Safety Action Series

Creating the Link: Coordinating Inpatient and Community Resources for Patient, Family and Staff After a Severe Maternal Event
Speakers

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Disclosures

- Aimee Danielson, PhD has no conflicts of interest to disclose

- Camille Hoffman, MD, MSCS, FACOG

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Objectives

➢ Outline the importance of continued support for patients and families after transition out of the hospital following a severe maternal event.

➢ Provide a framework for communication in crisis situations for providers and staff.

➢ Review existing support networks from both the inpatient and community perspectives.

➢ Provide tips for how to successfully identify and create links to support resources in your local community.
Every unit

- Develop a unit-based protocol that includes resources for supporting patients, their families (including non-family support), and staff after a severe maternal event.
- Establish a facility-based multidisciplinary response team that integrates clinical staff and mental health professionals.
- Provide unit education on protocols and conduct unit-based drills (with post-drill debriefs) on patient, family, and staff support after a severe maternal event.
- Develop a unit culture where patients, families, and staff are informed about potential risk factors and are encouraged to speak up when they feel concern for patient well-being and safety.
Severe Maternal Morbidity (SMM)

Events to trigger Coordination of Care:

• Pregnant, peripartum, postpartum women receiving ≥4 units of blood products
• Pregnant, peripartum, postpartum women admitted to an ICU
• Other pregnant, peripartum, postpartum women who have an unexpected & severe medical event
The Inpatient Review Team

- Obstetricians, family medicine physicians, CNMs
- Anesthesia providers
- Obstetric (Perinatal) care nurses
- Mental health providers (SW, Behavioral Health Specialist, Psychologist, or Psychiatrist)
- Patient advocate(s)
- Regional perinatal center (if small birth facility)
- Birth facility Quality improvement team
- Birth facility administration
- Scribe
Inpatient perspective

- Coordinated care & debrief intrapartum/inpatient (interdisciplinary)
- NICU communication - SW, NICUs, NNPs
- Flag women with known MH issues (preexisting) to provide resources and/or help them initiate contact with while still inpatient
RECOGNITION

Every patient, family, and staff member

- Perform timely assessment of emotional and mental health status of patients, their families, and staff during and after a severe maternal event
- Build capacity among staff to recognize signs of acute stress disorder in patients, their families, and staff after a severe maternal event
Why These Events?

• Trauma is “In the eye of the beholder”
• A near death childbirth experience for mother or baby is always traumatic
• Traumatic experience does not equal Post-traumatic Stress Disorder, but...
• High risk for psychiatric symptomatology, including PTSD and MDD
• Readiness=Providers expecting and looking for psychiatric symptomatology in women who had near death experience or intrapartum death (mom or baby)
“Causes” of Post-Traumatic Stress Disorder

- 9% develop PTSD*

- Most often, PTSD is caused by a real or perceived trauma during delivery or postpartum.

- Women with a prior trauma history, such as rape or sexual abuse, are at the highest risk for experiencing postpartum PTSD (“double whammy”).

“Causes” of Post-Traumatic Stress Disorder

- Women in the highest tier of risk:
  - Mother experienced a severe physical complication or injury related to pregnancy or childbirth ("near death experience")
  - Baby dies or has a near death experience leading to NICU hospitalization
  - Mother experiences feelings of powerlessness, poor communication and/or lack of support and reassurance during the delivery

PTSD: Risk to Moms

- Increased risk of major depression (40-50%) comorbid with PTSD
- Decreased maternal bonding (with infant)
- Decreased infant attachment (to mother)
- Other long term adverse mental and physical health repercussions for the mother
- Resurrection of the trauma next pregnancy/delivery/postpartum period
PTSD: Risk to Babies

- Decreased maternal bonding (with infant)
- Decreased infant attachment (to mother)
- Poorer feeding & growing
- Long-term sequelae of:
  - Poorer and/or adverse neurodevelopment
  - Predisposition to perinatal mood & anxiety disorders in childhood/adolescence/adulthood
  - Poorer long-term mental & physical health
- Child Abuse & Neglect
PTSD: Risk to Families

- Partner depression, anxiety, PTSD
- Impaired and/or strained relationships
- Separation/Divorce
- Long term consequences on mental and physical health of the family
- Can impact family plan
Effects on the Care Team

- Depression, Anxiety, PTSD
- Lost sleep
- Lost work productivity
- Decreased job satisfaction
- Burn out - “Failure to Thrive”
- Poorer mental & physical health
Anticipation of the trauma caused by a Severe Maternal Event can mitigate the negative fall-out for EVERYONE involved.
Every severe maternal event

- Provide timely and effective interventions to patients, their families, and staff during and after a severe maternal event
- Communicate a woman’s condition with the patient and her family, when appropriate, after a severe maternal event
- Offer support and resources to patients, their families, and staff after a severe maternal event
A Communication Framework

Calgary-Cambridge Model Points in Breaking Bad News

• **Preparation:**
  – Know the personal details of the patient
  – Have all info readily available
  – Prepare yourself for what you will say
  – Have others present- ask the patient who she’d like present and, if possible, bring someone who has had prior contact with the patient

• **Introduction**
  – Introduce yourself
  – Spend a few moments establishing rapport
  – Ask for info from the recipient to establish her knowledge of the situation

• **Achieving understanding**
  – Speak clearly, use non-medical terminology
  – write down technical terms if necessary
  – Find out patient’s views
  – Assess the patient’s/family’s understanding of the diagnosis/situation

_Calgary-Cambridge Guide to the Medical Interview_
A Communication Framework

Calgary-Cambridge Model Points in Breaking Bad News

- **Pacing & shared control**
  - allow for pauses- silences are useful
  - Try to lead the patient towards making the diagnosis
  - Let the patient take some of the lead and involve them in the management decisions
  - Allow questions!

- **Responding to emotions**
  - Touch the patient/relative if appropriate
  - Reassure them that it is alright to cry. Allow expression of emotion
  - Eye contact and non-verbal communication!!
  - Show your own emotion

- **Honesty**
  - Offer both worst and best scenarios
  - If appropriate, leave the recipient of the news with some hope
  - Take responsibility for any mistakes and apologize
  - Do NOT BE AFRAID to say “I’m sorry,” “I don’t know” *if* you are and you don’t

_Calgary-Cambridge Guide to the Medical Interview_

A Communication Framework

*Calgary-Cambridge Model Points in Breaking Bad News*

- **Support**
  - Highlight any positive help (i.e. pain relief)
  - Offer continuing support
  - Offer practical advice
  - Have a plan for the future and help the patient/relative to plan this
- **Closure**
  - Summarize at the end of discussion
  - Finish with positive points
  - Close discussion by inviting questions
  - Make sure the patient can get home OK
  - Set the next meeting
  - Give a telephone number/way to contact

Interventions to Mitigate Impact for Patient and Family

- Continuous caregiver support during labor (female caregiver, doula, midwife)
- Creation of protected space (limit presence of trainees and extraneous staff)
- Intention to Preserve of Normalcy
- Compassion (in cases of infant loss, door sign)
- Clear & Gentle Communication
- After Childbirth, Debrief with mother and family
  - Clarify why procedures were conducted
  - Answer questions
After the Adverse Event: Post-Discharge Considerations

- Possible psychological/psychiatric complications
- Possible series of perinatal medical complications that leads to chronic disease
- A healthy mother being discharged while her baby remains in the NICU is very painful
- Mothers with a baby who was harmed in childbirth, with ongoing/unresolved medical issue, *at highest risk* (30% of NICU Moms have PTSD)
- Child who has long-term effects is a constant trigger for the trauma.
After the Adverse Event: Post-Discharge Considerations

• Don’t forget about the woman who has a catastrophic event, recovers, and walks out seemingly healthy with a healthy baby.

• Pregnancy after a traumatic childbirth or perinatal loss is frequently fraught.
Existing Support Networks

- Involve Hospital Social Workers *within most hospitals
- Outpatient Psychiatry/Behavioral Health
- Pediatrics
- Bereavement Services
- Local Health Department
  – To help identify mental health support systems for least resourced individuals
- Consider including coping assessment in post-delivery nursing phone contact
- Include screening for depression and anxiety at postpartum OB visit (Pediatrics visits, if possible)
Tips: Locating Community Perinatal Mental Health Resources

- Involve Hospital Social Workers
- Connect with local PSI chapter
- Query outpatient Psychiatry/Behavioral Health
- Query Pediatrics, NICU
- Query local Health Department
- Identify local support groups (new mother, postpartum depression, and/or perinatal loss)
- Provide educational brochure, community resources, warm line, for family at discharge
Resources

- See Council on Patient Safety Website and Patient, Family, and Staff Support after a Severe Maternal Event Safety Bundle

[www.safehealthcareforeverywoman.org](http://www.safehealthcareforeverywoman.org)
National Resources

- **Postpartum Support International**  Provides specific information on support groups and providers by region.  [www.postpartum.net](http://www.postpartum.net)

- **Postpartum Progress**  [www.postpartumprogress.org](http://www.postpartumprogress.org)

- **Mass General Women’s Mental Health Center**  [www.womensmentalhealth.org](http://www.womensmentalhealth.org)


- **Solace for Mothers**  Provides and creates support for women who have experienced childbirth as traumatic  [www.solaceformothers.org](http://www.solaceformothers.org)

- **Pregnancy Loss and Infant Death Alliance (PLIDA)**  [www.plida.org](http://www.plida.org)
Every unit

- Establish a culture of huddles for high-risk patients and post-event debriefs to identify successes and opportunities for improvement
- Conduct a multidisciplinary review of severe maternal morbidity events for systems issues, to include patient perspectives where feasible
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee
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

Prevention of Surgical Site Infections Following Major Gynecologic Surgery Patient Safety Bundle

February 8, 2016 | 11:00 a.m. Eastern

Barbara Levy, MD, FACOG, FACS
Vice President, Health Policy
American College of Obstetricians and Gynecologists

Joseph Pellegrini, PhD, CRNA
Associate Professor and Director
Nurse Anesthetist Program, University of Maryland School of Nursing

Click Here to Register
Future Safety Action Series

Maternal Mental Health: Perinatal Depression and Anxiety Patient Safety Bundle

Coming February 2016

John Keats, MD, CPE, FACOG
Market Medical Executive, Cigna Health Care of Arizona

Susan Kendig, JD, WHNP-BC, FAANP
Director of Policy, National Association of Nurse Practitioners in Women's Health

Click Here to Pre-Register
Registrants will receive notification of time and dial in once available