YOU CAN BE A LEADER, YOU CAN BE A DOER, BUT YOU CAN'T DO BOTH EFFECTIVELY: PRACTICAL TAKEAWAYS FOR WHEN CRISIS STRIKES ON THE LABOR AND DELIVERY

AHA Team Training Monthly Webinar

September 25, 2019

RULES OF ENGAGEMENT

- Audio for the webinar can be accessed in two ways:
  - Through the phone (*Please mute your computer speakers)
  - Through your computer
- A Q&A session will be held at the end of the presentation
- Written questions are encouraged throughout the presentation and will be answered during the Q&A session
  - To submit a question, type it into the Chat Area and send it at any time during the presentation

UPCOMING TEAM TRAINING EVENTS

Courses

Registration for 2019 TeamSTEPPS Master Training Courses is still open. We've got three more courses this year, with our next one on October 3-4 with MetroHealth. View our course schedule to learn more and register.

New! TeamSTEPPS Master Training Course for Outpatient Care

Nov 6-7 | Durham, NC

Do you struggle with teamwork and communication in your medical office or outpatient setting? Sign up today for a TeamSTEPPS Master Training Course specific to outpatient care. These tools can create a common language and way of doing business that can make care coordination all the easier. Learn more and register.

UPCOMING TEAM TRAINING EVENTS

Learn more about our National Conference to be held June 3-5, 2020 in New Orleans. We're looking for presenters and poster authors – You can view our Call for Proposals here.

CONTACT INFORMATION

Web: www.aha.org/teamtraining

Email: TeamTraining@aha.org

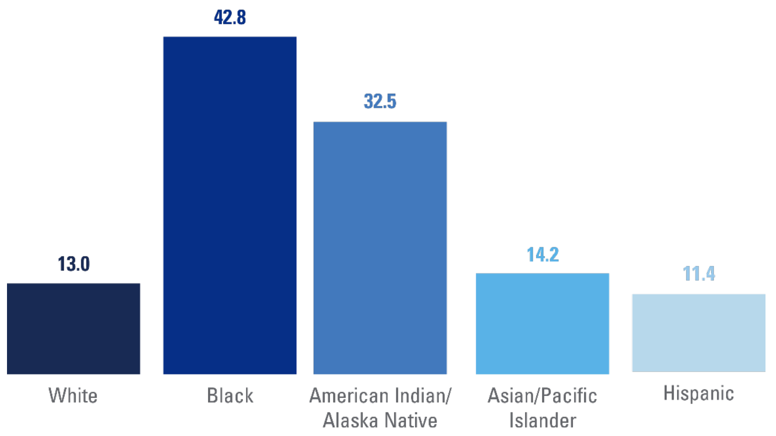
Phone: 312-422-2609

MATERNAL MORTALITY AND MORBIDITY

The Centers for Disease Control and Prevention estimates about 700 women die each year from complications related to pregnancy, and more than half of those deaths are preventable.

Racial & Ethnic Disparities

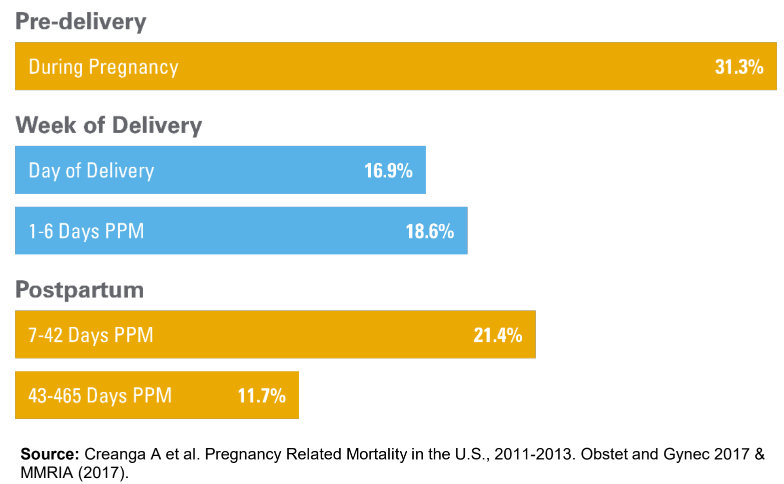
Complex clinical, social and structural determinants contribute to racial and ethnic disparities in pregnancy-related mortality.



Source: CDC Pregnancy Mortality Surveillance System.

The Need to Consider the Continuum of Care

Almost **two-thirds** of pregnancy-related deaths occurred outside the week of birth.



Source: Creanga A et al. Pregnancy Related Mortality in the U.S., 2011-2013. Obstet and Gynec 2017 & MMRIA (2017).

BETTER HEALTH FOR MOTHERS & BABIES

- Models and tools
- Case studies and best practices
- Information for patients and families
- Advocacy and policy
- Additional resources and contacts

To explore more resources, please visit: https://www.aha.org//better-health-for-mothers-and-babies.

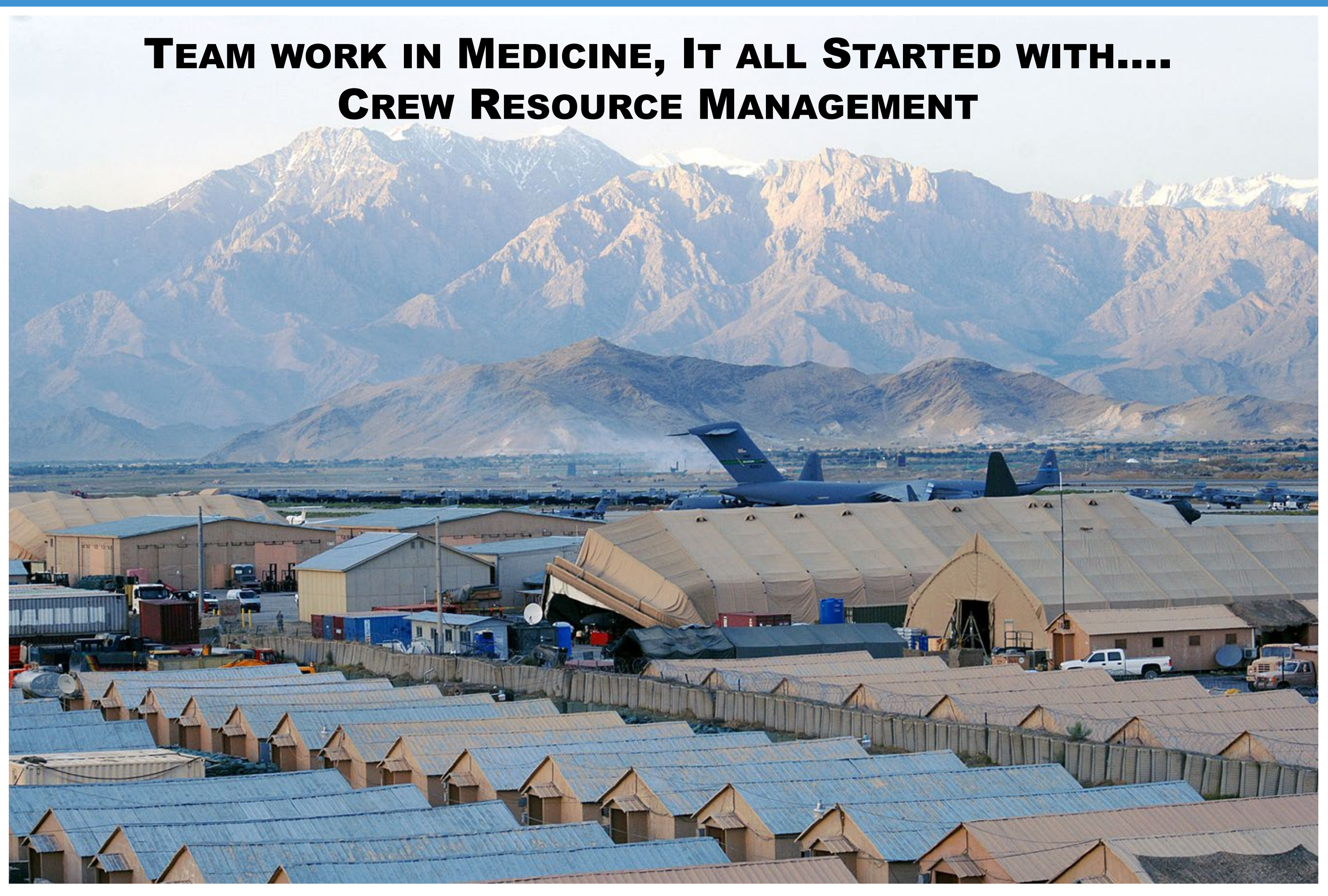
TODAY'S PRESENTER

COL(Ret) Peter G. Napolitano, MD
Maternal-Fetal Medicine
Professor of Obstetrics and Gynecology
Director, Obstetric Simulation Team Performance
University of Washington, Seattle WA

OBJECTIVES

- Define the roles and responsibilities of a leader during medical emergencies
- Understand lessons can we learn from combat medicine and our acute care subspecialties
- Understand how can the we use the whole team, safety bundles and simulation drills to effectively improve our management of obstetric emergencies.

BAGRAM AIR FIELD: AFGHANISTAN



HISTORY OF OBSTETRIC CARE DELIVERY

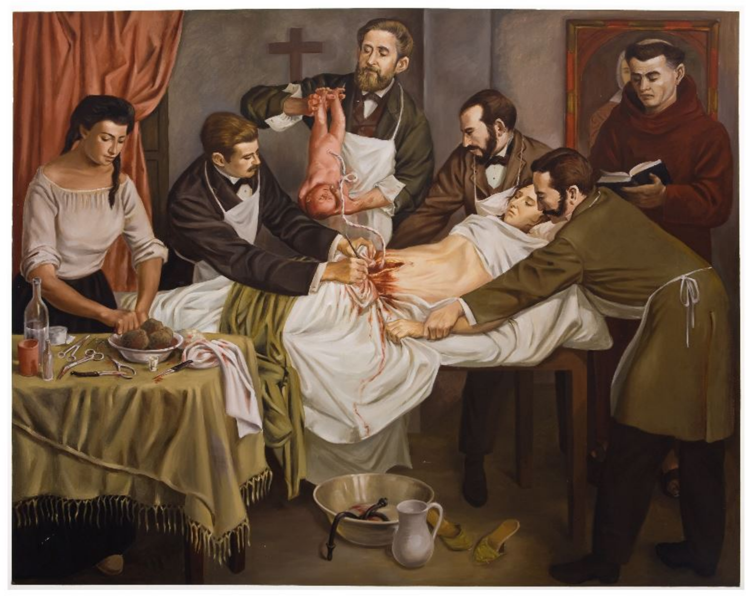
Obstetrix – is Latin word for Midwife: It is thought to derive from the Latin word Obstare – "To Stand Before".

The earliest birth attendants were women.

Image from Slideshare.net

HISTORY OF OBSTETRIC CARE DELIVERY

Turn of the Century brought Modern Surgical Technique and MEN….



Painting depicting the first successful cesarean section in Latin America in 1844. By Enrique Grau. xx1995.814.3 International Museum of Surgical Science Collection

The History of the Department of Gynecology and Obstetrics

Since The Johns Hopkins Hospital was founded in 1889, the Department of Gynecology and Obstetrics' physicians and researchers have been at the forefront of advancing women's health. Our faculty members have helped to change the face of obstetrics and gynecology in the United States — from their academic study to their impact on women and their babies.

IN OBSTETRICS WE ARE STILL A SINGLE FIGHTER PILOT

"JUST A ROUTINE OPERATION" HUMAN FACTORS IN PATIENT SAFETY

Martin Bromiley

https://www.youtube.com/watch?v=JzlvgtPIof4

EFFECTIVE TEAM LEADERS:

- Organize the team
- Articulate clear goals
- Make decision through collective input of members
- Empower members to speak up and challenge, when appropriate
- Actively promote and facilitate good teamwork
- Skillful at conflict resolution

YOU CAN'T BE A LEADER AND A DOER EFFECTIVELY.....

Effective Team Leaders:

1. Need to be easily identifiable
2. Stand back – Airport Tower view
3. Make sure communication happens
4. Must have situation awareness
5. Assign roles to members, what their job is "right here right now"
6. Ensure we follow our guidelines, SOP's and checklist
7. It isn't controlling "the chaos," it's adding structure to that "chaos."

LESSONS WE CAN LEARN FROM THE BATTLEFIELD MEDICINE… LEADERS CAN BE ANY MEMBER OF THE TEAM…

86th Combat Support Hospital; Baghdad, Iraq

Ibn Sina Hospital

Nurse leads trauma resuscitation during mass casualty event.

LESSONS WE CAN LEARN FROM THE BATTLEFIELD MEDICINE… LEADERS CAN BE ANY MEMBER OF THE TEAM…

101st Airborne Combat Support Brigade Clinic; Bagram, Afghanistan; 2011

Mass casualty event run by 18-year-old medic.

LESSONS WE CAN LEARN FROM THE BATTLEFIELD MEDICINE… LEADERS CAN BE ANY MEMBER OF THE TEAM…

Simulation – Courses and In situ Team Drills

Emergencies in Clinical Obstetrics
Instructor Course

Version 2 | Last Updated May 2018

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AHA Team Training

PATIENT SAFETY BUNDLES

PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

READINESS

Every unit

- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION

Every patient

- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE

Every hemorrhage

- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

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Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women's Health Care disseminates patient safety bundles to help facilitate the standardization process. This bundle reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Although the components of a particular bundle may be adapted to local resources, standardization within an institution is strongly encouraged.

The Council on Patient Safety in Women's Health Care is a broad consortium of organizations across the spectrum of women's health for the promotion of safe health care for every woman.

May 2015

For more information visit the Council's website at www.safehealthcareforeverywoman.org

Consensus Statement

National Partnership for Maternal Safety

Consensus Bundle on Obstetric Hemorrhage

Elliott K. Main, MD, Dena Goffman, MD, Barbara M. Scavone, MD, Lisa Kane Low, PhD, CNM, Debra Bingham, DrPH, RN, Patricia L. Fontaine, MD, MS, Jed B. Gorlin, MD, David C. Lagrew, MD, and Barbara S. Levy, MD

Hemorrhage is the most frequent cause of severe maternal morbidity and preventable maternal mortality and therefore is an ideal topic for the initial national maternity patient safety bundle. These safety bundles outline critical clinical practices that should be implemented in every maternity unit. They are developed by multidisciplinary work groups of the National Partnership for Maternal Safety under the guidance of the Council on Patient Safety in Women's Health Care. The safety bundle is organized into four domains: Readiness, Recognition and Prevention, Response, and Reporting and System Learning. Although the bundle components may be adapted to meet the resources available in individual facilities, standardization within an institution is strongly encouraged. References contain sample resources and "Potential Best Practices" to assist with implementation.

(Obstet Gynecol 2015;126:155–62)
DOI: 10.1097/AOG.0000000000000869

Obstetric hemorrhage is the most common serious complication of childbirth and is the most preventable cause of maternal mortality.[1,2] Furthermore, recent data suggest that rates of obstetric hemorrhage are increasing in developed countries, including the United States,[3] and that rates of hemorrhage-associated severe maternal morbidity exceed the morbidities associated with other obstetric and medical conditions.[4,5]

Standardized, comprehensive, multidisciplinary programs have demonstrated significant reductions in morbidity.[6,7] Therefore, a workgroup of the Partnership for Maternal Safety, within the Council on Patient Safety in Women's Health Care and representing all major women's health care professional organizations, has developed an obstetric hemorrhage safety bundle.[8] The goal of the partnership is the adoption of the safety bundle by every birthing facility in the United States. A patient safety bundle is a set of straightforward, evidence-based recommendations for practice and care processes known to improve outcomes.[9] Such a bundle is not a new guideline, but rather represents a selection of existing guidelines and recommendations in a form that aids implementation and consistency of practice. The consensus bundle on obstetric hemorrhage is organized into four action domains: Readiness, Recognition and Prevention, Response, and Reporting and Systems Learning. There are 13 key elements within these four action domains (Box 1). It is anticipated that few, if any, hospitals will have 100% of these elements in place at the start of this quality improvement process, and this document should serve as a checklist from which to work. Low-resource hospitals should be able to accomplish most of these recommendations, but, if some are

From the California Maternal Quality Care Collaborative, Stanford, California; the American College of Obstetricians and Gynecologists, District II, New York, New York; the Society for Obstetric Anesthesia and Perinatology, Milwaukee, Wisconsin; the American College of Nurse-Midwives, Silver Spring, and the American Association of Blood Banks, Bethesda, Maryland; the Association of Women's Health, Obstetric and Neonatal Nurses, and the American Congress of Obstetricians and Gynecologists, Washington, DC; and the American Academy of Family Physicians, Leawood, Kansas.

Barbara S. Levy, MD, is an employee of the American Congress of Obstetricians and Gynecologists (ACOG). All opinions expressed in this article are the authors' and do not necessarily reflect the policies and views of ACOG. Any remuneration that the authors receive from ACOG is unrelated to the content of this article.

This article is being published concurrently in the July/August 2015 issue (Vol. 44, No. 4) of Journal of Obstetric, Gynecologic, & Neonatal Nursing, *the July/August 2015 issue (Vol. 60, No. 4) of* Journal of Midwifery & Women's Health, *and the July 2015 issue (Vol. 121, No. 1) of* Anesthesia & Analgesia.

Corresponding author: Elliott K. Main, MD, California Maternal Quality Care Collaborative, Stanford University–Medical School Office Building, X2C22, Stanford, CA 94305; e-mail: main@CMQCC.org.

Financial Disclosure
Dr. Gorlin is employed by Innovative Blood Resources and is the American Association of Blood Banks (AABB) Liaison to the American College of Obstetricians and the Gynecologists, the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN), and the California Maternal Quality Care Collaborative (CMQCCL). The other authors did not report any potential conflicts of interest.

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ISSN: 0029-7844/15

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OBSTETRIC EMERGENCIES

Box 1. Obstetric Hemorrhage Safety Bundle From the National Partnership for Maternal Safety, Council on Patient Safety in Women's Health Care

Readiness (Every Unit)

1. Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compression stitches
2. Immediate access to hemorrhage medications (kit or equivalent)
3. Establish a response team—who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
4. Establish massive and emergency-release transfusion protocols (type-O negative or uncrossmatched)
5. Unit education on protocols, unit-based drills (with postdrill debriefs)

Recognition and Prevention (Every Patient)

6. Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
7. Measurement of cumulative blood loss (formal, as quantitative as possible)
8. Active management of the 3rd stage of labor (department-wide protocol)

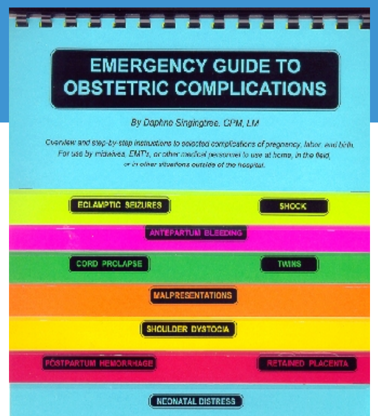
Response (Every Hemorrhage)

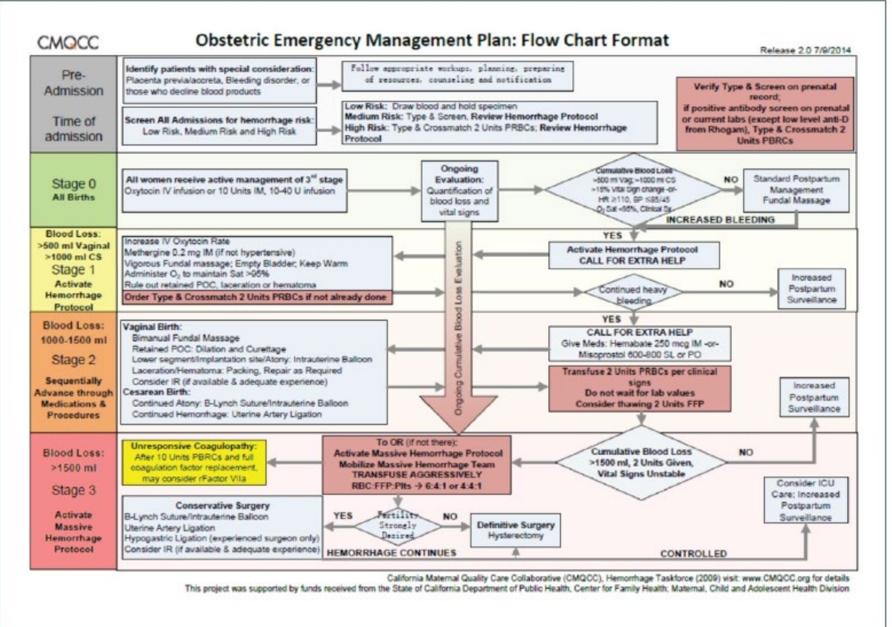
9. Unit-standard, stage-based obstetric hemorrhage emergency management plan with checklists
10. Support program for patients, families, and staff for all significant hemorrhages

Reporting and Systems Learning (Every Unit)

11. Establish a culture of huddles for high-risk patients and postevent debriefs to identify successes and opportunities
12. Multidisciplinary review of serious hemorrhages for systems issues
13. Monitor outcomes and process metrics in perinatal quality improvement committee

Modified from: http://www.safehealthcareforeverywoman.org/





OBSTETRIC EMERGENCIES

https://patientcarelink.org/wp-content/uploads/2016/06/HRETHEN_ChangePackage_OBHarm.pdf

LEADERSHIP PEARLS I'VE LEARNED…

- ✓ Check the small things
- ✓ Remain calm - If the equipment fails, your knowledge remains
- ✓ Lead from the front - Leadership cannot be delegated while tasks can
- ✓ Perpetual optimism - is a force multiplier
- ✓ Don't take counsel of your fears or naysayers

SUMMARY

- Any team member can be the leader but they have to know their roles and responsibilities to bring “structure to the chaos.”
- Combat Medicine, Emergency Medicine, Code/RRS Teams and Trauma teams know the leader isn’t the doer.
- Use the whole team and our safety bundles.
- Time we get over our egos… It is time move on from the single pilot model and embrace the team to provide better and safer obstetric care.

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QUESTIONS?

- Stay in touch! Email teamtraining@aha.org or visit www.aha.org/teamtraining