COUNCIL ON PATIENT SAFETY
IN WOMEN'S HEALTH CARE
safe health care for every woman

PRACTICING FOR PATIENTS

Teamwork and Communication in Obstetrical Emergencies

Teamwork and communication are essential to quality healthcare and patient safety. TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety) is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among healthcare professionals.

KEY TeamSTEPPS® CONCEPTS AND TOOLS RELATED TO POSTPARTUM HEMORRHAGE EVENTS

READINESS

- **Brief:** a short planning session prior to an event or shift.

  Ex: patient has risk factors for PPH, let's be prepared with equipment/ medications.

- **Huddle:** a quick meeting to share information and regain situation awareness.

  Ex: team discusses causes for PPH, uterotonics given, plans for going to the OR.

RECOGNITION & PREVENTION

- **Situation Awareness:** state of mindfulness and knowing external factors that may affect care.
- **Cross Monitoring:** watching each other's back and speaking up if you notice something.

RESPONSE

- **SBAR:** brief summary of Situation-Background-Assessment-Recommendation that is critical information provided to team members as they arrive to an event.

  Ex: "We are having a postpartum hemorrhage with uterine atony. Patient is a 42y/o G5P5 s/p NSVD 1 hour ago. QBL is 1200cc, BP 95/60. I have given oxytocin and called for methergine."

- **Call-Out:** critical information that is relayed clear, concise and timely to team

  Ex: "The patient's blood pressure has dropped to 90/60 and she is tachycardic to 120 bpm. "
  "The blood bank has been called and is activating the massive transfusion protocol."

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- **Check Back:** closed-loop communication to ensure that information conveyed by the sender is understood by the receiver and acknowledged

  Ex: Doctor "Give 0.2mg Methergine IM"
  Nurse "0.2mg Methergine IM given"
- **Psychological Safety:** team members are encouraged to speak up for patient safety.
- **Role Clarity:** assign specific tasks to team members.
- **Shared Mental Model:** team members have a common goal which is communicated.
- **Handoff:** transfer of information during transitions in care.

REPORTING

- **Debrief:** a nonjudgmental team meeting after an event discussing lessons learned and reinforcing positive behaviors, essential to process improvement.

  Ex: all team members after PPH, what went well, what should we change

Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women's Health Care disseminates patient safety tools to help facilitate the standardization process. This tool reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Although the components of a particular tool may be adapted to local resources, standardization within an institution is strongly encouraged.

The Council on Patient Safety in Women's Health Care is a broad consortium of organizations across the spectrum of women's health for the promotion of safe health care for every woman.

September 2018