Minnesota Hospital Association

Road Map to a Perinatal Patient Safety Program

Patient Safety | *Perinatal Safety*

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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The Perinatal Patient Safety Road Map provides evidence-based recommendations/standards for Minnesota hospitals in the development of a comprehensive Perinatal Safety Program which includes strategies in the following areas: patient education, elective delivery, fetal/uterine assessment, operative vaginal delivery, maternal/obstetric morbidity and mortality reduction, trial of labor after a previous Caesarean section and provider/nurse training. The road map and accompanying tool kit were developed as part of the Minnesota Perinatal Safety Program which was made possible with funding through CMS' Partnership for Patients (P4P) Initiative.

We would like to thank the following individuals for sharing their time, expertise and stories which made the road map and tool kit possible.

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	Safe from HAI	Specific Actions(s)	Audit Questions	Yes	No
S	Safety Teams and Organizational Structure	1) Secure endorsements and resources for Perinatal Patient Safety Program.	1a) The facility's physician and administrative leadership endorse implementation and sustainment of the Perinatal Patient Safety Road Map practices.	☐	☐
			1b) Senior leadership has clearly communicated overall goals for the program.	☐	☐
			1c) Senior leadership regularly reviews progress toward goals and supports adding resources as appropriate.	☐	☐
			1d) The facility has a designated senior leadership sponsor for the Perinatal Patient Safety Program.	☐	☐
		2) Promote Perinatal Patient Safety Program representation champions throughout the facility.	2a) The facility has an interdisciplinary team (this could be an existing committee/team) involved in implementing the Perinatal Patient Safety Program with representation from across the facility.	☐	☐
			2b) The facility has a designated coordinator(s) for the Perinatal Patient Safety Program.	☐	☐
			2c) The coordinator(s) has designated time to serve in this coordination function.	☐	☐
			The facility has a process in place to designate members as the Perinatal Patient Safety Program champions/team members/liaisons with clear roles and expectations from the following:		
			2d) Physician(s)/provider(s) knowledgeable in obstetrics	☐	☐
			2e) Perinatal nurse(s)	☐	☐
			Additional team members can include, but are not limited to:		
			2f) Other clinicians/providers, e.g., pediatrics, anesthesia, surgeons, intensivist.	☐	☐
			2g) Safety/Quality/PI	☐	☐
			2h) Pharmacy	☐	☐
			2i) Blood bank/Lab	☐	☐
			2j) Obstetric surgical staff	☐	☐
			2k) The facility has a process in place to engage other team members as regular or ad-hoc members as appropriate, e.g., purchasing, education, human resources and patient/family.	☐	☐
		3) Identify gaps and develop action plans.	**The interdisciplinary team:**		
			3a) Reviews the Perinatal Patient Safety Program throughout the year and updates the plan as needed.	☐	☐
			3b) Reviews data results at least quarterly and identifies strengths and opportunities.	☐	☐
			3c) Develops a plan to prioritize and address improvement opportunities.	☐	☐

			3d) Commissions subgroups as needed to address priority issues requiring subject matter experts, e.g., pharmacy, respiratory, environmental services.		
A	**Access to Information**	1) Track progress on process and outcome measures.	**Data Collection** **A process is in place to collect perinatal process data for the following as applicable:**		
			1a) Use and completion of standardized tool to schedule deliveries.		
			1b) Review of all Early Elective Deliveries (EEDs) not meeting exclusion criteria.		
			1c) Progress on Perinatal Gap Analysis practices.		
			A process is in place to collect Perinatal Outcome measures for the following, at minimum:		
			1d) Number of EEDs not meeting exclusion criteria. N/A: ☐		
			1e) Low risk vertex singleton in first time mothers. N/A: ☐		
			1f) Outcome data is tracked on a regular basis for other areas as applicable. N/A: ☐		
			1g) Standard criteria exist for conducting observational and/or chart audits.		
			1h) A process is in place to audit the reliability of both the process and outcome data through chart audits.		
			1i) A process is in place to audit the reliability of both the process and outcome data through observational audits.		
			1j) The facility's documentation system (electronic or paper) is designed to capture sufficient detail about Perinatal Patient Safety Program events that do occur to allow for adequate event analysis.		
		2) Review and analyze data for improvement opportunities.	**Data Analysis**		
			2a) A process is in place to routinely review and analyze data for process improvement opportunities/defects.		
			2b) A process is in place to track progress against established targets e.g., run charts, control charts, dashboards, scorecards.		
			2c) A process is in place to prioritize and act upon identified issues.		
		3) Data is shared on a regular basis to promote system-wide learning and transparency.	**Perinatal Patient Safety Program data and learnings are shared on a regular basis:**		
			3a) Within units		
			3b) Across units		
			3c) With leadership		
			3d) With medical staff		
			3e) With the board(s)		
			3f) Perinatal Patient Safety Program events are routinely shared through stories as well as through data, e.g., include in daily briefings, units staff meetings, safety committees.		

F	**Facility Expectations**	1) Leadership establishes and communicates clear expectations.	1a) Direct patient care staff, e.g., nursing, physicians, respiratory therapy is informed of expectations and performance standards regarding their role in Perinatal Patient Safety Program.		
			1b) Support staff, e.g., environmental services, supply chain, facilities/operations, is informed of expectations and performance standards regarding their role in Perinatal Patient Safety Program.		
			1c) The facility has a well defined process to support a culture that encourages staff to speak up and "stop the line" to inform each other of non-compliance with the Perinatal Patient Safety Program expectations.		
			1d) The "stop the line" process clearly outlines:		
			When to stop the line;		
			How to stop the line, e.g., "I need clarity";		
			The chain of command to follow if not supported in stopping the line;		
			Clear communication to staff from managers and leadership that staff will be supported if they speak up.		
		2) Provide education for health care personnel and prescribers.	2a) Expectations and supporting Perinatal Patient Safety Program education have been incorporated into new employee orientation for direct care staff.		
			2b) Expectations and supporting Perinatal Patient Safety Program education have been incorporated into new employee orientation for support staff.		
			2c) Ongoing Perinatal Patient Safety Program education is provided to direct care staff at least annually.		
			2d) Ongoing Perinatal Patient Safety Program education is provided to support staff at least annually.		
			2e) Expectations and supporting Perinatal Patient Safety Program education have been incorporated into employee orientation for personnel employed by outside agencies and contracted personnel.		
			2f) Ongoing Perinatal Patient Safety Program education is provided for providers and agency staff at least annually.		
			2g) Expectations and supporting Perinatal Patient Safety Program education has been incorporated into new physician orientation.		
		3) Establish a structured communication process.	3a) The facility has structured communication tools, e.g., Situation, Background, Assessment, Recommendation (SBAR),for communication at all levels of the organization.		
			A structured hand-off process is in place throughout the organization with specific elements outlined that must be included for hand-offs:		
			3b) During shift-change		
			3c) Between departments/units		
			3d) To other facilities		
		4) Disclose unanticipated events.	**A process is in place to promptly inform families when an unanticipated perinatal patient outcome occurs and includes, at a minimum:**		
			4a) Direction on who should discuss the unanticipated outcome with the patient/ family and how that discussion should occur.		
			4b) A process for disclosing to, and updating, patient/ family as the event is reviewed and analyzed.		

			4c) Staff members receive training on when and how to disclose unanticipated outcomes.		
			4d) A designated person is available to provide support and just-in-time training to staff members who are about to disclose an unanticipated outcome to a patient/family.		
E	**Engagement of Patient and Families**	1) Educate and empower patient/ families.	1a) A process is in place to assess and address any barriers to patient/family ability to understand their role in the Perinatal Patient Safety Program (e.g., cultural, language, hearing impairment and health literacy).		
			1b) Patients/families are educated on their role in the Perinatal Patient Safety Program and what they can expect to see from staff and providers caring for them in the hospital, e.g., identification before lab draw or med administration, hand washing.		
			1c) A process is in place to assess patient/families' level of understanding of the education provided, e.g., teach back.		
			1d) The facility has a process in place to encourage patients and families to speak up if they have concerns about direct care/support staff/provider practices or other issues that may increase the risk for an unanticipated perinatal patient outcome.		
			1e) A process is in place to report back to patients/ families that have shared a concern.		

Perinatal Injuries Gap Analysis

Component of the Perinatal Safety Roadmap

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Specific Action(s)	Gap Analysis Questions	Yes	No	If answered question "No" – identify the Specific Action plan(s) including persons responsible and timeline to complete.
Patient Education				
1) Provide patient/family education.	1a) The facility has a process in place to provide information to the patient about risks, benefits and alternatives for maternal intra-partum procedures.	☐	☐	
	1b) The facility has a process in place to educate the patient and/or family about newborn screening per the Department of Human Services (DHS).	☐	☐	
Elective Delivery				
2) Scheduled induction and/or Caesarean.	2a) The facility has a hard stop policy in place to prevent elective deliveries < 39 weeks without medical indication.	☐	☐	
	The facility's practices include at minimum:			
	2b) Medical indications for scheduled delivery are defined.	☐	☐	
	2c) Hospital staff is authorized to not schedule an elective delivery before 39 weeks and 0 days of gestation.	☐	☐	
	2d) Providers are required to obtain approval from physician leadership before performing an elective scheduled delivery before 39 weeks.	☐	☐	
	The facility utilizes the following criteria to establish gestational age for all elective deliveries:			
	2e) Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater.	☐	☐	
	2f) Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography.	☐	☐	
	2g) It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result.	☐	☐	
	2h) The facility has a process in place to document both gestational age and medical indications for delivery as a pre-requisite to schedule delivery prior to 39 weeks.	☐	☐	
	2i) The facility has developed and maintains a list of medical indications for delivery prior to 39 weeks.	☐	☐	
	2j) The facility has accepted the following list of evidence and consensus based medical indications for delivery prior to 39 weeks. The facility should not be limited to this list; additional criteria can be added using evidence and expert opinion based on practice.	☐	☐	
	Indications include, but are not limited to the following: **Fetal indications** Growth restriction Fetal anomalies Multiple gestation Fetal demise Isoimmunization Abnormal fetal testing **Obstetric indications** Placenta abnormalities; previa, abruption Previous uterine surgery (classical C-section, myomectomy) Amniotic fluid abnormalities PROM **Maternal indications** Hypertensive disease Diabetes Lupus Renal disease Pulmonary disease Liver disease Coagulation defect			

Specific Action(s)	Gap Analysis Questions	Yes	No	If answered question "No" – identify the Specific Action plan(s) including persons responsible and timeline to complete.
	2j) The facility has a quality improvement process in place to review all deliveries less than 39 weeks, for appropriateness of the medical indications.	☐	☐	
Fetal/Uterine Assessment				
3) Estimated fetal size Fetal heart rate	3a) The facility requires that all patients have estimated fetal size documented prior to delivery. 3b) The facility requires that the fetal heart rate assessment is documented in the medical record using the National Institute of Child Health and Human Development (NICHD) terminology. 3c) The facility has a policy in place that outlines the appropriate and safe administration of uterotonics relative to fetal heart rate assessment.	☐ ☐ ☐	☐ ☐ ☐	
4) Pelvic exam	4a) The facility requires provider/RN do a vaginal exam and document dilatation, effacement, station, presenting part prior to the induction/augmentation as clinically appropriate.	☐	☐	
5) Uterine contractions	5a) The facility has standard practices in place for the appropriate and safe administration of uterotonics relative to uterine contractions. 5b) The facility has standard practices in place for documenting uterine activity in the medical record using the National Institute of Child Health and Human Development (NICHD) terminology. 5c) The facility has standard practices in place for the management of abnormal uterine contractions.	☐ ☐ ☐	☐ ☐ ☐	
Operative Vaginal Delivery				
6) Operative Vaginal Delivery	6a) The facility has standard practices in place for appropriate and safe performance of operative vaginal delivery. The guidelines may include: alternative labor strategies, prepared patient, high probability of success, maximum number of application and pop-offs predetermined, exit strategy available, communication and documentation with infant caregivers about use of operative vaginal delivery. 6b) The facility has a quality improvement process in place to review operative vaginal deliveries that fall outside the facility's standard practices.	☐ ☐	☐ ☐	
Maternal/Obstetric Morbidity and Mortality Reduction Strategies				
7) Management of Hypertensive Emergencies	7a) The facility has a process in place for assessment and management of hypertensive emergencies which include blood pressure parameters and medication regimen, e.g., standard order sets or protocols.	☐	☐	
8) Postpartum hemorrhage	8a) The facility has a process in place for assessment and management (medical/surgical/mechanical) of postpartum hemorrhage which includes risk assessment and management of the patient, staff recognition and response, e.g., standard order sets and medication regimen. 8b) The facility has a plan for management/transfusion/transfer for the patient with massive blood loss, e.g., massive transfusion protocol, inter-facility transfer guidelines, surgical options, uterine tamponade balloon.	☐ ☐	☐ ☐	

Specific Action(s)	Gap Analysis Questions	Yes	No	If answered question "No" – identify the Specific Action plan(s) including persons responsible and timeline to complete.
9) VTE prevention	9a) The facility has a process in place for assessment and management of VTE prevention which includes mechanical prophylaxis for all C-sections, unless contraindicated and pharmalogical interventions as appropriate, e.g., SCIP protocol.	☐	☐	
10) Peri-operative infection prevention strategies	10a) The facility has a process in place for routine administration of appropriate weight based pre-operative antibiotics within 1 hour prior to incision, e.g., pre-op order set.	☐	☐	
11) Minnesota Maternal Mortality reporting requirement	11a) The facility has a process in place to ensure awareness of and compliance with the Minnesota Maternal Mortality reporting Statute #4615.0080 among hospital Quality, and Obstetric and Emergency Department providers.	☐	☐	
Trial of Labor after Previous Caesarean Section				
11) Trial of labor after previous Caesarean	11a) The facility's process for possible vaginal births after Caesarean delivery (VBAC) includes counseling and offering a trial of labor (which should include referral to another hospital) after previous Caesarean delivery (TOLAC). 11b) The facility has a process in place for appropriate and safe administration of uterotonics relative to TOLAC which includes no third trimester prostaglandins.	☐ ☐	☐ ☐	
Provider and Nurse Training				
12) Provider and staff education	**The facility provides periodic interdisciplinary education which includes:** 12a) Education for providers and nurses on electronic fetal monitoring using the National Institute of Child Health and Human Development (NICHD) common language. 12b) Maternal/newborn team crisis training on issues such as: shoulder dystocia, Postpartum hemorrhage, emergency delivery, newborn resuscitation, hypertensive emergency. 12c) Training on individual communication skills and team collaboration, e.g., SBAR, TeamSTEPPS, briefs, debriefs, handoffs, simulation.	☐ ☐ ☐	☐ ☐ ☐	

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