Why Are We Here?

Perinatal Patient Safety Program

Regional PPSP Mission

1. Decrease human error
2. Identify and improve patient care systems
3. Improve the reliability of performance
Regional PPSP Purpose

1. To create a “culture of safety” in L&D
2. Create high reliability Perinatal unit

PPSP Components

- Program wide initiative
- SCAL Regional Steering Committee
- Medical Center Steering Committees/Teams
- Educational Programs
  - Safety Attitude Questionnaires
  - Human Factors Training
  - SBAR Communication Training
  - Critical Event Team Training (CETT)
  - EFM PPSP Video Series
- Just Culture Environment

JCAHO Sentinel Event Alert, Issue 30, July 2004

- Conduct team training in perinatal areas to teach staff to work together and communicate more effectively
- High risk events (shoulder dystocia, STAT C/S, hemorrhage, neonatal resuscitation)- conduct drills to help staff prepare for such events, and debriefings to evaluate team performance and identify areas for improvement
- Apply evidence based guidelines to: FHR interpretation and communication, availability of personnel, neonatal resuscitation areas
- Why do they make these recommendations?
JCAHO Perinatal Sentinel Events

- Communication Breakdowns- the Primary Cause of More Than 70% of Events Analyzed
- 55% - Organizational Culture a barrier to communication and teamwork
- 47% - Staff competency issues
- 40% - Orientation and training processes
- 34% - Inadequate fetal monitoring

Reoccurring Clinical Problems*

- Inability to recognize and respond to fetal distress,
- Inability to effect timely cesarean birth for fetal distress,
- Inability to resuscitate a depressed infant,
- Inappropriate use of pitocin, leading to uterine hyperstimulation, uterine rupture, & fetal distress.
- Inappropriate use of forceps / vacuum leading to fetal trauma and shoulder dystocia.
- “If you get these things right, you eliminate 80% of perinatal liability claims” - Eric Knox

Characteristics of High Reliability Units

- Safety is the hallmark of organization culture.
- Operation of the systems is considered to be a team rather than an individual function.
- Communication is highly valued and rewarded.
- Emergencies are rehearsed and the unexpected practice
- Successful operations are viewed as potentially dangerous; that is, success leads to system simplification, shortcuts or what has been termed “the normalization of deviance.”

*MMR Company data of 250 hospitals over 10 years
Teamwork: WHY BOTHER?

- Error Reduction
  - In complex environments, teams outperform individuals- even in medicine!
  - Patient Safety, Cost, Professional Duty
- Job Satisfaction/Morale, Staff Retention
  - Safety Attitude Questionnaire.

What works to improve Communications and Teamwork

- Briefing: Is there a plan? S-B-A-R
- Assertion: “I see a problem” or Hint and Hope
- Situational Awareness: same page?
- Leadership
- Simulations: CETT
- Debriefings

What is a Briefing?

**Definition:**

A briefing is a dialogue or discussion between two or more people using concise and relevant information to promote clear and effective communication
When to Brief

- Start of work - Multidisciplinary Rounds
- New Team Members
- Pre-Procedure
- Change in Situation

Situational Brief

**S-B-A-R:**

- Situation
- Background
- Assessment
- Recommendation

Assertion

“Individuals speak up, and state their information with appropriate persistence until there is a clear resolution.”
Situational Awareness: An Overview

A shared and accurate understanding of “what’s going on” and “what is likely to happen next”

- Allows us to recognize events around us, act correctly when things proceed as planned, and react appropriately when they don’t.
- As with other Human Factors skills, SA is owned by the entire team.

Verbalizing **Red Flags** to Help Restore Situational Awareness

SEE IT  
SAY IT  
FIX IT

**RED FLAG CHECKLIST**

**TASK MANAGEMENT**
- Task Saturation
- Fixation / pre-occupation
- Failure to prioritize
- Being rushed, feeling pressured
- Deviating from normal practice
- Trying something new under pressure

**SELF-MANAGEMENT**
- Boredom / fatigue
- Personal problems - health: mental, physical
- Workload, multi-tasking
- Intuition:
  - “Doesn’t feel right”.
  - “Something feels wrong”
**RED FLAG CHECKLIST**

**COMMUNICATION**
- ☼ Reduced / poor communication
- ☼ Feels awkward
- ☼ Interruptions
- ☼ Unresolved issues
- ☼ Verbal violence

**TEAM MANAGEMENT**
- ☼ Uncertainty about the game plan
- ☼ No one in charge.
- ☼ Resource management: workload, lack of planning, poor collaborative decision-making

---

**CRITICAL EVENT DRILLS**

**What are they?**

- ✓ Lifelike and focus on normal human errors
- ✓ Normal noise - confusion - resources
- ✓ Situation must be diagnosed and managed by team exactly as in real life, system weaknesses revealed.
- ✓ Do your usual job at all times
- ✓ Blame free and confidential. Don’t share scenarios

---

**CRITICAL EVENT DRILLS**

**What good are they?**

- ✓ Drills offer a “safe” learning environment. When events are rare, CETT improves performance that degrades over time or with stress
- ✓ Drills safely reveal positive & negative communication patterns
- ✓ Drills safely reveal system design strengths and weaknesses and may reduce the frequency of emergencies but: NEVER TO ZERO!
CRITICAL EVENT DEBRIEFING

✓ What went well?...... Why?
✓ What could be better?......Why?
✓ What systems' problems did we find?
✓ What communication problems did we find?
✓ What teamwork glitches did we find?

DEBRIEFING GOLDEN RULE

Critique the performance . . .
not the person