Debriefs and System Improvement after an Obstetric Emergency

Thursday, August 3, 2023
2:00 – 3:30PM EST
The Alliance for Innovation on Maternal Health is a national, cross-sector commitment designed to support best practices that make birth safer, improve maternal health outcomes, and save lives.

You can find more information at saferbirth.org.
Before We Get Started

▶ You are muted upon entry to the call.
▶ You will have the ability to unmute yourself during Q&A times.
▶ We encourage participants to remain muted to reduce background noise.
▶ If you are experiencing technical difficulties, please chat an AIM staff member or email aim@acog.org.

This presentation will be recorded. Both the slides and recording will be available on the AIM COLS 2022-2023 Webpage and shared in the follow-up newsletter.
1. Welcome
2. Speaker Presentation: Kimberly D. Harper & Kathleen M. Zacherl
3. Q/A
4. Closing
Introductions

Kimberly Harper, MSN, RN, MHA
Perinatal Neonatal Outreach Coordinator,
UNC Center for Maternal and Infant Health

Kathleen Zacherl, MD
UCONN Assistant Professor of Obstetrics and Gynecology
Debriefs and Systems Improvement after an Obstetric Emergency

Kimberly D. Harper, MSN, RN, MHA
Kathleen M. Zacherl, MD, FACOG
Team Superpowers

What would you say is your most valuable strength that you bring to your team?
Shared Norms

- We seek and offer different pathways for participation
- We build a culture of belonging and teamwork - prioritizing relationships, and striving for inclusivity
- We value all the different strengths that each team member brings
- Take care of yourself
Team-based Communication Strategies and Best Practices
Shared Language

Debriefing

Teams

Culture of safety

Shared mental model
Reporting and Systems Learning

Debrief
- Post-event
- Reviews timeline of events
- Identify successes, barriers, opportunities

Brief
- Plan of care
- Assess resources, goals of care, contingency plans

Huddle
- Recurring/scheduled or ad hoc for change in patient status
- Sharing critical changes
- Key safety reminders can be reviewed
Debriefing

- Team reflection
- Continuous improvement
- Lessons learned
- Reinforce positive behaviors
What is a team?

- 2 or more people
- Work toward a common and valued goal
- Complementary skills and specific roles
Culture change

- Organizations still struggle with culture change
- Implementation is key to successful debriefing and improvement
Start a debrief movement
Shared mental model

- The perception of, understanding of, or knowledge about a situation or process that is shared among team members through communication

- High performing teams have shared mental models

Rouse, Cannon-Bowers, and Salas, 1992
Best practices for debriefing

- Make it routine
- Short
- Bame-free
- Immediately after event

- All team members
- Respectful feedback, validate all comments
- Document action items and distribute
Safety is not about the absence of negatives, it is about the presence of capacities.

Safety II

"Work as done" versus "Work as imagined"

Communication in debriefing

Successes, barriers, opportunities

Celebrate wins & "good catches"

Focus on solutions

Value everyone’s input

Start small

Safety II
Scenario

Cindy: nurse manager of ED

- Transferred patient to a perinatal referral center
- Precipitous delivery in the field with hemorrhage
- Stabilized mother and infant
- Transfused and gave obstetric hemorrhage meds
- Cindy gathers the team
- Team asks why they would need to debrief since "it all went great."

- What would be the benefits of debriefing?
- Strategies for Cindy
- Which team members should be included?
- How can Cindy facilitate buy-in from the team to debrief?
Key Elements to Review and Document
Core Components of Debriefing

1. Psychological Safety
2. Reactions, defuse emotions
3. Encourage all to participate
4. Review events
5. Analysis (debriefing tool)
6. Focus on SYSTEMS and SOLUTIONS
7. Lessons learned/Action items
8. Gratitude
Debriefing Tools

**Shared mental model to create an action plan**

- Pluses/Deltas
- W³: What, So What, Now What
- TALK©: Target, Analysis, Learning, Key Actions
- ACOG “Obstetric debriefing form”
# Obstetric Team Debriefing Form

Remember, debriefing is meant to be a learning experience and a way to address both human factors and systems issues to improve the response for next time.

There is to be no blaming/finger-pointing.

<table>
<thead>
<tr>
<th>Type of event:</th>
<th>Date of event:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of event:</td>
<td></td>
</tr>
</tbody>
</table>

**Members of team present:** (check all that apply)

- [ ] Primary RN
- [ ] Primary MD
- [ ] Anesthesia personnel
- [ ] Neonatology personnel
- [ ] Nurse Manager
- [ ] OB/Surgical tech
- [ ] Charge RN
- [ ] MFM leader
- [ ] Unit Clerk
- [ ] Resident(s)
- [ ] Patient Safety Officer
- [ ] Other RNs

**Thinking about how the obstetric emergency was managed,**

<table>
<thead>
<tr>
<th>Identify what went well: (Check if yes)</th>
<th>Identify opportunities for improvement: “human factors” (Check if yes)</th>
<th>Identify opportunities for improvement: “systems issue” (Check if yes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Communication</td>
<td>Equipment</td>
</tr>
<tr>
<td>Role clarity (leader/supporting roles identified and assigned)</td>
<td>Role clarity (leader/supporting roles identified and assigned)</td>
<td>Medication</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Teamwork</td>
<td>Blood product availability</td>
</tr>
<tr>
<td>Situational awareness</td>
<td>Situational awareness</td>
<td>Inadequate support (in unit or other areas of the hospital)</td>
</tr>
<tr>
<td>Decision making</td>
<td>Decision-making</td>
<td>Delays in transporting the patient (within hospital or to another facility)</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**For identified issues, fill in table below**

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>ACTIONS TO BE TAKEN</th>
<th>PERSON RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
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<td>2</td>
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<td>4</td>
</tr>
</tbody>
</table>

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**Safe Motherhood Initiative**

Revised March 2019

[AIM Alliance for Innovation on Maternal Health Logo]
Pluses/Deltas

- What went well?
- Why did it go well?
- What does the team want to maintain and build on?

- Opportunities for improvement
- Action-oriented, begin with a verb
- Specific
- Attainable
- Things to be acted on!
Step 1: Target
What shall we discuss to improve patient care?
Share your perspective.

Step 2: Analysis
Explore your agreed target, if appropriate consider:
1. What helped or hindered... communication / decision making / situational awareness?
2. How can we repeat successful performances or improve?

Step 3: Learning Points
What can the team learn from the experience?

Step 4: Key Actions
What can we do to improve and maintain patient safety?
Who will take responsibility for actions? Who will follow up?

Values

Positivity: Identify positive strategies and behaviours. Avoid negative comments, choose neutral expressions.
Focus on finding solutions, rather than pointing out blame.
Professional communication, valuing everybody’s input.
Step by step: Identify small objectives and follow up outcomes.

Fig. 1. TALK© debriefing card.

Scenario

Coverage found so all members can be present

Vitals abnormal on arrival with bleeding

IV was difficult, hemorrhage meds available, blood ordered

Transfused and gave obstetric hemorrhage meds

Patient's bleeding improved, vitals stabilized

Transferred to regional perinatal center

Scenario

Team members:
- Cindy (nurse manager)
- Charlie (primary nurse)
- John (2nd nurse)
- Stephanie (triage nurse)
- Tristan (nurse practitioner)
- Bob (unit clerk)
- Dr. Scott (ED physician)
- Dr. Regan (2nd ED physician)

Questions:
- Approach to debriefing
- Key items to debrief
Implementation Strategies for Improvement
Acting on action items
Create Infrastructure
Infrastructure

- Align with hospital mission
- Integrate into activities such as quality committees, leadership walk rounds
- Connect with local leaders (medical directors, nursing leadership, QI mentors)
- Start small
- Find first followers as champions
- Close the feedback loop!
Kaizen: Change for the better

"Kai"= change
"Zen"= good

- Continuous improvement
- Small improvement by those who do the work
- Tie these improvement efforts with organization's mission and leadership.
- Debriefing as a way to empower front line staff

Kaizen

Before
Our little patients under 5 years old are often screaming and won’t be still or lay down during Ultrasound procedures. The parents are frustrated and many times cannot find a way to calm the infant down.

After
We now have tiny bottles of “wedding” bubbles and we ask the parents to gently blow them over the top of the child to calm and entertain them.

The Effect
Happy babies make for happy parents, which make for happy staff, resulting in Joyful Service, and peace of mind.

<table>
<thead>
<tr>
<th>Name</th>
<th>Supervisor</th>
<th>Date</th>
<th>Estimated Cost Savings (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hope Woodard</td>
<td>Gina Bonner</td>
<td>5-9-07</td>
<td>Priceless!</td>
</tr>
</tbody>
</table>
Celebrate!

- "Good catch" awards
- What went well
- Improvement efforts
Scenario

**Action items:**

**Questions:**
- Ways to act on action items within organizations
- How to close the loop?
## Kaizen example from scenario

<table>
<thead>
<tr>
<th>Obstetrical Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before</strong></td>
</tr>
<tr>
<td>Delay in gathering meds for obstetrical patients with hemorrhage</td>
</tr>
</tbody>
</table>

### The Effect

Decreased time to respond to obstetrical patients

### Staff member

Cindy
Putting it all together
Questions?
Thank you!

Any questions - aim@acog.org