Speaker Panel

Maternal-Fetal Medicine

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Midwifery/Nursing

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Disclosures

- Richard Berkowitz, MD, FACOG has no real or perceived conflicts of interest to disclose.
- Lisa Kane Low, PhD, CNM, FACNM, FAAN has no real or perceived conflicts of interest to disclose.
- Barbara Scavone, MD has no real or perceived conflicts of interest to disclose.
Objectives

- Provide history of initiative and background on National Partnership for Maternal Safety

- Review the resources made available by the Council:
  - Obstetric Hemorrhage Patient Safety Bundle
  - Severe Maternal Morbidity (SMM) Forms

- Provide a recap of the 2014 Safety Action Series sessions related to obstetric hemorrhage

- Serve as an open forum for attendees to ask questions and share implementation experiences, tips, and pieces of wisdom
Background
Background

- ACOG-CDC Maternal Mortality/Severe Morbidity Action Meeting occurred in Atlanta, November 2012
- Participants identified key priorities:
  - 6 multidisciplinary working groups were formed

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Background

• Concept of bundles developed by Institute for Healthcare Improvement (IHI)
• Goal: to help health care providers more reliably deliver the best care for patients
• Provides a structured way of improving processes of care
• Includes a straightforward set of evidence-based practices
• When performed correctly and consistently there is a noted improvement in patient outcomes

IHI. Evidence-Based Care Bundles. Available at: http://www.ihi.org/topics/bundles/
The Council

Formed in late 2011, the Council on Patient Safety in Women’s Health Care brings partner and subspecialty organizations together with patients under the central goal of improving health care for all women.

Mission
Continually improve patient safety in women’s health care through multidisciplinary collaboration that drives culture change

Vision
Safe health care for every woman

Purpose
The Council on Patient Safety in Women’s Health Care’s purpose is to reduce harm to patients by fostering:
  • Investigation to better understand the causation of harm
  • Programs and tools to implement patient safety initiatives
  • Education to promote patient safety
  • Dissemination of patient safety information
  • A health care culture of respect, transparency, and accountability
Council Composition
The National Partnership for Maternal Safety

- American Academy of Family Physicians (AAFP)
- American Association of Birth Centers (AABC)
- American Association of Blood Banks (AABB)
- American Hospital Association (AHA)
- American College of Nurse-Midwives (ACNM)
- American College of Obstetricians and Gynecologists (ACOG)
- Association of Maternal and Child Health Programs (AMCHP)
- Association of State and Territorial Health Officials (ASTHO)
- Association of Women’s Health Obstetric and Neonatal Nurses (AWHONN)
- California Maternal Quality Care Collaborative (CMQCC)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare and Medicaid Services (CMS)
- Cynosure
- Florida Perinatal Quality Collaborative
- Health Resources and Services Administration (HRSA)
- Hospital Corporation of America (HCA)
- National Association of Nurse Practitioners in Women’s Health (NPWH)
- The Preeclampsia Foundation
- PULSE of New York
- Society for Maternal and Fetal Medicine (SMFM)
- Society for Obstetric Anesthesia and Perinatology (SOAP)
- The Joint Commission (TJC)
- Voluntary Hospital Association (VHA)
Severe Maternal Morbidity Data Abstraction and Assessment Tools
Severe Maternal Morbidity (SMM)

What events should be reviewed?

- Pregnant, peripartal or postpartum women receiving 4 or more units of PRBCs
- Pregnant, peripartal or postpartum women who are admitted to an ICU as defined by the center.
- Other pregnant, peripartal or postpartum women who have an unexpected and severe medical event – at the discretion of the facility
Tools to Help Conduct SMM Review

• Developed out of the National Partnership for Maternal Safety
• Available for free download from Council’s website
• To help with conducting facility-based review for systems learning

http://safehealthcareforeverywoman.org/get-smm-forms.php
Tools to Help Conduct SMM Review

**Part A - SMM Abstraction Forms**

- Trained abstractor
- Capture analyzable and descriptive data from medical record
- Narrative of key aspects of morbidity
- Focused questions regarding care quality
  - Was hypertension recognized appropriately
  - Did woman appropriately receive magnesium
  - Was severe hypertension treated in a timely fashion
  - Was woman delivered in a timely fashion
Tools to Help Conduct SMM Review

Part B – SMM Assessment Forms

- Identify whether opportunities to alter outcome (strong, possible, none)
- If yes enumerate and make specific recommendations
- Identify things that went well
- Conduct of committee
  - Just culture or other non-judgmental approach
2014 Focus: Obstetric Hemorrhage
Obstetric Hemorrhage Patient Safety Bundle

“What every birthing facility in the US should have...”

- Developed out of the National Partnership for Maternal Safety and endorsed by the Council in July 2014
- Available for free download from Council’s website
- 2014 Safety Action Series topics addressed various bundle components

Obstetric Hemorrhage Safety Bundle

**READINESS**
- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compression stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Established 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 debriefs)

**RECOGNITION & PREVENTION**
- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of CUMMULATIVE blood loss (formal, as quantitative as possible)
- Active management of 3rd Stage of labor (department-wide protocol)

**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**
- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Review all serious hemorrhages for systems issues
- Monitor outcomes and process metrics in Perinatal QI committee
Rollout and Role of the Council
In Summary - Deliverables

Evidence Based Care Bundles

– **Obstetric Hemorrhage**
– Severe Hypertension in Pregnancy
– VTE Prophylaxis

Supplemental

– Maternal Early Warning Criteria
– Severe Maternal Morbidity Data Abstraction and Assessment Tool
– Patient, Staff, and Family Support
Implementation

• The National Partnership for Maternal Safety
• The Council on Patient Safety in Women’s Health Care will:
  • Provide oversight for the implementation of the 3 safety bundles within 3 years
  • Track implementation throughout the US using lessons learned from IHI 5 Million Lives Campaign
  • Provide a platform for facilities to share best practices
  • Systematically review the impact of these initiatives

www.safehealthcareforeverywoman.org

IHI. 5 Million Lives Campaign. Available at: http://www.ihi.org
## Review of 2014 Safety Action Series

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Questions & Open Discussion
Review of Submitted Questions

*Has ACOG published a formal recommendation to do QBL on all deliveries? If so where is it published?*

At this time no formal opinion from ACOG exists. ACOG and AWHONN have held workshops and training around QBL and various additional resources are available.

Existing Resources:

– AWHONN Standard Recommendation
– CMQCC Standard Recommendation
– August 2014 Safety Action Series on QBL
– National Maternal Health Initiative 2013
  • One of 7 safety objectives
Review of Submitted Questions

Suggestions for how to reduce death from OB hemorrhage in rural, low resource, remote settings where village birth attendants are the only people present at 60% of births in countries like Tanzania. We are conducting training sessions in one of these locations in a subsistence farming region in rural Tanzania.

Helpful resources:
- Rethinking WHO guidance: review of evidence for misoprostol use in the prevention of postpartum haemorrhage
- WHO recommendations for the prevention and treatment of postpartum haemorrhage
- Guideline for attendance at a physiologic (expectant) 3rd stage of labour
- Misoprostol for the treatment of postpartum haemorrhage in low resource settings (would apply to all countries and is not different from what is recommended in US)
Much of the teaching about early response to hemorrhage is to react to changes in vital signs. Do we have any evidence to tell us how to incorporate QBL into that thought process? Does QBL just serve as a sensitizer to risk rather than a trigger to specific action? Secondarily, why do we distinguish between vaginal delivery and Cesarean for abnormal blood loss (>500 vs. >1000)?

QBL is expected to be a trigger in addition to vital signs. Clinicians should recognize that QBL may be inaccurate and should also look for changes in vital signs.

To address the distinction of blood loss volume between vaginal and cesarean deliveries it is important to note that the thresholds described are meant to indicate loss outside of the expected range. In ACOG’s work with the reVITALize Data Definitions Initiative, Early Postpartum Hemorrhage was defined to as not delineate between the loss thresholds for vaginal and cesarean births.
Review of Submitted Questions

Any consideration for the correlation of PPH to the rampant use of Pitocin? Of course some inductions and augmentations are medically indicated....but I'm curious about fully informed consent when providers are offering their patients elective induction, as well as for "soft-call" medical inductions, particularly when the Bishop score is so low, repeated cervical ripening and prolonged hours of Pitocin could possibly be putting the patient more at risk than is medically necessary. It's crucial to have the PPH bundle and early recognition. Risk screening is so important, but if risk can be decreased, shouldn't that be a priority?

The workgroup did receive questions around women who may be at higher risk but bundle does not address decision making around inductions or augmentations. Other resources does exist regarding the prevention of primary cesarean:

- **SMFM/ACOG Obstetric Care Consensus**

Further, the involvement of other organizations and coordinated efforts to prevent primary cesarean births tie in to the idea of the Partnership – “all hands on deck” and the need to collaborate and coordinate efforts to move forward together.
Review of Submitted Questions

Our facility is creating a new postpartum hemorrhage policy. We would like to see other facilities' policies if they would be willing to share.

The PPH bundle will be released in the manuscript (published in Anesthesia & Analgesia, Journal of Midwifery & Women's Health, Obstetrics & Gynecology, Journal of Obstetric, Gynecologic, & Neonatal Nursing) will provide reference links to the many resources we reviewed as part of the overall project.

There is also the California Maternal Quality Care Collaborative PPH Toolkit -- it has many of the examples of worksheets etc.
Q&A Session

Press *1 to ask a question

You will enter the question queue
Your line will be unmuted by the operator for your turn

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org
Next Safety Action Series

Changes to the Joint Commission Sentinel Events Chapter – a Focus on Severe Maternal Morbidity

Thursday, January 29, 2015 | Noon ET

Lisa Buczkowski, RN, MS
Associate Director
Office of Quality & Patient Safety
The Joint Commission

Gerry Castro, PhD, MPH
Project Director
Patient Safety Initiatives
The Joint Commission

Ron Wyatt, MD, MHA, DMS (HON)
Medical Director
Healthcare Improvement
The Joint Commission

Speaker TBD
Use of severe maternal morbidity reporting forms within an organization

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