"10 Ways to Make Your OB Unit a "Suit Free" Zone: A Checklist for Perinatal Risk Professionals"

Larry Veltman, MD, FACOG, CPHRM, DFASHRM

Optima Health Care Insurance Services

May 16, 2024

Recently!

NEWS

Iowa jury awards more than $97M to family of boy injured at birth

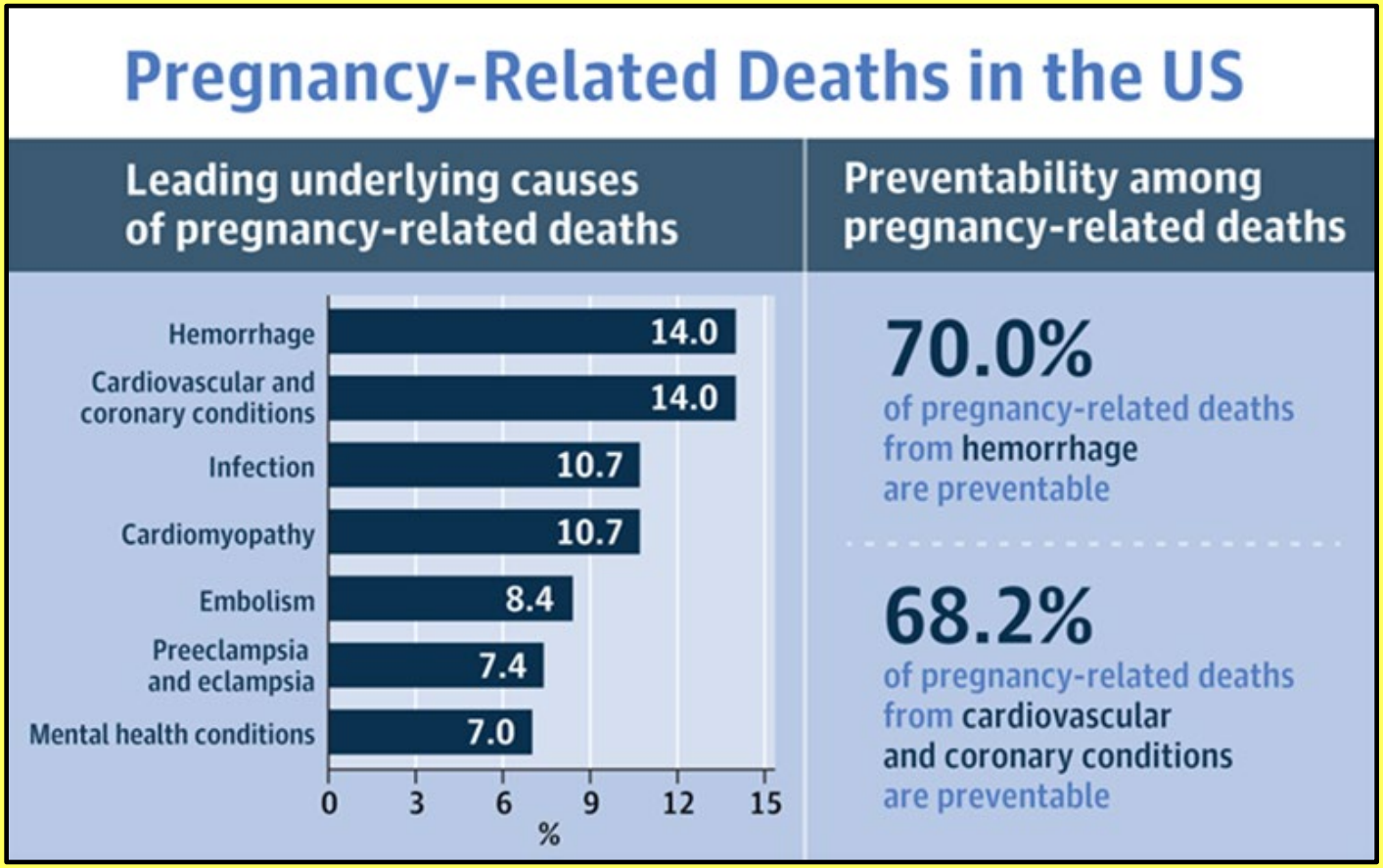
by: Associated Press
Posted: Mar 25, 2022 / 09:46 AM CDT
Updated: Mar 25, 2022 / 09:46 AM CDT

WAYNE

Michigan mom, son awarded $120M in malpractice lawsuit over delayed C-section

Michigan mom, son awarded $120M in malpractice lawsuit over delayed C-section

MM and SMM:
Still An Enormous Challenge



Review to Action. Report from Nine Maternal Mortality Review Committees. https://reviewtoaction.org. Published 2018.

What’s the most dangerous thing about OB?

When Almost Everything Turns Out OK

- High public expectations.
  "Was it bad luck or bad medicine?"
- Difficult to learn from mistakes.
- Shortcuts are more likely.

What Drives Shortcuts?

1. "As providers become more comfortable with their tasks, …and…by the fact that harm is relatively rare making dangerous shortcuts more engrained in practice."

   -Canadian Medical Protective Association, 2018

2. The law of small numbers:
   "In my personal experience."
   "I've never had a problem."
   "My patients are different."

3. Lack of complications ≠ lack of risk.

4. Lack of accountability for process deviations.

The Slippery Slope of Obstetrics

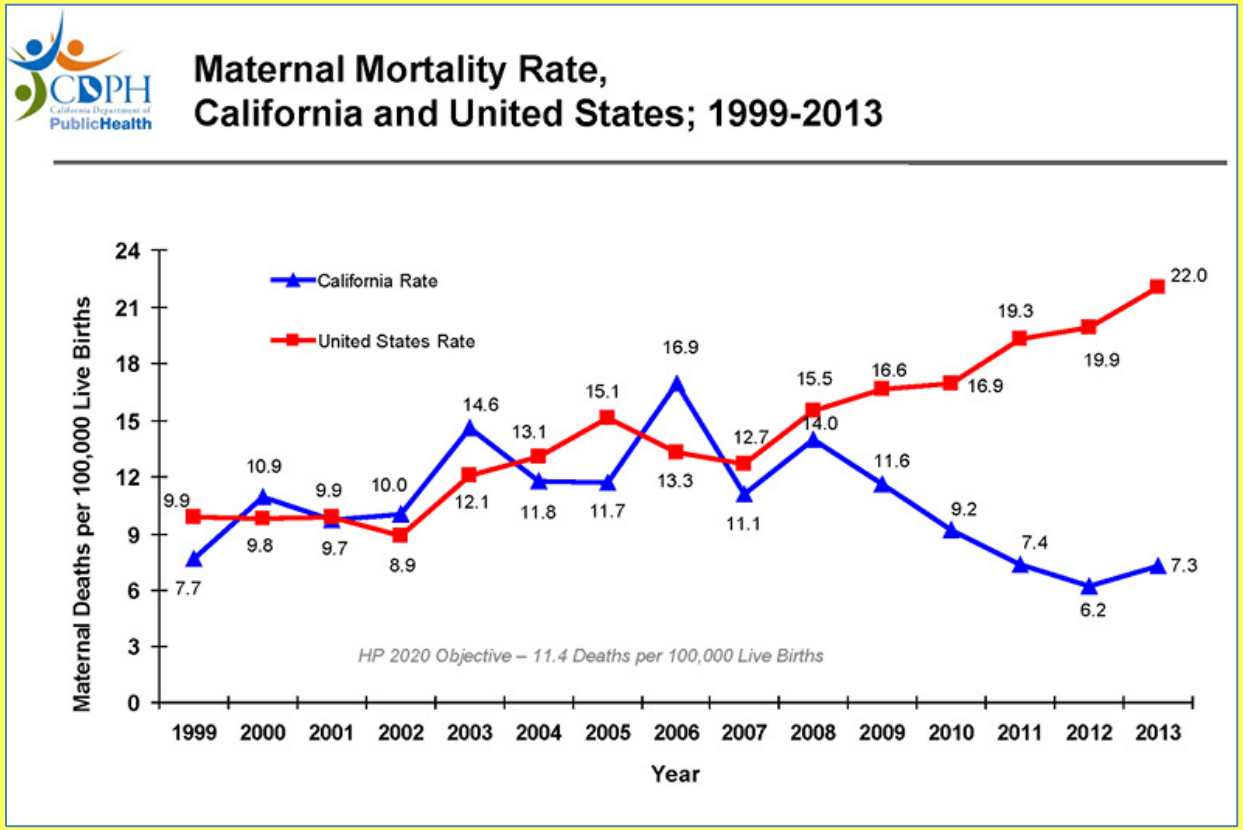
- **Delighted**
  - "We loved every part of it."
- **Disappointed**
  - "Everything came out fine, but this place needs work."
- **Disgruntled**
  - "Nothing seemed to go right. No way will I recommend it for anyone's delivery."
- **Disgusted**
  - "They really screwed up. They should have sectioned her earlier."
- **Devastated**
  - "Our hopes are dashed. Our baby will never be like the other kids."
- **Deposed**
  - "Someone did something wrong and now they have to pay."

Adapted from Brian Wong, MD

How Have We Done?

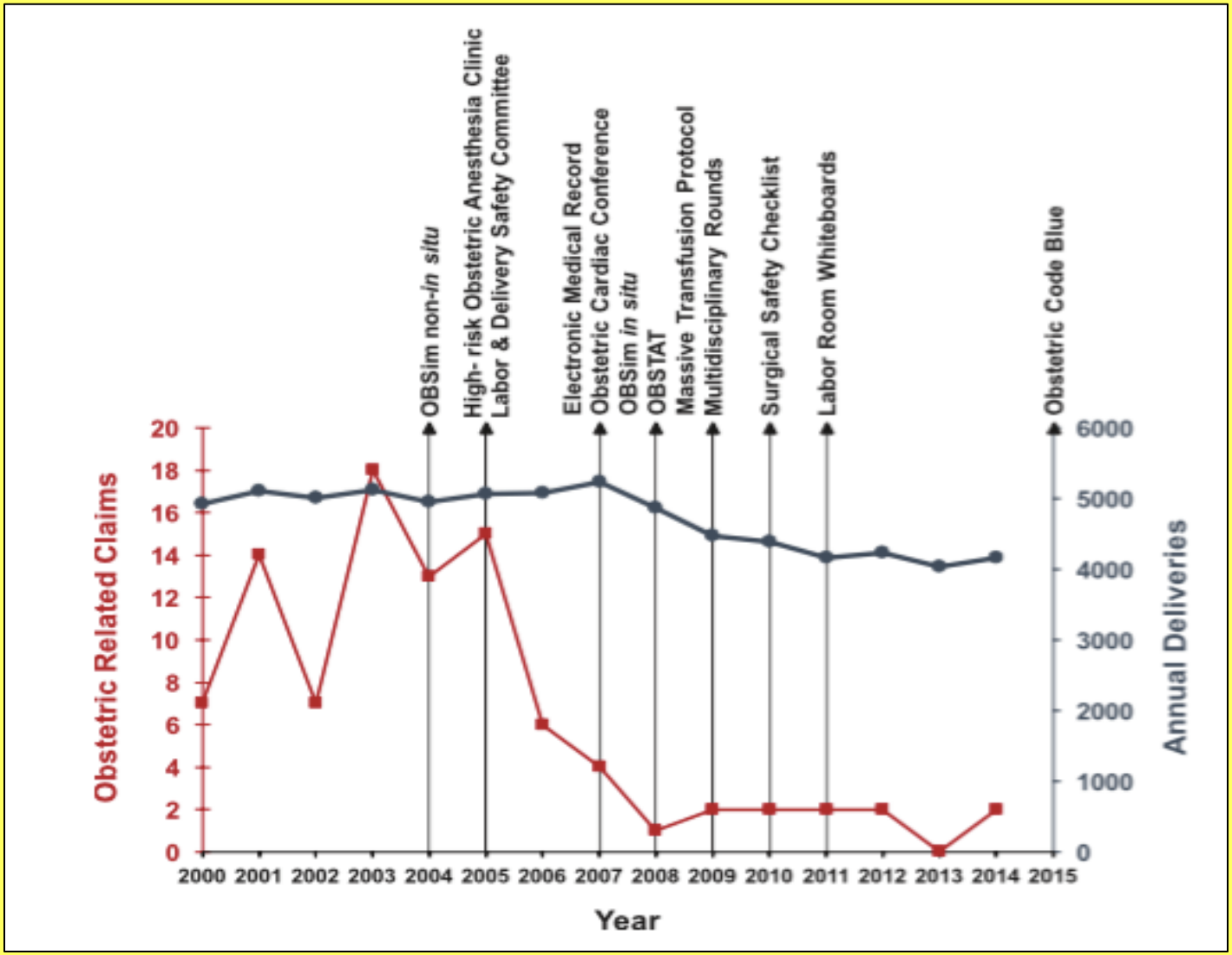
California: 55% decrease in maternal mortality

One life saved per 10,000 live births = approx. 400 US lives!



How Have We Done?

Stanford University



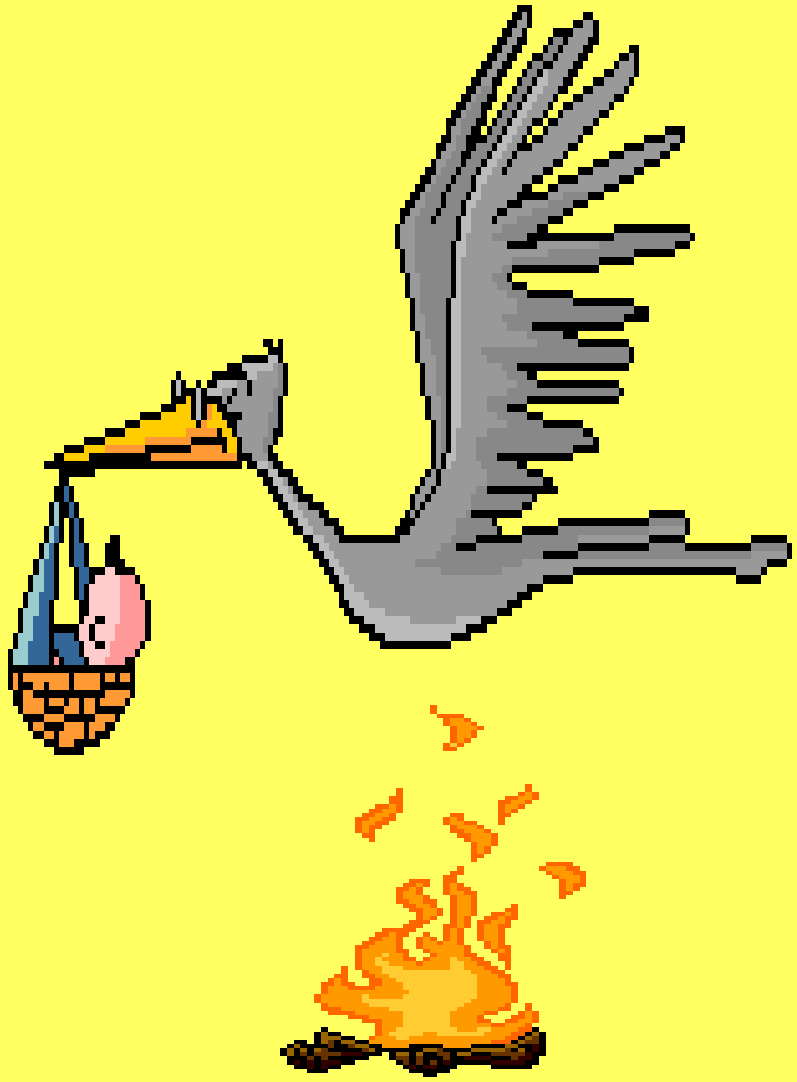
Anesth Analg 2016;123:1181–90

Current OB Liability "Hot Spots"

Response to fetal intolerance…ability to do a timely delivery

Maternal mortality / severe maternal morbidity

Improper use of forceps or vacuum



Oxytocin administration

Newborn resuscitation

Management of shoulder dystocia

The Question:

How can (perinatal units) deliver the safest possible care that is standardized, replicable and predictable—while embracing the variations, disruptions and unexpected events that are inherent in everyday obstetrical practice?

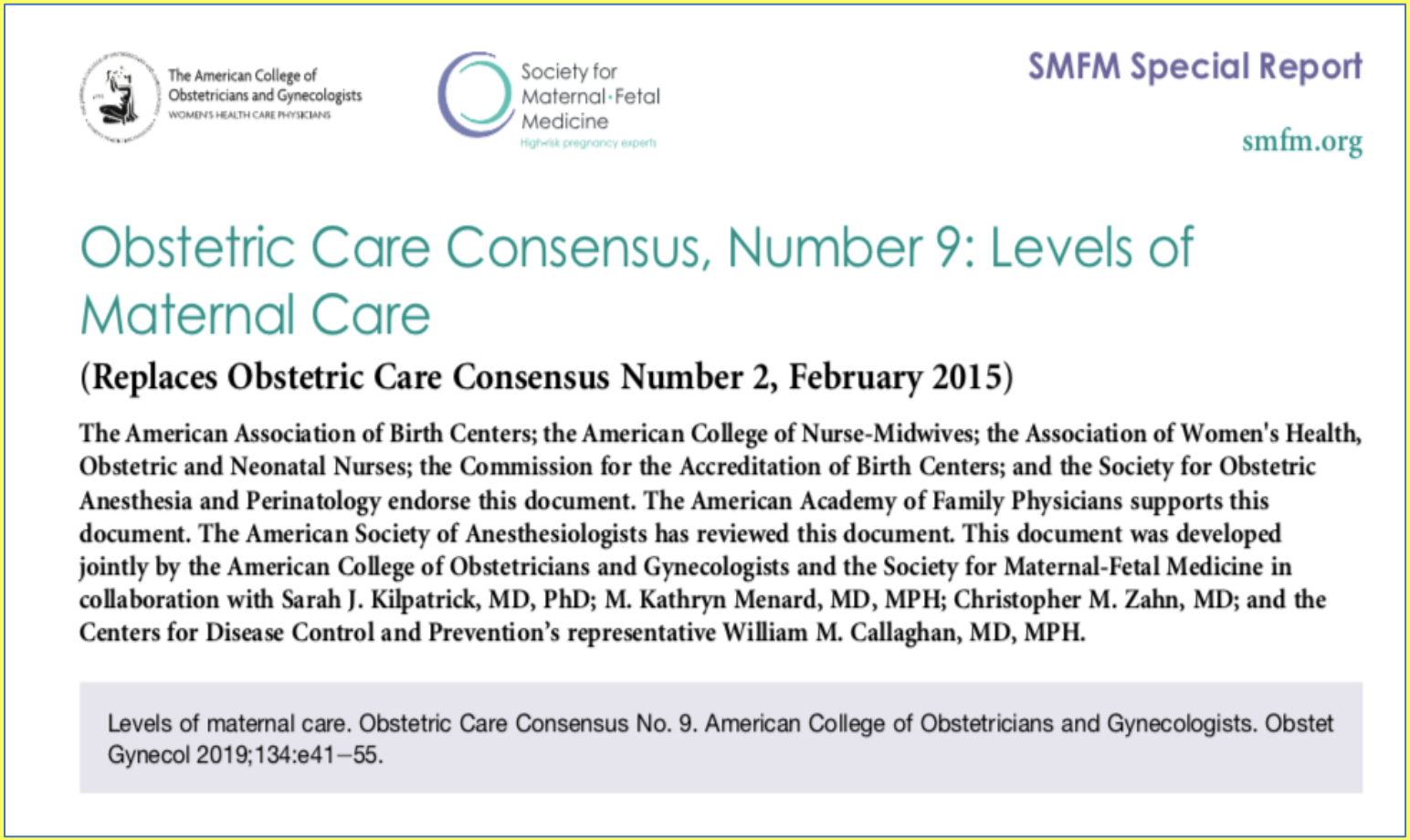
(Safety Science 117 (2019) 490–500)

The Answer:

10 Ways To Make A Perinatal Unit Even Safer

10. Answer the question: “Should she deliver here”?

Define Yourself



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

Society for Maternal-Fetal Medicine
High-risk pregnancy experts

SMFM Special Report

smfm.org

Obstetric Care Consensus, Number 9: Levels of Maternal Care

(Replaces Obstetric Care Consensus Number 2, February 2015)

The American Association of Birth Centers; the American College of Nurse-Midwives; the Association of Women's Health, Obstetric and Neonatal Nurses; the Commission for the Accreditation of Birth Centers; and the Society for Obstetric Anesthesia and Perinatology endorse this document. The American Academy of Family Physicians supports this document. The American Society of Anesthesiologists has reviewed this document. This document was developed jointly by the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine in collaboration with Sarah J. Kilpatrick, MD, PhD; M. Kathryn Menard, MD, MPH; Christopher M. Zahn, MD; and the Centers for Disease Control and Prevention's representative William M. Callaghan, MD, MPH.

Levels of maternal care. Obstetric Care Consensus No. 9. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;134:e41–55.

Levels of Maternal Care (LoMC) Considerations

Five (5) levels:

- Birthing centers
- Levels I-IV

Capabilities – e.g., imaging, blood bank, ICU

Protocols – e.g., massive fluid, emergencies

Healthcare personnel

- Nursing
- Primary provider for deliveries
- Obstetric surgeon
- MFM
- Director of Obstetrics
- Anesthesia
- Consultants
- ICU

January 1, 2022

Maternal Levels of Care Verification

The Joint Commission

ACOG

The Joint Commission offers Maternal Levels of Care Verification in collaboration with the American College of Obstetricians and Gynecologists (ACOG).

For Every Hospital: Ensure A Tertiary Relationship

- Link every lower risk hospital with a tertiary center.
- Tertiary center provides resources.
  - MFM Consultation
  - QI resource
  - Protocol development
  - Simulation training
  - Telemedicine

N Engl J Med 2017; 376:1304-1305

9. Implement an early warning system with an appropriate escalation policy:

Get a physician to the bedside.

MEOWS, MEWT, EOWS, MERC, TREWS

Physiological parameters	Normal values	Yellow alert	Red Alert
Respirator rate	10-20 breaths per minute	21-30 breaths per minute	< 10 or >30 breaths per minute
Oxygen saturation	96-100%		< 95 %
Temperature	36.0-37.4°C	35-36 or 37.5- 38°C	< 35 or > 38°C
Systolic blood pressure	100-139 mmHg	150 – 180 or 90 – 100 mmHg	>180 or < 90 mmHg
Diastolic blood pressure	50-89 mmHg	90–100 mmHg	>100 mmHg
Heart rate	50-99 beats per minute	100- 120 or 40 -50 beats per minute	>120 or < 40 beats per minute
Neurological response	Alert	Voice	Unresponsive, pain

Table 1: Maternal Early Warning Scores

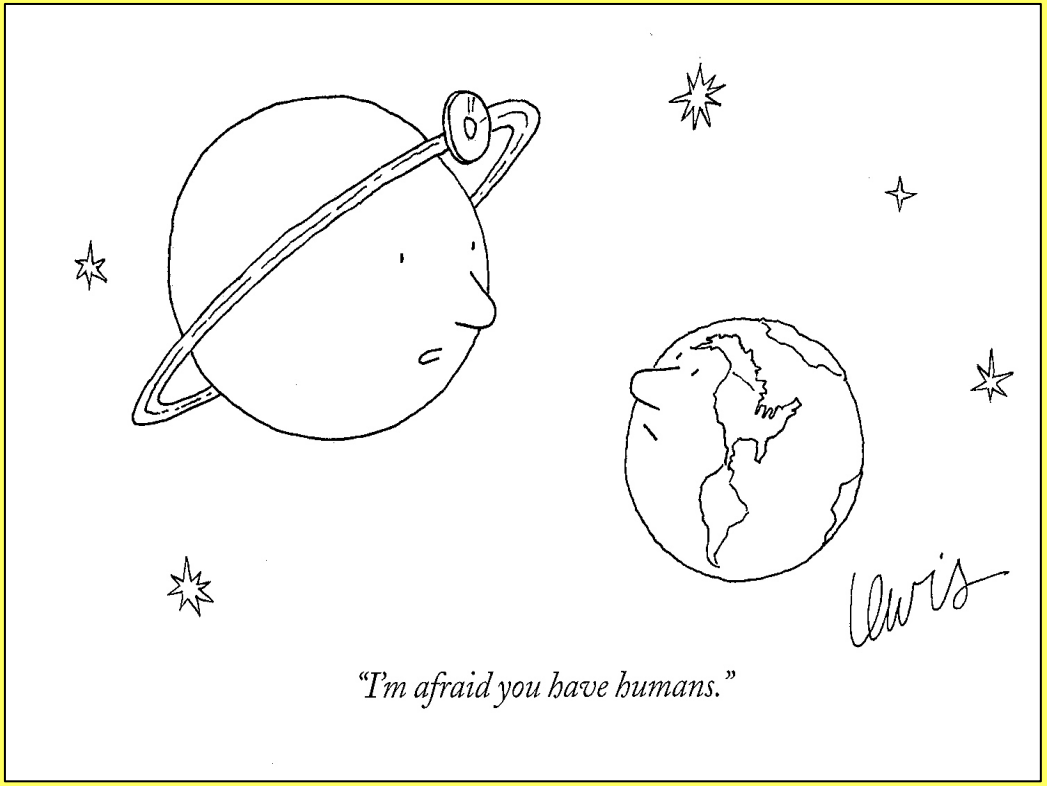
https://resources.wfsahq.org/atotw/maternal-early-warning-scores-mews/

Effective Escalation Policy

An abnormal parameter would require:

1. Prompt reporting to a physician or other qualified clinician.
2. Prompt bedside evaluation by a physician or other qualified clinician with the ability to activate resources in order to initiate emergency diagnostic and therapeutic interventions as needed.
3. Accountability for variances.

8. Recognize and mitigate human factors and their implications for perinatal safety.



Joint Commission: Root Causes for Perinatal Events

2004 through 2014 (N=125) *The majority of events have multiple root causes*	
Human Factors	65
Communication	60
Assessment	51
Leadership	49
Information Management	27
Continuum of Care	19
Physical Environment	17
Care Planning	14
Medication Use	12
Anesthesia Care	7

Available at www.jointcommission.org

Some Human Factors & OB Safety

- Fatigue
- Drift
- Cognitive & Implicit Bias
- Inattentional blindness

Fatigue

- "…slower reactions, reduced ability to process information, memory lapses, absent-mindedness, decreased awareness, lack of attention, underestimation of risk, reduced coordination…"
- Fatigue can lead to errors and accidents, ill-health and injury, and reduced productivity."

- MITIGATE: avoid multiple shifts, adequate back up, educate re: "macho" culture.

https://www.hse.gov.uk/humanfactors/topics/fatigue.htm

Clinical Drift/Shortcuts

"Familiarity with tasks leads to a lack of perception or risk or a mistaken belief that the risk is justifiable."

-Canadian Medical Protective Association, 2018

MITIGATE: Education, accountability for process deviation even without harm.

Bias

- Cognitive Bias
  - Error that occurs in processing and interpreting clinical information.
  - *Confirmation, anchoring, bandwagon effect, halo effect, etc.*
- Implicit Bias
  - Beliefs and prejudices that reside outside of our conscious awareness.
  - *Race, ethnicity, age, gender, LGBTQIA+, ability*

- MITIGATE: education, include bias issues in debriefs.

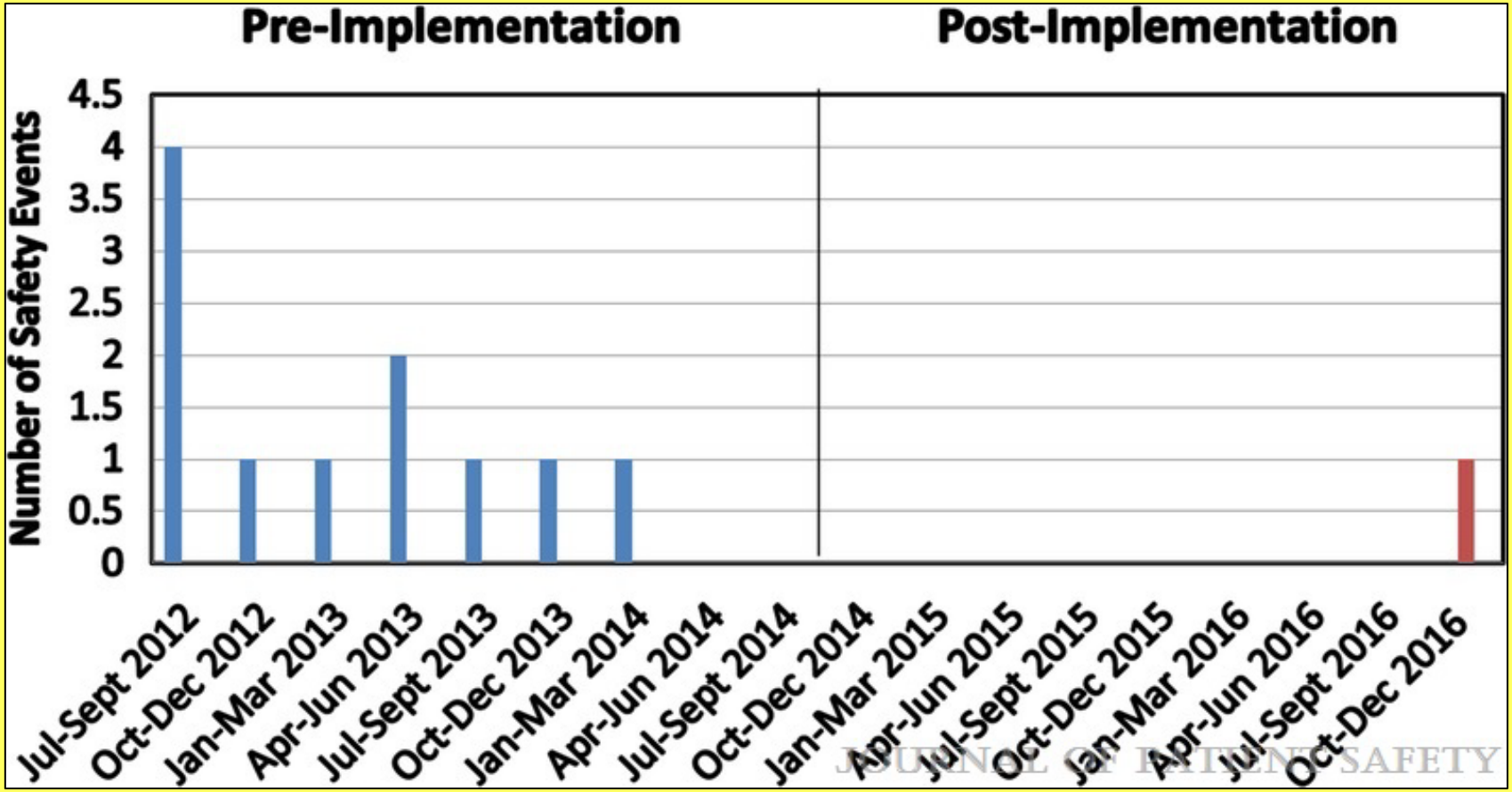
“How could they have missed that?”

- **Inattentional blindness**: The failure to notice a fully-visible, but unexpected object because attention was engaged on another task, event, or object.
  - Second stage “traps”.
  - Alarm fatigue with EFM, infant security.

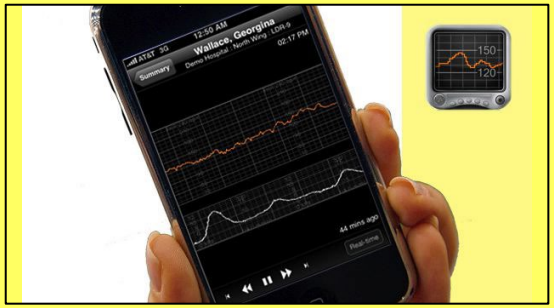
- MITIGATE: breaks, second opinions, supervisor oversight, “another set of eyes”.

7. If you can afford it, put an obstetrician and anesthesiologist in house. If you can't, ensure that all physicians can and will view tracings off site.

In-House Obstetricians



Journal of Patient Safety16(3):e179-e181, September 2020.



Viewing The Tracing Off Site

6. Standardize when possible, especially when it comes to oxytocin administration & management of tachysystole.

Is This Standardized?

Follow oxytocin regimen as ordered:

- ❑Low dose regimen:

Oxytocin initiated at 2 milliunits /minute. It may be increased every 15 - 30 minutes by 2 milliunits/minute until adequate progress of labor or a desired uterine pattern.

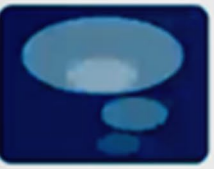
- ❑High-dose regimen:

Oxytocin initiated at 6 milliunits/minute. It may be increased by 6 milliunits/minute every 15-30 minutes until adequate progress of labor or a desired uterine pattern.

Not Such Good News: Oxytocin Mis-Use

1. In closed legal claims related to labor induction or augmentation with oxytocin, **75% resulted in a settlement**. More than **70%** showed **a failure to appreciate and act** on severity of EFM abnormalities with or without uterine tachysystole.

   CMPA Perspective, March 2014



2. Excessive use of contraction stimulating drugs found to be **underlying problem in 45% of brain injuries.**

   Clark SL, Belfort MA, Dildy GA, Meyers JA. Reducing obstetric litigation through alterations in practice patterns. Obstet Gynecol. 2008 Dec;112(6):1279-1283.

3. **Incautious use of oxytocin in 71%** of births with **severe asphyxia seeking legal action.**

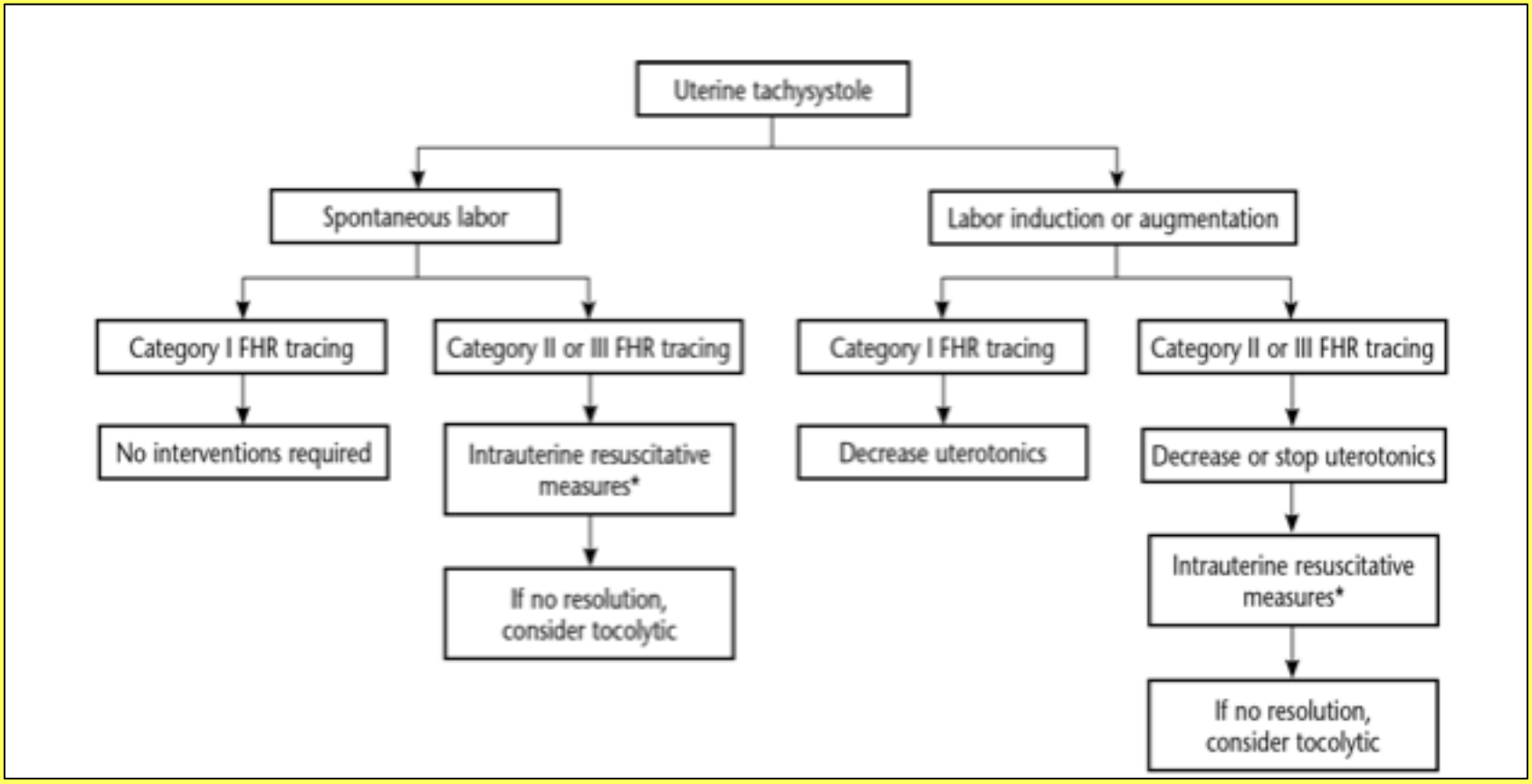
   Berglund S, Grunewald C, Pettersson H, Cnattingius S. Severe asphyxia due to delivery-related malpractice in Sweden 1990-2005. BJOG. 2008 Feb;115(3):316-323

4. **Oxytocin misuse** found in **47%** of babies born with **metabolic acidosis.**

   Jonsson M, Nordén SL, Hanson U. Analysis of malpractice claims with a focus on oxytocin use in labour. Acta Obstet Gynecol Scand. 2007;86(3):315-319.

PeriGen

Tachysystole: A Standard Approach



https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2010/11/management-of-intrapartum-fetal-heart-rate-tracings

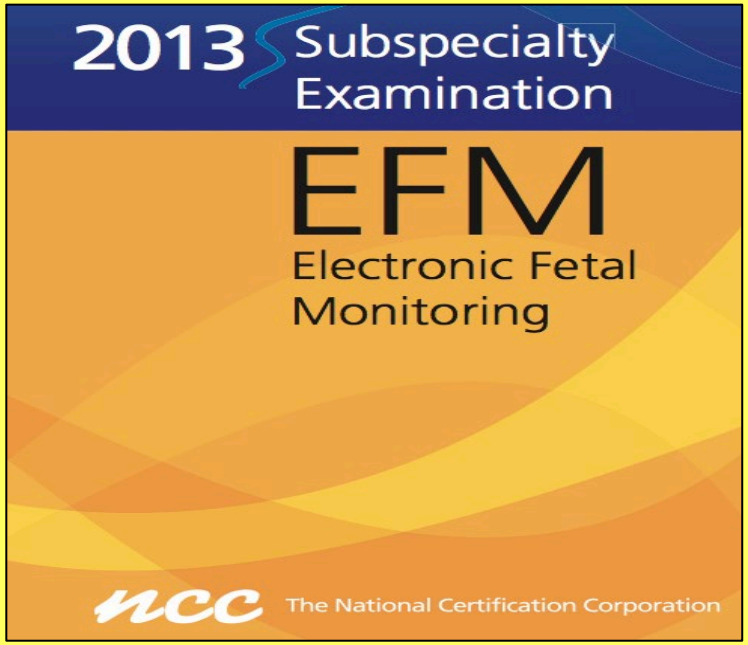
5. Ensure/require collaborative multidisciplinary credentialing for EFM and simulation training.

CLINICAL OPINION www.AJOG.org

EDUCATION

The case for an electronic fetal heart rate monitoring credentialing examination

Richard L. Berkowitz, MD; Mary E. D'Alton, MD; James D. Goldberg, MD; Dan F. O'Keeffe, MD; Jean Spitz, MPH; Richard Depp, MD; Michael P. Nageotte, MD



Simulation Training & Claims

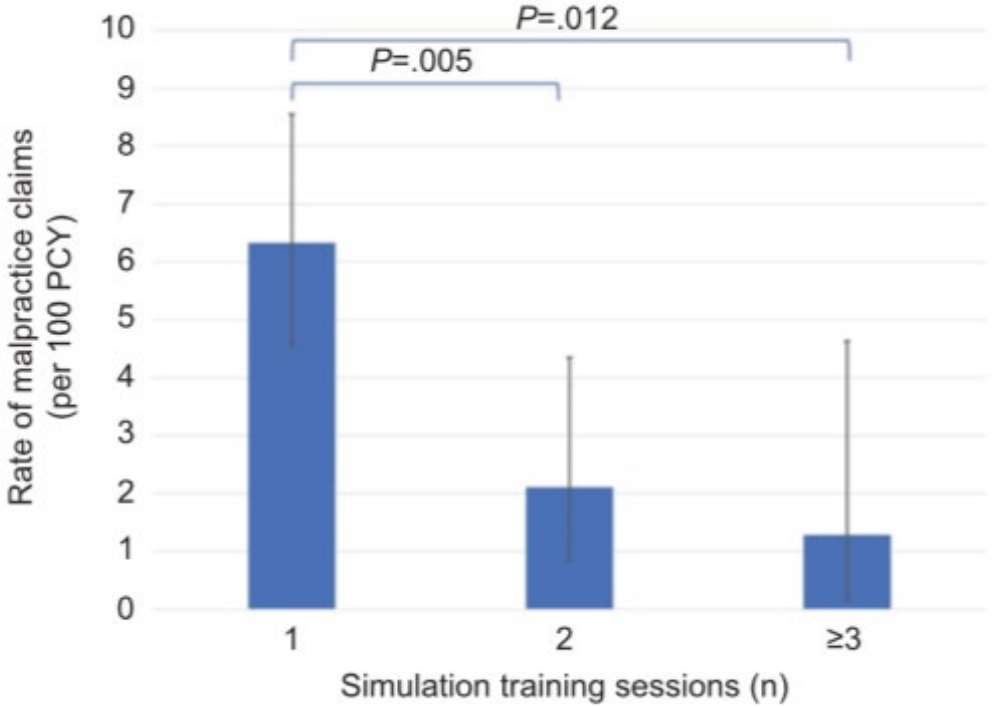
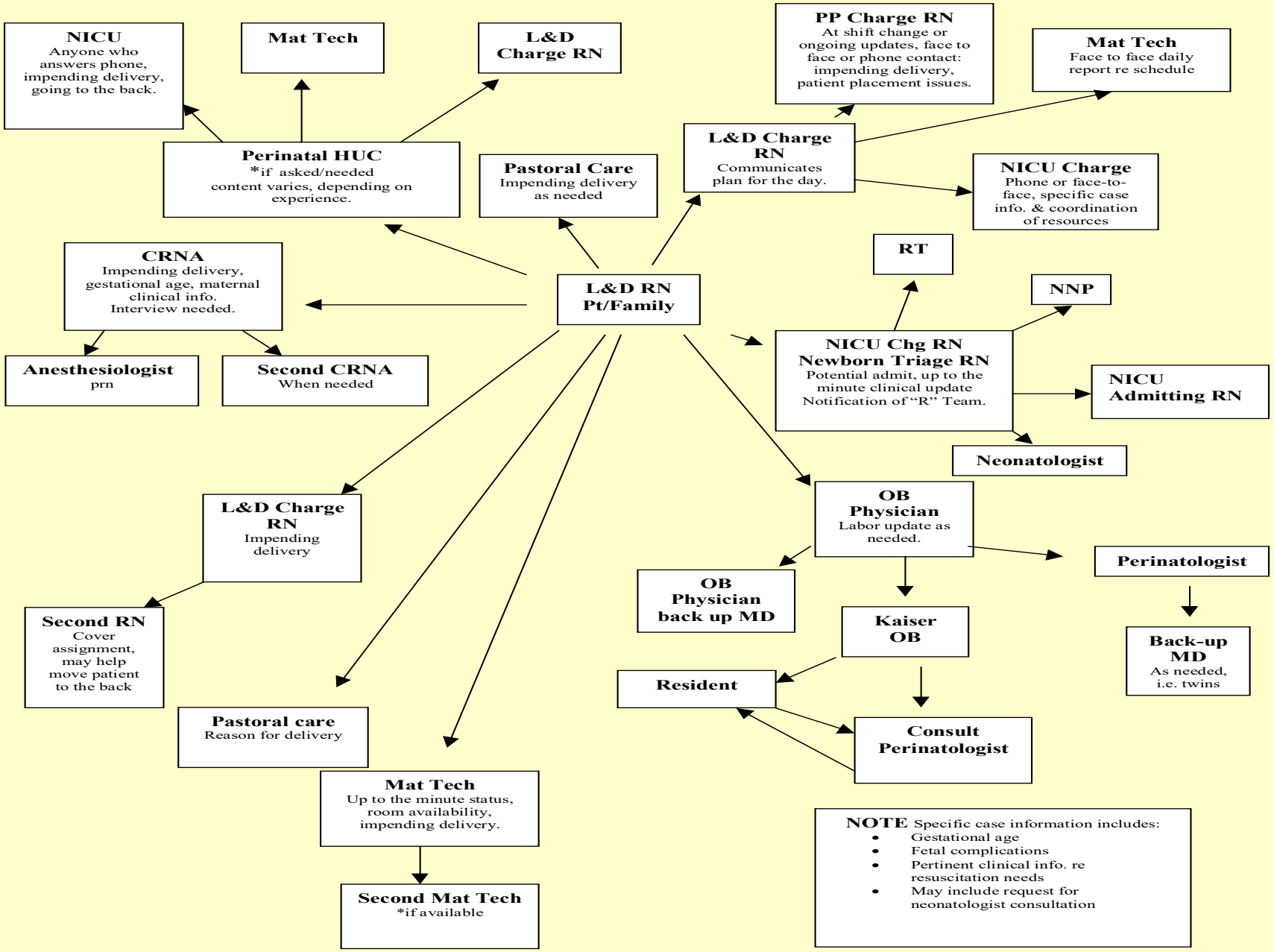


Fig. 1. Rate of medical malpractice claims by number of simulation training sessions attended. *Error bars* represent the 95% CIs. PCY, physician coverage years.

Schaffer. Simulation Training and Medical Malpractice. Obstet Gynecol 2021.

4. Enhance Interprofessional Communications

- Implement structured conversations.
- Improve “speak up” climate.
- Eliminate incivility/intimidation.
- Ensure working escalation policy.
- Debrief significant events.


NICU
Anyone who answers phone, impending delivery, going to the back.
Mat Tech
L&D Charge RN
PP Charge RN
At shift change or ongoing updates, face to face or phone contact: impending delivery, patient placement issues.
Mat Tech
Face to face daily report re schedule
Perinatal HUC
*if asked/needed content varies, depending on experience.
Pastoral Care
Impending delivery as needed
L&D Charge RN
Communicates plan for the day.
NICU Charge
Phone or face-to-face, specific case info. & coordination of resources
CRNA
Impending delivery, gestational age, maternal clinical info. Interview needed.
L&D RN Pt/Family
RT
NNP
NICU Chg RN
Newborn Triage RN
Potential admit, up to the minute clinical update Notification of "R" Team.
NICU Admitting RN
Neonatologist
Anesthesiologist
prn
Second CRNA
When needed
L&D Charge RN
Impending delivery
OB Physician
Labor update as needed.
Perinatologist
OB Physician back up MD
Kaiser OB
Back-up MD
As needed, i.e. twins
Second RN
Cover assignment, may help move patient to the back
Resident
Pastoral care
Reason for delivery
Consult Perinatologist
Mat Tech
Up to the minute status, room availability, impending delivery.
Second Mat Tech
*if available
NOTE Specific case information includes:
Gestational age
Fetal complications
Pertinent clinical info. re resuscitation needs
May include request for neonatologist consultation

JCAHO - 167 Perinatal Deaths Or Permanent Disability (2004 - 2010)

Communication failures in

72%

The Strongest Predictor of Team Clinical Excellence:

"Caregivers feel comfortable speaking up if they perceive a problem with patient care."

Pronovost, et al., Improving patient safety in intensive care units in Michigan. J Crit Care. 2008 Jun;23(2):207-

Challenges to Speaking Up

- Thought something was wrong but wasn't certain.
- Fear of retaliation/having to continue working with the person.
- Normalization: "That's just they way they've always done it."

Dixon-Woods M, Aveling EL, Campbell A, et al. What counts as a voiceable concern in decisions about speaking out in hospitals: A qualitative study. *Journal of Health Services Research & Policy*. January 2022.

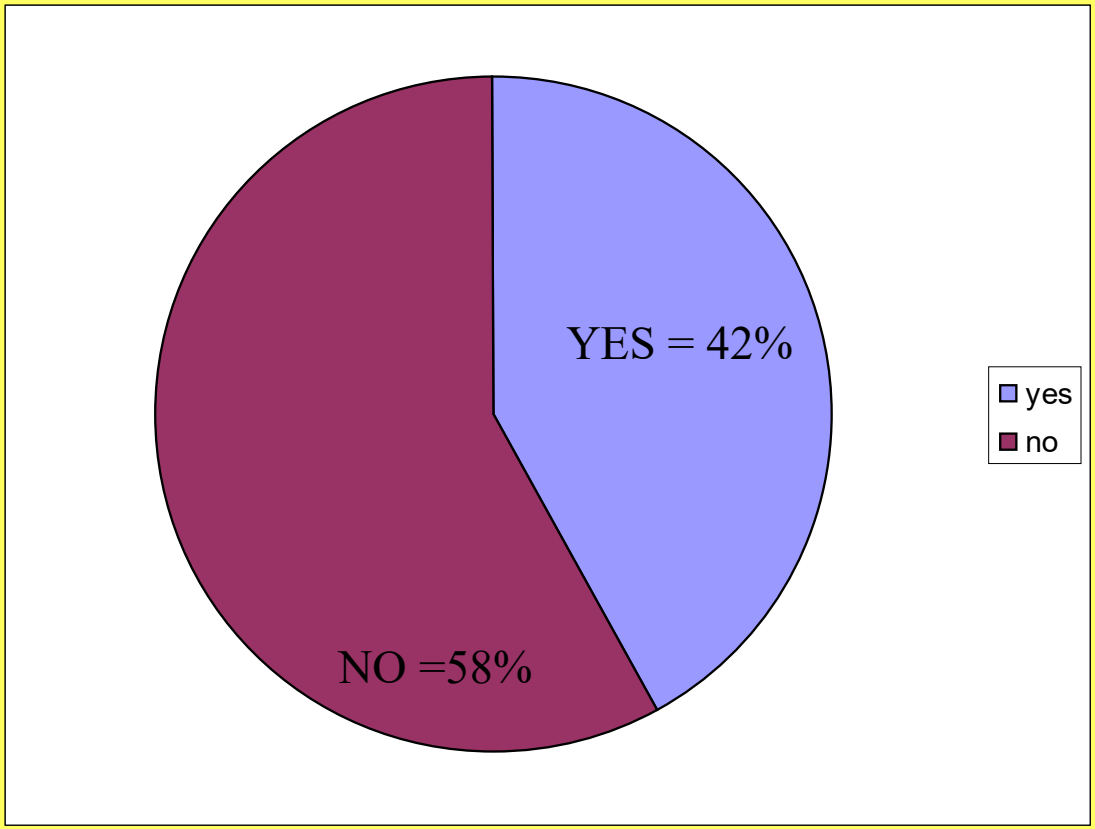
A Key Safety Principle

Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.

IT'S ESSENTIAL TO TEAMING AND LEARNING

Edmonson, Amy, Psychological Safety and learning behavior in work teams. Administrative Science Quarterly; June 1999; 44,2.

Have There Been Specific Adverse Outcomes As A Result of Unprofessional, Disruptive Behavior?



3. Address the obstetrical "hot spots"

- Implement the AIM Bundles
-Eliminate delivery delays
-Drill for emergencies

The AIM Bundles

Saferbirth.org

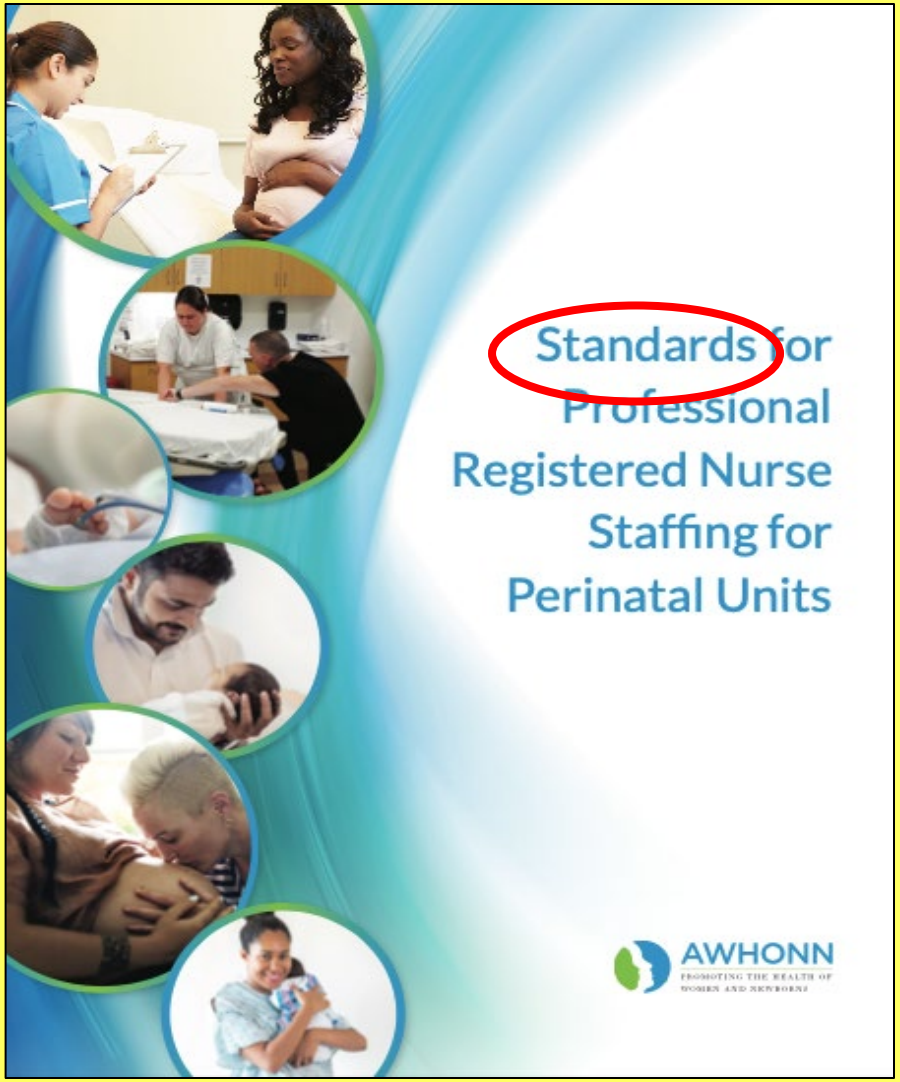
Preventing Delays

- Priority nomenclature.
- OB and anesthesia availability.
- Moving the patient and opening the OR/packs.
- Ancillary staffing: CSTs.
- Fetal monitor in the OR.
- Cesarean under local?
- Resuscitation expertise.
- DRILL.

2. Nursing

1. Make every effort to staff the unit with experienced perinatal nurses.
2. Provide robust education for inexperienced nurses.
3. Enhance the reporting culture.
4. Assure accurate productivity metrics to make your business case for safety.

May, 2022


Standards for
Professional
Registered Nurse
Staffing for
Perinatal Units
AWHONN

Address Nursing Inexperience

Unit-based Educator, Preceptors, and Mentors

LOST MOTHERS

Many Nurses Lack Knowledge of Health Risks for New Mothers, Study Finds

A nationwide survey shows that postpartum nurses often fail to warn mothers about potentially life-threatening complications, mainly because they need more education themselves.

by **Nina Martin**, ProPublica, and **Renee Montagne**, NPR, Aug. 17, 5 a.m. EDT

Suplee PD ; Bingham D ; Kleppel L.Nurses' knowledge and teaching of possible postpartum complications. MCN Am J Matern Child Nurs. 2017 Aug 15; [Epub ahead of print]

Improve Unit's Reporting Culture

- Voluntary, efficient and confidential.
- Appropriate distribution.
- Written policy: consequences, obligations, rights, protections, privilege.
- Reasonable follow up and organizational response.
- Absence risks discouragement, cynicism, underreporting.

- Dekker, S., Just Culture. Restoring Trust and Accountability in Your Organization. CRC Press. 2016.
- Rowland, P., Organisational paradoxes in speaking up for safety: Implications for the interprofessional field, Journal of Interprofessional Care (2017), 31:5, 553-556.

Got Scripts?

- When being treated with disrespect.
- Ordering increases in oxytocin when deemed unsafe.
- When you need immediate evaluation at the bedside.
- When you don’t understand the reasoning.
- When it’s time to quit the vacuum.

Getting Credit For What We Do: The Business Case For Safety

Resource allotment

- Not only the number of deliveries or midnight census.

- It's also about:
  - Antenatal inpatients
  - Outpatient testing
  - Triage visits without admission
  - Acuity

1. Engage the medical staff, develop obstetrical leadership, and strengthen accountability for care with robust peer review.

What's The Problem With The Obstetricians?

Components of An Engaged Medical Staff

- Sees safety as a unit-wide issue.
- Attends departmental meetings.
- Participates in drills/simulations.
- Is an education resource for nursing.
- Behaves professionally.
- Seeks out and adopts evidence-based best practices.
- Holds each other accountable with robust peer review.

Robust Peer Review

- Strong departmental leadership.
- Strong safety reporting ethic.
- Appropriate committee structure/specialty specific.
- Ensure accountability for clinical, process, behavioral issues.
- Utilize external peer review if necessary.
- Link peer review to reappointment.

A Perinatal Safety Checklist for Risk Professionals

- ❑ Maternal level of care determined.
- ❑ Early warning system established.
- ❑ Human factors/implicit bias training occurs.
- ❑ In-house OB/view tracings off-site.
- ❑ Standardization of processes – oxytocin/tachysystole.
- ❑ EFM/simulation training participation necessary for privileges.
- ❑ Speak up climate/reporting culture is strong.
- ❑ AIM bundles implemented.
- ❑ Nursing staffing, education, and metrics addressed.
- ❑ The medical staff is engaged and accountable.