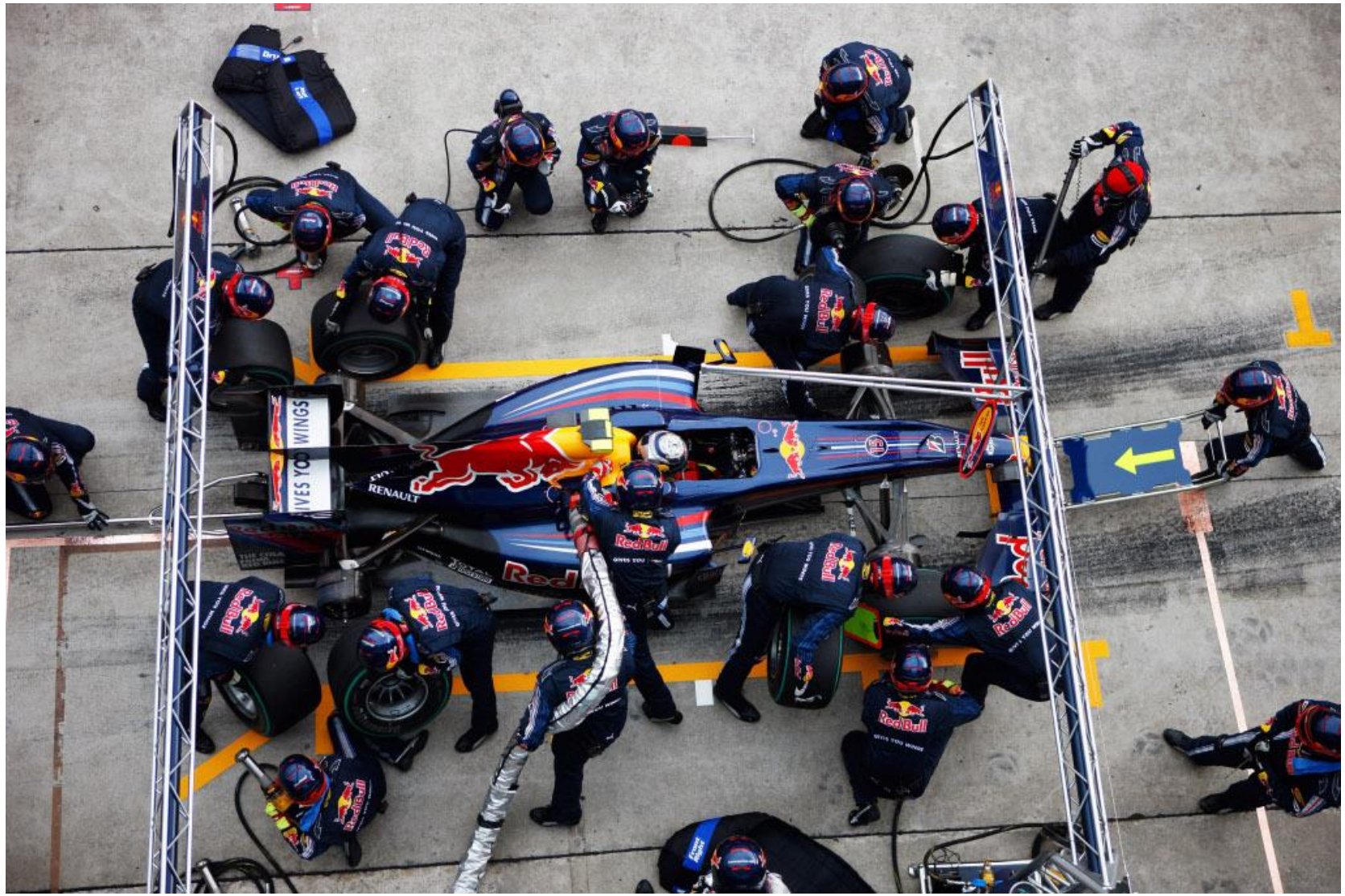


High Reliability: TeamSTEPPS

- 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.




RENAULT
Red Bull

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™

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

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…

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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

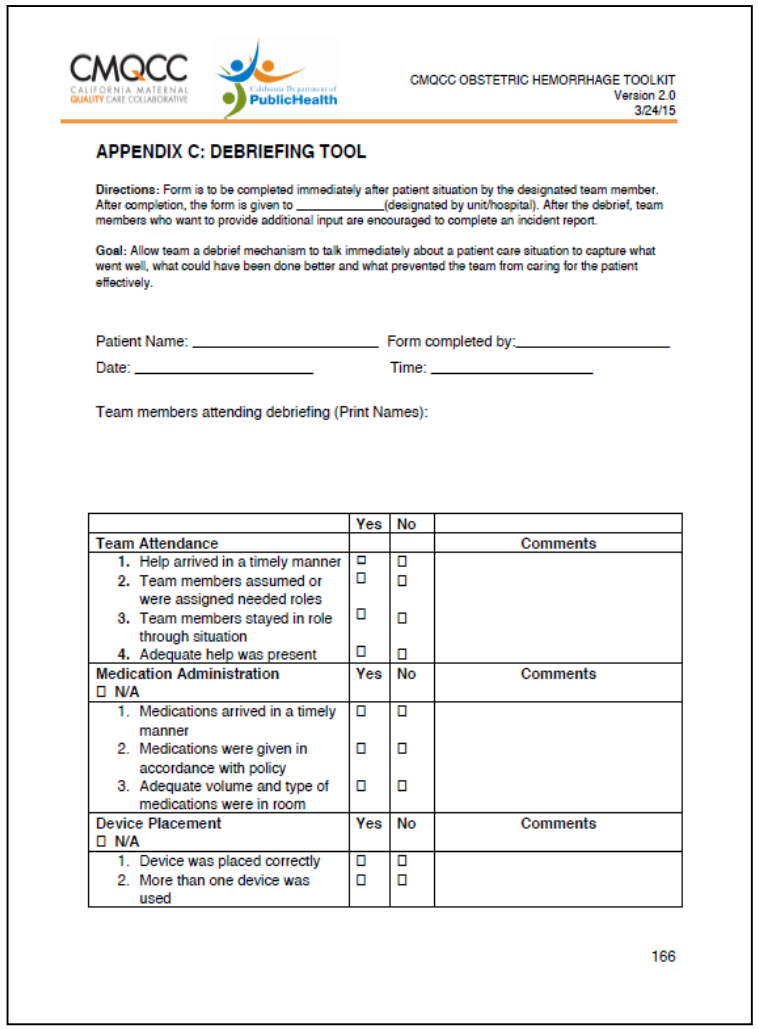
- Who?
  - Entire interdisciplinary team (obstetrics, nursing, pediatrics, and anesthesia)
  - Social Work: most severe events
- What?
  - All deliveries vs. just certain trigger events
- When?
  - As close to an event as possible to maximize the potential for information gathering and identification 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



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APPENDIX C: DEBRIEFING TOOL

Directions: Form is to be completed immediately after patient situation by the designated team member. After completion, the form is given to _____(designated by unit/hospital). After the debrief, team members who want to provide additional input are encouraged to complete an incident report.

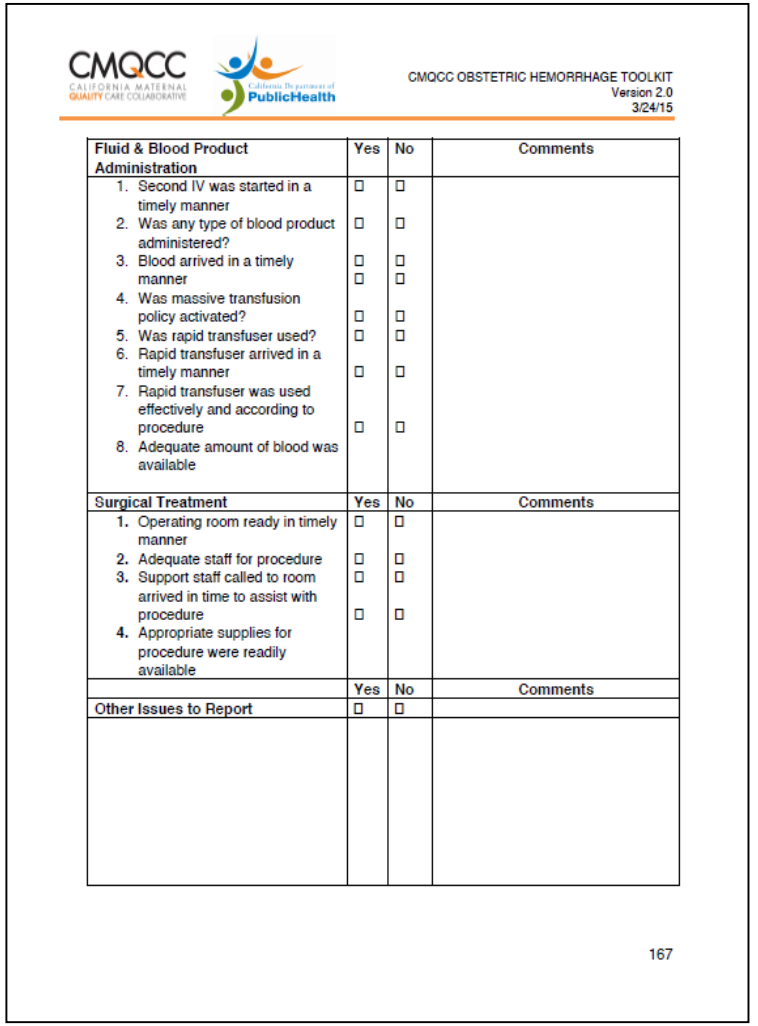
Goal: Allow team a debrief mechanism to talk immediately about a patient care situation to capture what went well, what could have been done better and what prevented the team from caring for the patient effectively.

Patient Name: _____ Form completed by:_____

Date: _____ Time: _____

Team members attending debriefing (Print Names):

	Yes	No	
Team Attendance			**Comments**
1. Help arrived in a timely manner	☐	☐	
2. Team members assumed or were assigned needed roles	☐	☐	
3. Team members stayed in role through situation	☐	☐	
4. Adequate help was present	☐	☐	
Medication Administration ☐ N/A	**Yes**	**No**	**Comments**
1. Medications arrived in a timely manner	☐	☐	
2. Medications were given in accordance with policy	☐	☐	
3. Adequate volume and type of medications were in room	☐	☐	
Device Placement ☐ N/A	**Yes**	**No**	**Comments**
1. Device was placed correctly	☐	☐	
2. More than one device was used	☐	☐	



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Fluid & Blood Product Administration	**Yes**	**No**	**Comments**
1. Second IV was started in a timely manner	☐	☐	
2. Was any type of blood product administered?	☐	☐	
3. Blood arrived in a timely manner	☐ ☐	☐ ☐	
4. Was massive transfusion policy activated?	☐	☐	
5. Was rapid transfuser used?	☐	☐	
6. Rapid transfuser arrived in a timely manner	☐	☐	
7. Rapid transfuser was used effectively and according to procedure	☐	☐	
8. Adequate amount of blood was available			
Surgical Treatment	**Yes**	**No**	**Comments**
1. Operating room ready in timely manner	☐	☐	
2. Adequate staff for procedure	☐	☐	
3. Support staff called to room arrived in time to assist with procedure	☐ ☐	☐ ☐	
4. Appropriate supplies for procedure were readily available			
	Yes	**No**	**Comments**
Other Issues to Report	☐	☐	

https://www.cmqcc.org/resource/ob-hem-appendix-c-debriefing-tool

Debriefing in Obstetrics-Tools

Obstetric Team Debriefing Form

Remember: Debriefing is meant to be a learning experience and a way to address both human factors and systems issues to improve the response for next time. There is to be no blaming/finger-pointing.

Type of event: _____ Date of event: _____

Location of event: _____ Person completing form: _____

Members of team present: (circle all that apply)
Primary RN, Primary MD, Charge RN, Resident(s), Other RNs
Anesthesia personnel, Neonatology personnel, MFM leader, Patient Safety Officer
Nurse Manager, OB/Surgical tech, Unit Clerk, Antepartum team (RNs, PA, Fellow, Resident)

Thinking about how the obstetric event was managed…

Identify what went well (Check if yes)
- ☐ Communication
- ☐ Role clarity (leader/supporting roles identified and assigned)
- ☐ Teamwork
- ☐ Situational awareness
- ☐ Decision-making
- ☐ Other: _____

Identify opportunities for improvement: **"human factors"** (Check if yes)
- ☐ Communication
- ☐ Role clarity
- ☐ Teamwork
- ☐ Situational awareness
- ☐ Decision-making
- ☐ Human error
- ☐ Other: _____

Identify opportunities for improvement: **"systems issue"** (Check if yes)
- ☐ Equipment/supplies/accessibility
- ☐ Medication
- ☐ 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: _____

For identified issues, please fill in table below…

Issue	Actions to be Taken	Person Responsible

DO NOT place any patient identification on this form.

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: **“<u>human factors</u>”?** (Check if yes)

- ☐ Communication
- ☐ Role clarity
- ☐ Teamwork
- ☐ Situational awareness
- ☐ Decision-making
- ☐ Human error
- ☐ Other: _____

Opportunities for improvement:

Identify opportunities for improvement: **“<u>systems issues</u>”?** (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?


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Hemorrhage Education Plan

Webinar:

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

Regional Training:

- Clinical Simulation Drills and Debrief

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Questions?