

DOWNLOAD PDF QUALITY IMPROVEMENT FOR EMERGENCY OBSTETRIC CARE.

Chapter 1 : Preparing for Clinical Emergencies in Obstetrics and Gynecology - ACOG

Quality Improvement for Emergency Obstetric Care?, below.) WHY FOCUS ON EMERGENCY OBSTETRIC CARE? Every year, almost , women in the world die from pregnancy-related complications, and.

The protocol should provide for a full evaluation of the problem. Training all staff in a formal emergency communication process, using a standardized communication tool such as SBAR (Situation-Background-Assessment-Recommendation), may further optimize effective response to a patient care issue. Lack of teamwork and suboptimal communication have been cited as the leading cause of perinatal and maternal death⁶. Standardized responses and practices will increase the efficiency of care and allow a continuous quality improvement process to accurately assess the effectiveness of the interventions. Rapid response teams may include advanced practice nurses, respiratory therapists, and first responders who approach the scenario in a standardized fashion. The activation of a rapid response team should be simultaneous with the event. All regular clinical team members have the authority to activate a rapid response team when a critical event or criteria are noted, or for any potential serious emergency in which a team response is required⁵. By designating criteria that define an emergency, it becomes clear when to call for help, thus increasing the utilization of the rapid response team³⁻⁵. This contrasts with the conventional, serial chain of command that traditionally was followed before an intervention could be initiated. Early activation of a rapid response team has been associated with a decrease in cardiac arrest, improved survival of hospitalized patients, and decreased admissions to an intensive care unit⁷. It is important to emphasize that calling a resident physician in a teaching hospital is not a substitute for triggering a rapid response team intervention. Similarly, calling the in-house physician in a nonteaching setting does not substitute activating a rapid response team intervention. Establishing a rapid response team is a multistep process^{3, 8, 9}. Clinicians, support staff, and stakeholders must be identified; this may include the page operator, as well as staff in the blood bank or the hospital laboratory⁵. Criteria for activation of a rapid response team should be determined. Debriefing, with feedback and process improvement, must be established⁵. Finally, the effectiveness of the rapid response team process should be evaluated on a regular basis. A rapid response team can be divided into four components: Activators are individuals who may activate the rapid response team, and may include clinicians, specialists, or clerical staff. Team members from the nursing staff or floor staff are trained to monitor for disturbances that require activation of the rapid response team. Responders are clinicians who arrive at the bedside, along with the attending physician, to stabilize the patient and determine her disposition. Options may include transfer to a higher level of care, revision of the current treatment plan, or a handoff to the primary nurse or physician. When the responders arrive, the activators must be prepared to exchange information. A communication protocol such as SBAR allows team members to exchange information in a clear and concise manner. This will help ensure that expeditious care is provided to the patient. Early in the response phase, a discussion, or brief, should be conducted to assign essential roles, establish expectations, and anticipate outcomes and possible contingencies. The primary purpose of the communication protocol is to exchange critical patient information and establish a treatment plan. A team huddle, designed to reinforce plans already in place and to assess the need to adjust the plan, also may be used to review situational awareness and to troubleshoot and revise the current plan of action, if needed. A check-back closed loop communication strategy used to verify and validate information exchanged, a time-out/planned period of quiet and interdisciplinary discussion focused on ensuring that key procedural details have been addressed, or a call out strategy used to communicate important or critical information may be used to ensure closed loop communication. Team members should be debriefed after the event in an effort to evaluate and improve their response. The quality improvement team reviews the activation, implementation, and outcomes of the rapid response team. Their assessment and recommendations are formulated into an action review, which may be implemented by administration. Resources for setting up such an initiative, as well as other resources, may be

DOWNLOAD PDF QUALITY IMPROVEMENT FOR EMERGENCY OBSTETRIC CARE.

found on the web sites of these organizations. Successful implementation of a rapid response team may involve overcoming logistic, political, institutional, social, financial, or anthropologic barriers. Leadership from senior medical and nursing personnel is crucial. Emergency Drills and Simulation The principle that standardized care can result in safer care applies to emergency situations as well as to routine care. This training may use a comprehensive curriculum that addresses communication strategies such as TeamSTEPPS 12 or a less structured teamwork model or a curriculum that focuses on specific clinical scenarios, such as shoulder dystocia. A sophisticated simulated environment or an everyday workspace can meet the needs of the trainees as long as it mirrors the existing clinical setting and resources. By conducting a drill in the actual patient care setting, issues related to the physical environment may become obvious. Simulation training can identify and correct common clinical errors made during emergencies. Protocols, activation criteria, and critical interventions can be reinforced by being posted on walls, printed on pocket cards, or uploaded as screen savers to promote a sustained culture of safety. Emergency drills allow team members to practice effective communication in a crisis. Adult learning theory supports the importance of experiential learning. Many aspects of the medical environment may compromise effective communication, including a hierarchical hospital structure, emotional intensity and stress of a situation, and the range of educational backgrounds and clinical understanding of various team members. Other barriers to improved response to medical emergencies include inadequate leadership, adherence to traditional models, fear of criticism, hierarchy and intimidation, failure to function as a team, and lack of education and orientation of involved staff 14. Effective teamwork requires a team leader to coordinate the response, but it also empowers all members of the team to contribute and share information. By practicing together, barriers that hinder communication and teamwork can be overcome. Effective drills may lead to improved standardization of response, health care provider satisfaction, and patient outcomes. Developing rapid response teams and training using drills and simulations may allow for faster and improved response to emergent situations, thereby potentially maximizing patient outcomes.

Conclusion The obstetrician-gynecologist practices in an environment where emergencies will occur. Preparation for these situations requires allocation of resources and supplies, planning, and collaboration. Inpatient emergencies can be mitigated by a rapid response team that has designated roles, streamlined communication, prompt access to emergency supplies, and ongoing education and training. The criteria used to activate a rapid response team must be defined and disseminated among potential activators. A protocol with standardized interventions and onsite drills will improve the care given in an emergency. The exact nature of the protocol will vary widely depending on the work environment and resources available. Prompt recognition of and response to critical clinical scenarios, teamwork, and training enhance patient safety and mitigate the severity of adverse outcomes. Retrieved June 13, 2013.

Resource This resource is for information purposes only. Referral to this resource does not imply the endorsement of the American College of Obstetricians and Gynecologists. This resource is not meant to be comprehensive. The exclusion of a source or web site does not reflect the quality of that source or web site. Please note that web sites are subject to change without notice. Retrieved June 20, 2013.

Severe maternal morbidity among delivery and postpartum hospitalizations in the United States. To err is human: National Academy Press; Introduction of an obstetric-specific medical emergency team for obstetric crises: Am J Obstet Gynecol; Improving hospital systems for the care of women with major obstetric hemorrhage. The effect of a rapid response team on major clinical outcome measures in a community hospital. Crit Care Med; Best practices in prenatal care: J Perinat Neonatal Nurs; Nurs Womens Health; N Engl J Med; Simulation in obstetrics and gynecology. Obstet Gynecol Clin North Am; Obstetric medical emergency teams are a step forward in maternal safety! J Emerg Trauma Shock; 3: Preventing infant death and injury during delivery. Sentinel Event Alert Issue American College of Obstetricians and Gynecologists.

DOWNLOAD PDF QUALITY IMPROVEMENT FOR EMERGENCY OBSTETRIC CARE.

Chapter 2 : EngenderHealth |

In this module, we will learn about a globally recognized package of such interventions called emergency obstetric care, or EmOC. We will spend some time learning about how emergency obstetric care is assessed and monitored at the national and sub-national levels, including quality improvement measures.

This article has been cited by other articles in PMC. Abstract Background Lack of timely and quality emergency obstetric care EmOC has contributed significantly to maternal morbidity and mortality, particularly in low- and middle-income countries LMICs. Following set criteria, we included articles, assessed for quality based on a newly developed checklist, and extracted data using a pre-designed extraction tool. We used thematic summaries to condense our findings and mapped patterns that we observed. To analyze experiences and recommendations for improved EmOC assessments, we took a deductive approach for the framework synthesis. Results Twenty-seven studies met our inclusion criteria, with 17 judged as high quality. The highest publication frequency was observed in Most assessments were conducted in Nigeria and Tanzania four studies each and Bangladesh and Ghana three each. Seventeen studies conducted facility-based surveys, whereas others used mixed methods. For different reasons, intrapartum and very early neonatal death rate and proportion of deaths due to indirect causes in EmOC facilities were the least reported indicators. Key emerging themes indicate that data quality for EmOC assessments can be improved, indicators should be refined, a holistic approach is required for EmOC assessments, and assessments should be conducted as routine processes. Conclusions There is clear justification to review how EmOC assessments are being conducted. Synergy between researchers, EmOC program managers, and other key stakeholders would be critical for improved assessments, which would contribute to increased accountability and ultimately service provision. In these countries, maternal mortality remains a major public health challenge with hemorrhage, hypertension, obstructed labor, infection, and complications of unsafe abortion leading to more than three-quarters of maternal deaths 2. Evidence suggests that provision of timely and quality emergency obstetric care EmOC by a skilled health care professional can potentially reduce the maternal morbidity and mortality that would otherwise occur 4 , 5. Six of the eight care packages constituted basic emergency obstetric care BEmOC: These six care packages in addition to the provision of caesarean and blood transfusion services make up comprehensive emergency obstetric care CEmOC. Incorporating evidence from the field and literature, the guidelines were reviewed and updated in 8. In the updated guideline version 2. In this update, although refining some of the previously listed indicators, two new indicators were added, making a new total of eight indicators Table 1.

Chapter 3 : Patient Safety and Quality Improvement - ACOG

Posted on May 23, January 17, One of the strategies that hospitals, clinics, and other health care facilities are using to reduce maternal death and disability is quality improvement.

Chapter 4 : Quality Improvement Toolkits | Transforming Maternity Care

The purpose of this newly revised manual and accompanying toolbox is to assist health care providers working in emergency obstetric care (EmOC) settings to improve the quality of services within their facility.