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
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.

Pre-delivery
- During Pregnancy: 31.3%

Week of Delivery
- Day of Delivery: 16.9%
- 1-6 Days PPM: 18.6%

Postpartum
- 7-42 Days PPM: 21.4%
- 43-465 Days PPM: 11.7%

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 we can learn from combat medicine and our acute care subspecialties

• Understand how we can use the whole team, safety bundles and simulation drills to effectively improve our management of obstetric emergencies.
BAGRAM AIR FIELD: AFGHANISTAN

**Team work in Medicine, It all Started with... Crew Resource Management**
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.
HISTORY OF OBSTETRIC CARE DELIVERY

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

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
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.
Leadership

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

The American College of Obstetricians and Gynecologists
WOMEN’S HEALTH CARE PHYSICIANS

Emergencies in Clinical Obstetrics
Instructor Course

Version 2 | Last Updated May 2018
Copyrighted Materials
The American College of Obstetricians and Gynecologists

ALSO
Advanced Life Support in Obstetrics
\[ \text{New Course}\]
PATIENT SAFETY BUNDLES

Leadership

PATIENT SAFETY BUNDLES

CONSENSUS STATEMENT

National Partnership for Maternal Safety
Consensus Bundle on Obstetric Hemorrhage

Elliott K. Main, MD, Dana Gaffney, MD, Barbara M. Stouppe, MD, Lisa Kane Lewis, MD, CNM, Debra Rihnbaum, CM, Patricia L. Fontaine, MD, FNP, Jed N. Gural, MD, David C. Lagenau, MD, and Barbara S. Ley, MD

Hemorrhage is the most frequent cause of severe maternal morbidity and preventable maternal mortality and therefore 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 were 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 audit with implementation.

(OBSTETRICS & GYNECOLOGY 2015;126:385-42.)
DOI: 10.1097/AOG.0000000000000566

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

Standardized, comprehensive, multidisciplinary programs have demonstrated significant reductions in morbidity.5 Therefore, a workgroup of the Partnership for Maternal Safety, within the Council on Patient Safety in Women’s Health Care and representing all major maternal health care organizations, has developed an obstetric hemorrhage safety bundle.6

The goal of the partnership is the adoption of the safety bundle by every birth 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.7 Such a bundle is not a new guideline, but rather 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 System 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...
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 un mismatched)
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

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.
REFERENCES


QUESTIONS?

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