2023 Obstetric Emergency Readiness COL Offering #8

Debriefs and System Improvement after an Obstetric Emergency

Thursday, August 3, 2023
2:00 – 3:30PM EST

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

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.

This program is supported by a cooperative agreement with the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UC4MC28042, Alliance for Innovation on Maternal Health. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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

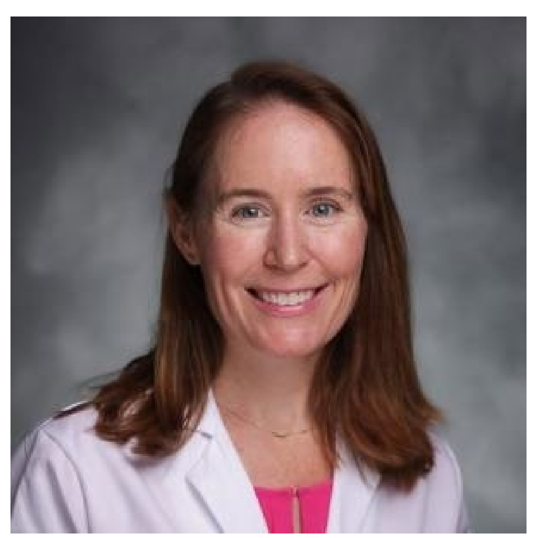
2 Speaker Presentation: Kimberly D. Harper & Kathleen M. Zacherl

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

Fanning RM, Gaba DM. The role of debriefing in simulation-based learning. Simul Healthc. 2007;2:115-125.

Reporting and Systems Learning

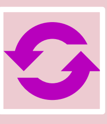
- Post-event
- Reviews timeline of events
- Identify successes, barriers, opportunities

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

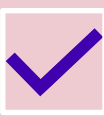
- Recurring/scheduled or ad hoc for change in patient status
- Sharing critical changes
- Key safety reminders can be reviewed

Debriefing

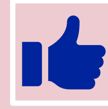
Team reflection



Continuous improvement

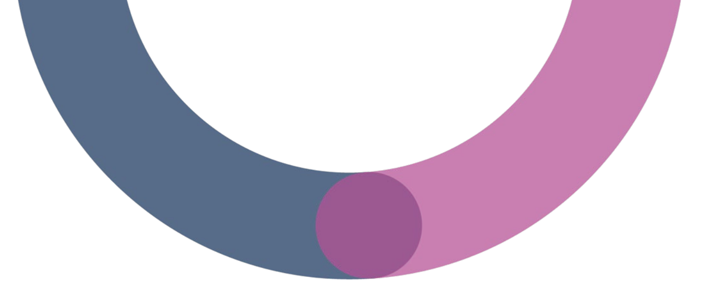


Lessons learned



Reinforce positive behaviors

What is a team?
• 2 or more people
• Work toward a common and valued goal
• Complementary skills and specific roles

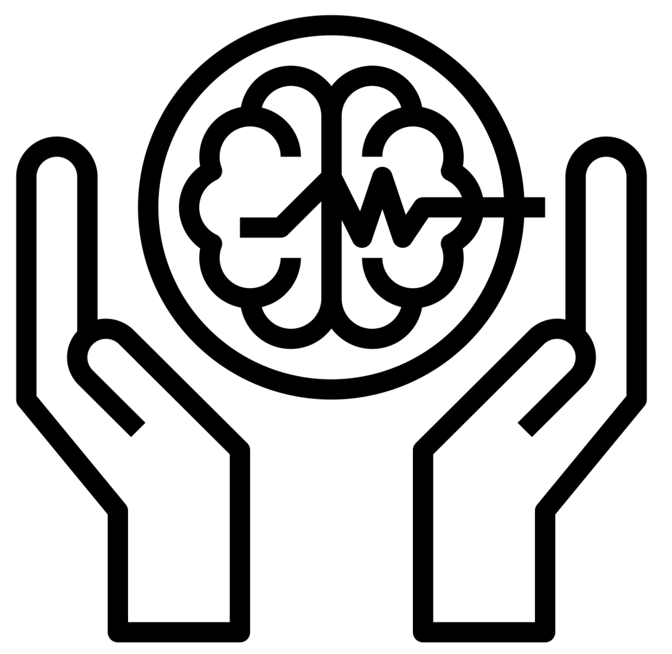


Culture change

- Organizations still struggle with culture change
- Implementation is key to successful debriefing and improvement

Duke Obstetrics
& Gynecology

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 I and II

Safety I	Safety II
• Learn from **risk and failure** • Review bad/unexpected outcomes	• Learn from **all events** • Everyday/mundane occurrences and the good outcomes • Debrief it all!

"Safety is not about the absence of negatives, It is about the presence of capacities."

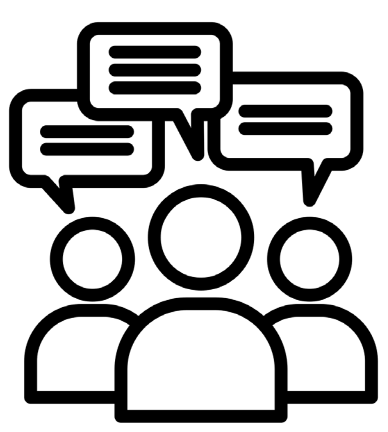
Sidney Dekker. Why do things go right? – Safety Differently. https://safetydifferently.com/why-do-things-go-right/. 2018.

Safety II

"Work as done" versus "Work as imagined"

Bentley SK, McNamara S, Meguerdichian MJ, et al. Adv Simul (Lond). 2021;6(1):9.

Communication in debriefing



Successes, barriers, opportunities

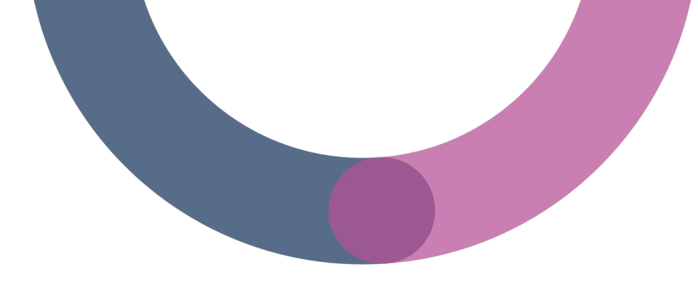
Celebrate wins & ”**good catches”**

Focus on **solutions**

Value everyone’s input

Start small

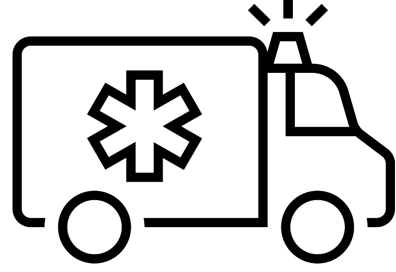
Safety II



Scenario

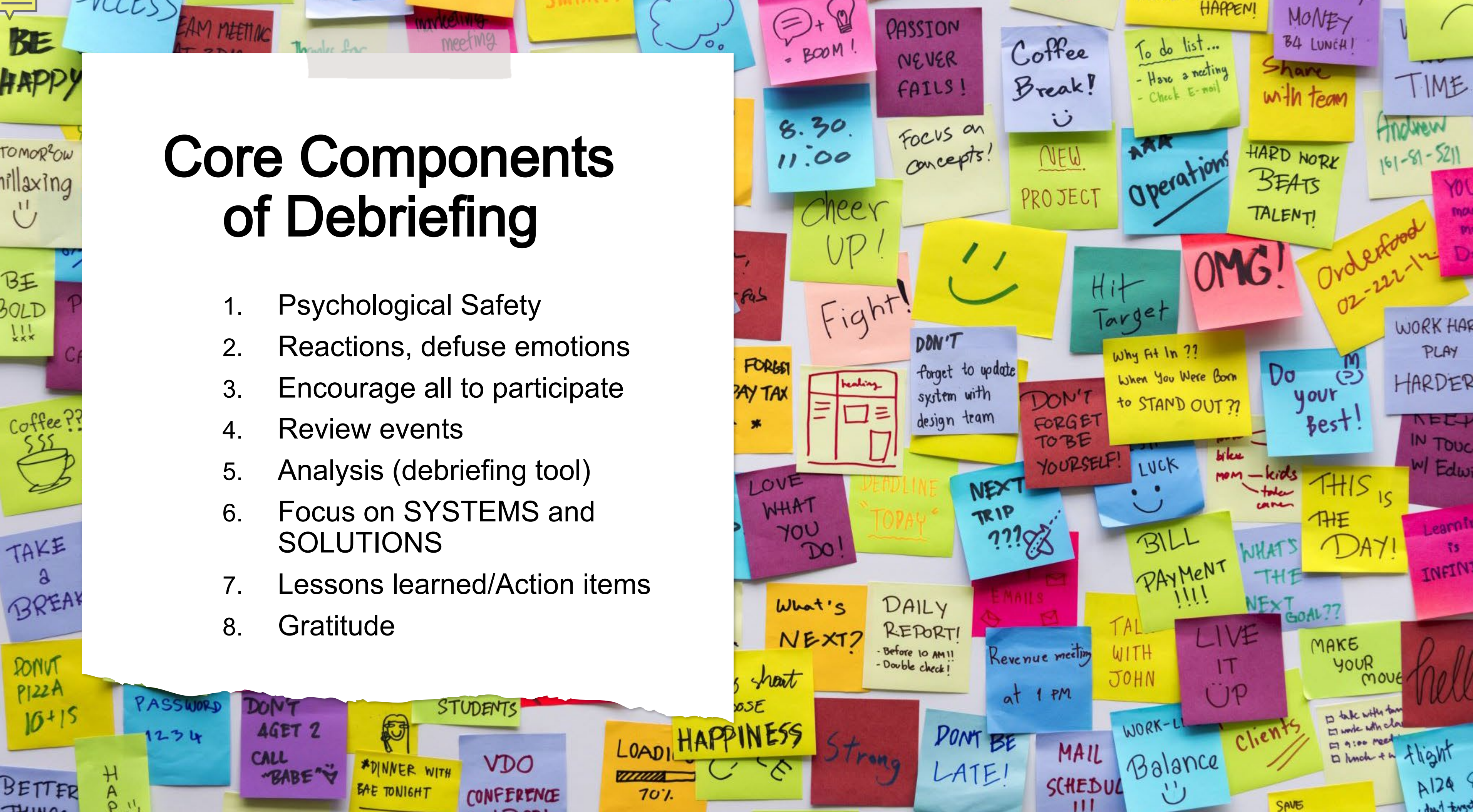
Cindy: nurse manager of ED

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”

ACOG 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.

Type of event: ______________________ **Date of event:** ______________________

Location of event: ______________________

Members of team present: (check all that apply)

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

Thinking about how the obstetric emergency was managed,

Identify what went well: (Check if yes)

- ☐ Communication
- ☐ Role clarity (leader/supporting roles identified and assigned)
- ☐ Teamwork
- ☐ Situational awareness
- ☐ Decision-making
- ☐ Other: ______________________

Identify opportunities for improvement: "human factors" (Check if yes)

- ☐ Communication
- ☐ Role clarity (leader/supporting roles identified and assigned)
- ☐ Teamwork
- ☐ Situational awareness
- ☐ Decision-making
- ☐ Other: ______________________

Identify opportunities for improvement: "systems issue" (Check if yes)

- ☐ Equipment
- ☐ Medication
- ☐ Blood product availability
- ☐ Inadequate support (in unit or other areas of the hospital)
- ☐ Delays in transporting the patient (within hospital or to another facility)
- ☐ Other: ______________________

Safe Motherhood Initiative

Revised March 2019

For identified issues, fill in table below

ISSUE	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE
	1	
	2	
	3	
	4	

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!

TALK©

T **Step 1: Target**
What shall we discuss to improve patient care?
Share your perspective.

A **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?

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

K **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.

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 734753

www.talkdebrief.org

CLÍNIC BARCELONA Hospital Universitari

Fig. 1. TALK© debriefing card.

Diaz-Navarro, et al. Clinical debriefing: TALK© to learn and improve together in healthcare environments. Trends in Anaesthesia and Critical Care 40 (2021): 4-8.

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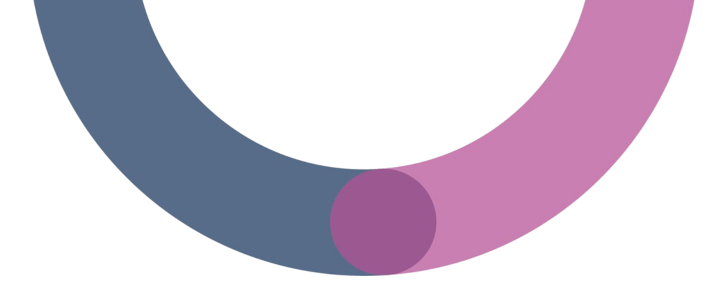
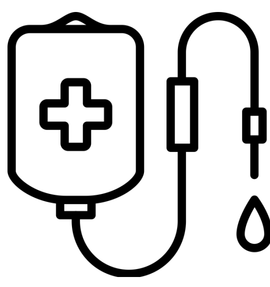


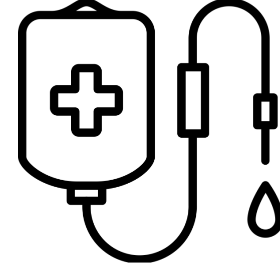
Scenario

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



Adapted from: https://www.ihi.org/communities/blogs/linking-quality-safety-and-wellness-through-health-care-debriefing

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

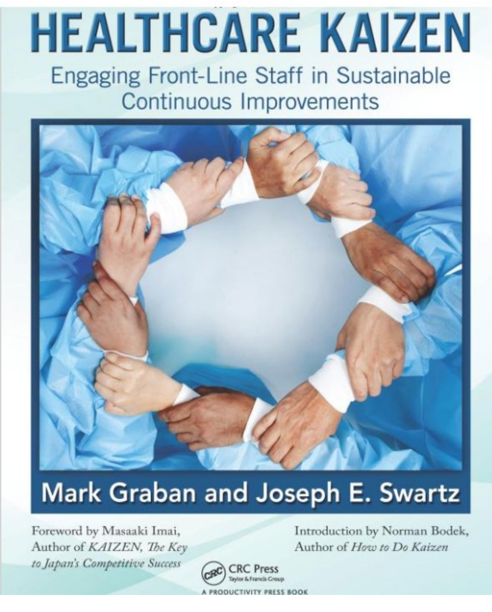
Acting on action items

Create Infrastructure

Infrastructure

Align	• Align with hospital **mission**
Integrate	• Integrate into **activities** such as quality committees, leadership walk rounds
Connect	• Connect with local **leaders** (medical directors, nursing leadership, QI mentors)
Start	• Start **small**
Find	• Find **first followers** as champions
Close	• 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

Graban, Mark., and Joseph E. Swartz. *Healthcare Kaizen: Engaging Front-Line Staff in Sustainable Continuous Improvements*. CRC Press, 2012.

Kaizen

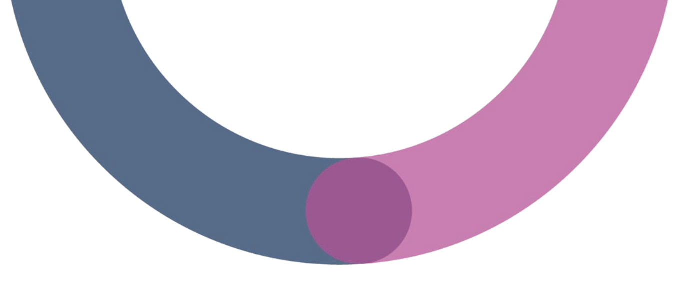
Bubbles for Babies			
Before		**After**	
Our little patients under 5 years old are often screaming and won't be still or lay down during Ultrasound procedures. The parents are frustrated and many times cannot find a way to calm the infant down.		We now have tiny bottles of "wedding" bubbles and we ask 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.			
Name	**Supervisor**	**Date**	**Estimated Cost Savings (Optional)**
Hope Woodard	Gina Bonner	5-9-07	Priceless!

Franciscan ST. FRANCIS HEALTH

Graban, Mark., and Joseph E. Swartz. *Healthcare Kaizen: Engaging Front-Line Staff in Sustainable Continuous Improvements*. CRC Press, 2012.

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

Obstetrical Patients	
Before	**After**
Delay in gathering meds for obstetrical patients with hemorrhage	Hemorrhage med pack
The Effect	
Decreased time to respond to obstetrical patients	
Staff member	
Cindy	

Putting it all together

Questions?

Thank you!

Any questions - aim@acog.org