Team Collaboration to Bring Patient Safety to "Perfect Storm" Events

OB STAT!

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Northwest Patient Safety Conference
May 1, 2018

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Our story…

Six women suffered post partum hemorrhages between Friday and Sunday!

Most women received IV Pitocin pre and post delivery. Premixed IV Pitocin had just been received from a new supplier.

A variety of physicians were involved in the care of the women, including obstetricians, family practitioners, and anesthesiologists.

Several women experienced significant harm…

Reported Patient Harm

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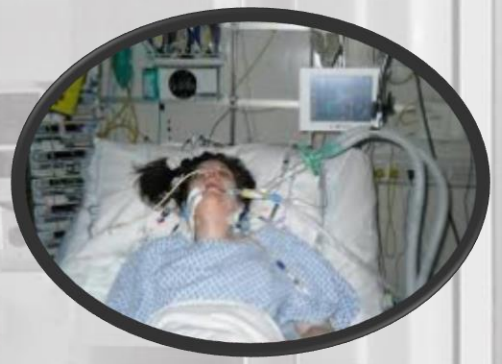
Reported Patient Harm



1 Code Blue

2 Went to ICU

2 Hysterectomies

3 Mass Transfusions

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Rapid Patient Safety Response in Suspected Event Clusters

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RAPID EVENT RESPONSE

The A R E A Process

Four Key Steps

The Rapid Event Response process involves four key steps. Specific actions are associated with each step. The ultimate goal of the *AREA* process is to ensure current and future patient safety.

ALERT

Create Situational Awareness

- ❑ Situational awareness
- ❑ Initial local leadership notification
- ❑ Quality variance report
- ❑ Identify key contact(s)

RESPOND

Ensure Patient Safety

- ❑ Staff debrief/interviews
- ❑ Document environment
- ❑ Sequester medications & equipment
- ❑ Validate events
- ❑ Implement safeguards
- ❑ Support caregivers

ESCALATE

Inform & Engage Key Stakeholders

- ❑ Broad leadership communication: Critical event SBAR
- ❑ Quality & Patient Safety partnership
- ❑ Subject matter experts
- ❑ Literature/Standards review

ANALYZE

Conduct CCA & Develop Action Plans

- ❑ Prep for Common Cause Analysis
- ❑ Interviews & timeline confirmation
- ❑ Key findings
- ❑ Action Plan & timeline
- ❑ Accountability
- ❑ Action item tracking

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RAPID EVENT RESPONSE

The A R E A Process

IMMEDIATE

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AFTER CORE FACTS CONFIRMED

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RAPID EVENT RESPONSE

The A R E A Process

FOLLOWING INVESTIGATION

Four Key Steps

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ALERT	RESPOND	ESCALATE	ANALYZE
Create Situational Awareness	***Ensure Patient Safety***	***Inform & Engage Key Stakeholders***	***Conduct CCA & Develop Action Plans***
❑ Situational awareness ❑ Local leadership notification ❑ Quality variance report ❑ Identify key contact(s)	❑ Staff debrief/interviews ❑ Document environment ❑ Sequester medications & equipment ❑ Validate events ❑ Implement safeguards ❑ Support caregivers	❑ Broad leadership communication: Critical event SBAR ❑ Quality & Patient Safety partnership ❑ Subject matter experts ❑ Literature/Standards review	❑ Prep for Common Cause Analysis ❑ Interviews & timeline confirmation ❑ Key findings ❑ Action Plan & timeline ❑ Accountability ❑ Action item tracking

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ALERT

Immediate Actions To Create Situational Awareness

Initial notification

File Quality Variance Report

Datix®

OB Team Huddle

Identify Point of Contact

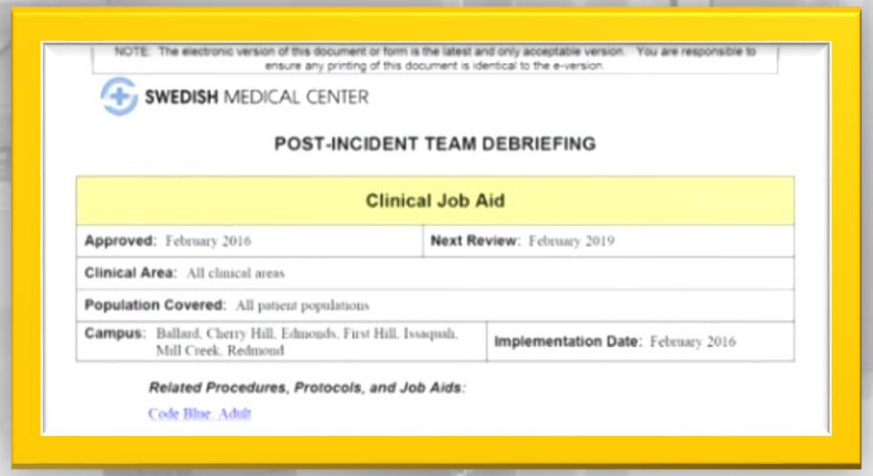
ALERT

Immediate Actions To *Create Situational Awareness*

RESPOND

Immediate Measures To Ensure Patient Safety

Provider and Staff Debrief & Interviews



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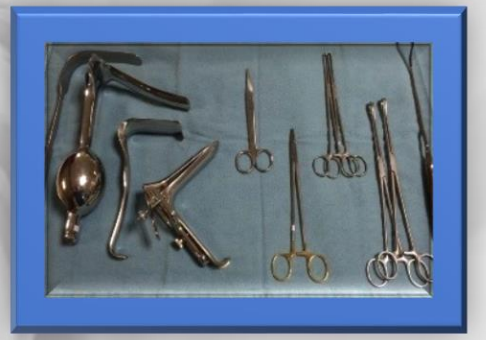
POST-INCIDENT TEAM DEBRIEFING

Clinical Job Aid	
Approved: February 2016	**Next Review:** February 2019
Clinical Area: All clinical areas	
Population Covered: All patient populations	
Campus: Ballard, Cherry Hill, Edmonds, First Hill, Issaquah, Mill Creek, Redmond	**Implementation Date:** February 2016

Related Procedures, Protocols, and Job Aids:

Code Blue: Adult

Sweep Environment & Examine Equipment



RESPOND

Immediate Measures To *Ensure Patient Safety*

Validate All Reported Events!

Support Caregivers

Obtain or Sequester Meds & Equipment

RESPOND

Immediate Measures To *Ensure Patient Safety*

Implement Safeguards

Change Environment & Equipment if Indicated

Establish Caregiver Communication & Escalation Process

RESPOND

Immediate Measures To *Ensure Patient Safety*

Implement Safeguards

Patient History & Labor Management Plan

Pitocin Process Change

RESPOND

Immediate Measures To *Ensure Patient Safety*

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Communication To Inform & Engage Key Stakeholders

Broad Leadership Communication

Initiate Critical Incident SBAR After Core Facts Confirmed

ESC

Communication To *Inform &*

S:	**EVENT DESCRIPTION:** *Briefly explain what occurred and* ***if the patient suffered any harm***	*Please put fact based, short synopses. Full description should be documented in eQVR/event report.* **Multiple OB patients, delivered between Friday and Sunday, reportedly had post-partum hemorrhages. Patient harm included …**
B:	**PATIENT NAME:**	**Multiple OB patients**
	MRN:	**X8875047, X3997834, X90024543**
	EVENT DATE:	00/00/0000
	CAMPUS:	**St. Elsewhere Hospital**
A:	**eQVR #:**	**EV9875X3**
	DISCLOSURE: *State if disclosure was given to patient and by who OR if it was not given*	**No**
	DEBRIEF: *State if debrief did or did NOT occur.*	**Manager held staff huddle. OB Medical Director sent communication to physicians.**
R:	**PLAN FOR REVIEW / FOLLOW-UP:**	Initial review into all possible cases in progress this morning (Monday AM) by manager and Quality department.

In Partnership with Quality & Patient Safety Explore…

Equipment Failure or Absence

Med Variances

Communication Gaps

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Communication To *Inform & Engage Key Stakeholders*

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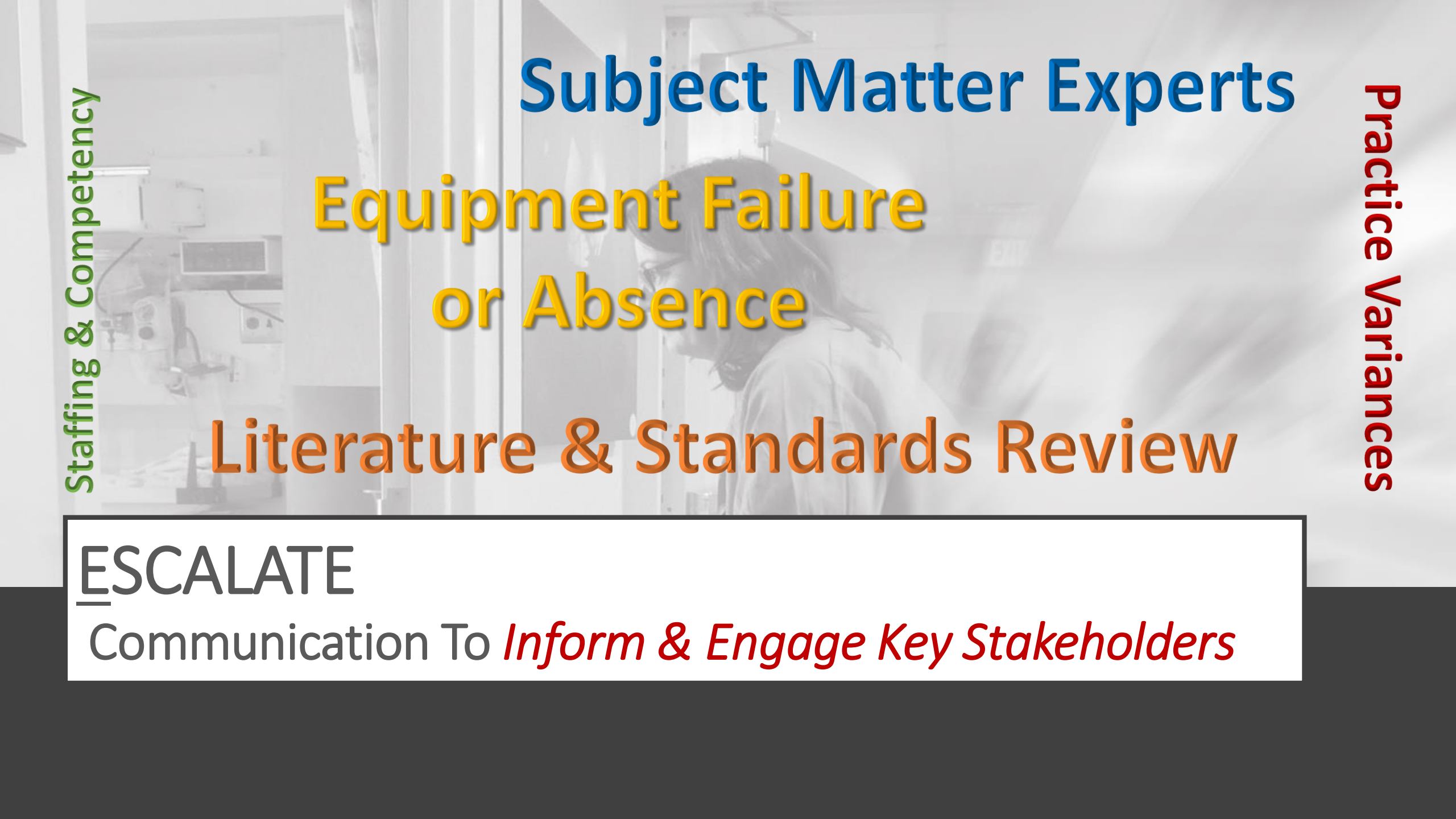
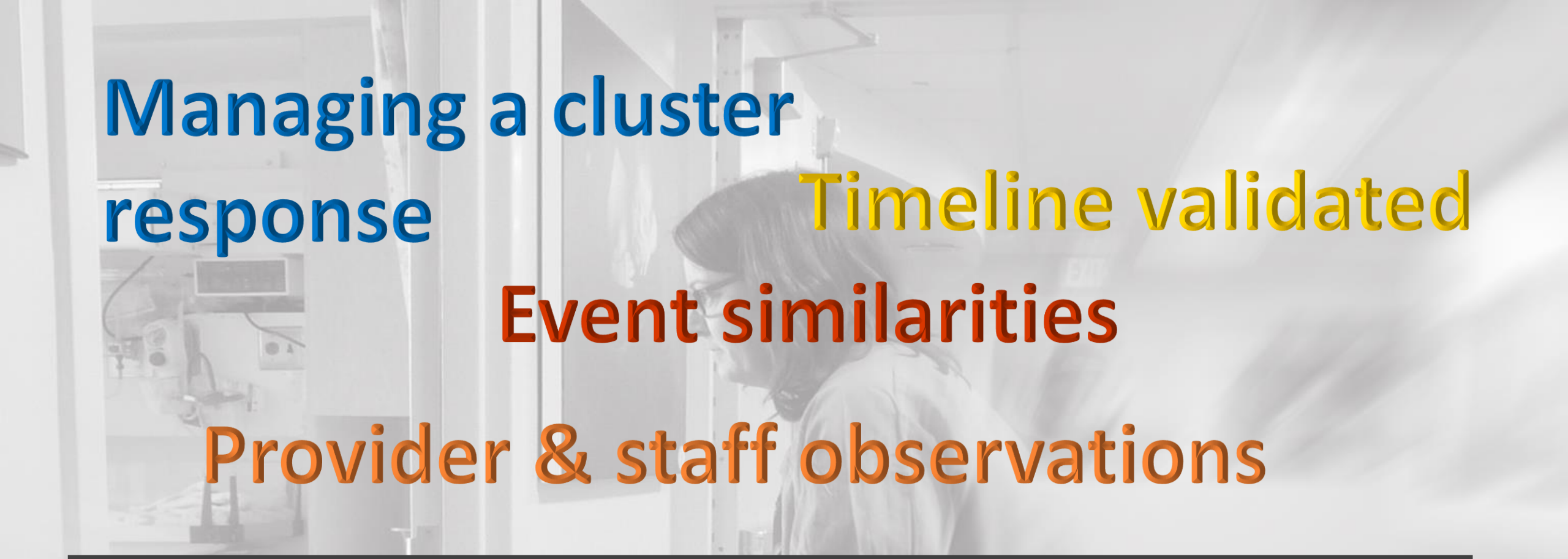
Communication To *Inform & Engage Key Stakeholders*



ESCALATE

Communication To *Inform & Engage Key Stakeholders*

ANALYZE
Conduct CCA & Develop Action Plans



ANALYZE

Conduct CCA & Develop Action Plans

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Conduct CCA & Develop Action Plans

CCA Findings: No Common Cause(s) Identified

Actions from Identified Opportunities for Improvement

~ Reduce provider labor & delivery practice variation

~ Modify blood administration processes: orders & blood release

~ Obtain rapid transfuser for OB Unit, validate caregiver competency

~ Monitor for consistent use of pre-labor screening checklist & iSTAT

~ Validate caregiver competency in PPH early warning signs & mgmt.

~ Re-educate on WSHA Safe Delivery Roadmap Tools and MEWS

OB Leadership continues to actively participate in AWHONN & the California Maternal Quality Care Collaborative.

Cluster Event Core Patient Safety Concepts

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PPH Cluster Key Learnings

- Ensuring Patient Safety is job one! Use PS principles & proceed with intentional urgency.
- Establish Point of Contact immediately, use defined methods of communication.
- Pause to ensure information is factual. Validate all potential events.
- Define roles & responsibilities of investigation support personnel.
- Communicate with leadership & frontline caregivers.
- Coordinate with Quality and/or Patient Safety Department.

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Edmonds strives for "a happily ever after," through safe deliveries, for EVERY mom and baby!

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