Southern California Patient Safety Collaborative
Fast Facts

Patient Safety First...
a California Partnership for Health

July 13th, 2011—Track III: Perinatal Safety

TeamSTEPPS helps prevent birth trauma: A (motion) picture is worth a thousand words!

Julia Slininger, RN, BS, CPHQ, Hospital Association of Southern California

- Team Strategies and Tools to Enhance Performance and Patient Safety goes where no program has gone before: beyond evaluation and improvement of systems, beyond quality improvement models, beyond human factors and crew resource management, to helping multidisciplinary staff members function as effective teams in the day-to-day environment.
- Mutual Respect and Mutual Support are key practices that can be learned and adopted with specific communication and conflict resolution tools, such as "Using CUS Words" ie: "Dr., I am **C**oncerned, I am **U**ncomfortable with this situation, and I think it may not **S**afe to proceed", to deal with a situation involving potential fetal distress.
- TeamSTEPPS materials, developed, trialed and tested by AHRQ and the DoD (and free to hospitals at www.ahrq.com/teamstepps), incorporate excellent videos demonstrating what ineffective (and error-prone) communication looks and sounds like, and how it can be improved. HASC will also be offering guided TeamSTEPPS training in 2012.

Quantitative Progress- Reaching for our Goal!

Julia Slininger, RN, BS, CPHQ, Hospital Association of Southern California

- With the Patient Safety First (PSF) Collaborative half way through its 3-year charter, review of performance data seem to indicate some progress, with run chart data for elective deliveries at less than 39 weeks showing rates that climb from 5% to 20% to 2%.
- The real story behind these data, once the number of reporting facilities for each quarter is revealed, is that we really don't know what our aggregate progress is, and that there is an opportunity for improvement in data capture. HASC is employing several strategies to help hospitals understand and address any/all barriers to data collection and submission, including individual contact by Julia Slininger or our MARSH consultants.
- The NHF website has also been updated with a correct listing of Birth Trauma ICD9 codes for accurate numerator data.

The Neurologically Compromised Newborn: A Checklist for the First 24 Hours

Larry Veltman, M.D., FACOG, Risk Management & Patient Safety Institute

- Obstetrics is rife with malpractice risk, and adverse obstetrical outcomes will frequently receive legal scrutiny. As in other critical care departments and interventions, a checklist can be very helpful to assure that standards of practice are all met. Dr. Veltman provided a draft checklist that facilities can use when delivering a "sick" newborn.
- Documentation "Do's and Don'ts" were covered, including a reminder that an adverse outcome should not be attributable to an intrapartum event in the obstetrical record since significant diagnostic investigation is usually required following the birth.
- The case was made for saving a section of the cord for 7 days in case cord blood gas analysis is later determined to be helpful, and indications for placental examination were reviewed.

Connecting the *Docs*! Can regional collaboration and telemedicine in the IE improve patient outcomes and ease the burdens of providing complex care?

Gretchen Page, MPH, CNM Inland Counties Regional Perinatal Program, Glen Thomazin MD, IEHP, Denise Cummins, LLUMC Perinatal Institute, Rosa Ortega, MCH Director St. Mary Medical Center

- Region 7- the Inland Counties- sees about 60,000 births annually, and covers a very large geographic area, having 9 hospitals with CCS designated community level NICU, but only one regional center. San Bernardino County alone is 215 miles wide and 150 miles from north to south.
- Very Low Birth Weight (VLBW) infants are at risk for poor birth and neonatal outcomes when certain perinatal diagnostic and treatment services are not readily available. Options to improve outcomes include early identification of VLBW cases with antepartum maternal transfer, or telemedicine options when the deliveries occur in hospitals with less VLBW cases.
- An Arkansas based program called ANGELS (which stands for Antenatal and Neonatal Guidelines, Education and Learning System), offers us a successful model to consider, with 6 areas of emphasis: Education & Support for OB Providers, Evidence-Based Guidelines, Evaluation & Research, Telemedicine Network & Clinics, Case Management, and a 24/7 Network Call Center

The March of Dimes Perinatal Safety Project Update

Victoria Lombardo, Associate State Director of Program Services

- The Genesis of the March of Dimes Campaign to reduce the number of elective *(non medically indicated)* deliveries at less than 39 weeks gestation was reviewed, including the initial publication in1979, in which ACOG cautioned against inductions before 39 weeks in the absence of a medical indication (Committee Opinion #22). ACOG has also noted that "a mature fetal lung maturity test result before 39 weeks of gestation, in the absence of appropriate clinical circumstances, is not an indication for delivery" (Committee Practice Bulletins #97 and #107).
- The emphasis of this effort is the recognition of continued development of the brain in the last few weeks of pregnancy, and the need for a paradigm shift in the scheduling of inductions for various reasons of "convenience" (mother or physician).
- Statistical correlations were presented between 37-38 week deliveries and
    - Increased NICU admissions
    - Increased transient tachypnea of the newborn (TTN)
    - Increased respiratory distress syndrome (RDS)
    - Increased ventilator support
    - Increased suspected or proven sepsis
    - Increased newborn feeding problems and other transition issues
- The March of Dimes Toolkit was review and free materials offered to all attendees.
  www.marchofdimes.com/medicalresources_39weeks.html

Presentations and additional materials from this meeting are available at www.HASC.org