Patient Safety Strategies
Are We on the Same Team?

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More than a decade ago, the Institute of Medicine released its landmark report, To Err is Human, which set an ambitious agenda for the United States to reduce the number of patients harmed by medical errors and preventable adverse events. In response, a significant number of methods to improve performance have gained traction, including checklists, simulation, and team training—all to address the concern that adverse events continue to occur within our hospitals. In fact, a recent study, using the Institute of Healthcare Improvement “Trigger Tools,” found that as many as one in three patients admitted to the hospital suffers an adverse event. Although our slow progress may seem disheartening, we as physicians must embrace continuously improving our processes to ensure safe and high-quality care; not only as our fiduciary duty to the public but also to ensure our own economic survival. Both current success and future improvement in quality are now tied to our reimbursement. Authorized by the Affordable Care Act, the Hospital Value-Based Purchasing program is the beginning of an historic change in how Medicare pays health care providers and facilities. For the first time, hospitals across the country will be paid for inpatient acute care based on quality, not just quantity, of services provided. The holy grail of attaining zero defects is no longer a journey: the race is on.

The implementation of checklists and standardized processes around the care of patients has been pivotal to developing a strong culture of safety and team-based care. Treatment-specific checklists regarding care as fundamental as oxytocin administration that are implemented by care teams have been shown to not only decrease cesarean delivery rates but ultimately to improve neonatal outcomes. Checklists and aviation-based team training, referred to as Crew Resource Management, have rendered the aviation industry a truly ultra-safe system. However, initial introduction of checklists in the hospital setting, including the labor and delivery unit, were likely to have been perceived to be both prescriptive and professionally demeaning. With outcome data now supporting checklist use, they have proven their worth in leveling the playing field across a broad range of elective and emergency situations. They enable every member of the team ultimately to feel valued and able to express concerns and positively influence outcomes. Ultimately, the use of checklists is completely dependent on all health care providers being on the same team; the entire team has to be engaged and cognizant that the checklist tool is intended to drive safe behaviors. Checklists are not to be confused, however, with bundles, which are a group of evidence-based interventions related to a disease process that, when executed together, result in better outcomes. Rather, checklists can be integral to bundles and help direct practitioners to use them appropriately during patient care.

Physicians and nurses can have disparate perceptions about the overall level of teamwork, with physician “team captains” assuming teamwork is functioning as long as their instructions are followed. Nurses, who may not have been empowered to express a significant voice in care decisions, may feel otherwise. Understanding the role of suboptimal communication in sentinel events, as well as the diverging perception of teamwork between obstetricians and perinatal nurses, it is much easier to recognize that the “neglected dyad” is the physician–nurse pair. Ideally, there should be a significant relationship between these two partners in care, but that is not always the case. Suboptimal communication is a common find-
ing in health care, and obstetrics is no exception: physicians, midwives, nurses, and staff train in isolated silos, with differing languages and contrasting perspectives, yet are expected to work in teams.

There are many opportunities to make the obstetrician–perinatal nurse dyad more effective. One of the first steps is to empower the nurse to be a true partner in the relationship, thereby giving nursing a voice to express observations, suggestions, and concerns. Team training based on crew resource aviation-management programs has been shown to enhance communication and, often, outcomes. The Veterans Health Administration presented data including more than 100,000 procedures over 3 years at 100 facilities and found that the decline in risk-adjusted surgical mortality was 50% greater in the groups that underwent team training compared with those that had not completed team training. Perhaps more poignant: the more training for the teams, the better the outcomes.

These seminars may include videos, lectures, and role-playing and are integrated with a mix of individual attendees (physicians, nurses, ancillary staff) within the obstetric team. Participants are familiarized with the concept of the “shared mental model” for communication—an organized way for team members to conceptualize how a team works and to predict and understand how their team members will behave so as to improve overall team performance. Other specific concepts and techniques that may be included are: 1) use of SBAR (Situation, Background, Assessment, Recommendation) structured communication and debriefing techniques; 2) communication key words CUS (Concerned, Uncomfortable, Scared); 3) the two-challenge rule, a quick conflict-resolution technique in which a team member may question an action two times and, if a sufficient answer is not provided, may halt that action; 4) the chain of command; and 5) elements of an effective hand-off of care.

Simulation training allows teams to practice together in a safe environment and may be the most important strategy that assures that teams will work well together even in the most difficult situations. The performance of the entire team generally is improved and the use of checklists and understanding of roles is better secured through repetitive and structured simulation training. The same care that goes into developing team training needs to be applied to the development of a sustainable and robust simulation program, which ideally should involve residents, faculty, and nurses. In particular, the debriefing portion of simulation provides an important framework for open communication among all team members without the stress and pressure of having to defend poor patient outcomes. The debriefing also allows a critical review of the checklists and safety tools that are developed in team training to create truly functional checklists for all team members. Simulation should serve as a vital part of all obstetric training programs, ensuring that all health care providers are on the same team and increasing the knowledge base for all participants.

The combination of both Crew Resource Management training and simulation is even more powerful and, when performed in a structured and consistent fashion, has been shown to improve outcomes in busy labor and delivery departments. The prevention of obstetric adverse events requires a strategic and multifaceted approach. When combined with education and the support of senior physician leadership, the use of checklists and bundles can have a wide-ranging effect in a relatively short period of time. For example, in an effort to reduce scheduled births between 36 0/7 and 38 6/7 weeks that lacked appropriate medical indication, Ohio maternity hospitals implemented the Institute for Healthcare Improvement Breakthrough Series interventions, resulting in an 80% reduction.

The American Congress of Obstetricians and Gynecologists has initiated the Voluntary Review of Quality of Care program, which involves an external review of practices focused on principles of patient safety, evidence-based practice, and consistency with the standards of professional and governing bodies. The Safety Certification in Outpatient Practice Excellence (SCOPE) for Women’s Health program is another program that integrates the promotion of the highest quality of women’s health care in the ambulatory setting. The American Academy of Family Physicians has endorsed “patient-centered” care that involves better communication, shared decision making, teamwork, and quality measure in the Institute for Healthcare Improvement–initiated “Quality Patient Care in Labor and Delivery: A Call to Action.” These resources and programs are found on the Institute for Healthcare Improvement, Joint Commission, and American Congress of Obstetricians and Gynecologists web sites.

Suffice it to say, human factors in both routine peripartum and unanticipated obstetric emergencies are a reality and enable errors to occur. We have embraced our innate human traits to quickly analyze and adapt to challenging situations, which is aptly referred to as human resilience. The use of checklists, team training, and simulation are modalities that, when used appropriately, can complement human resilience and as a result have successfully mitigated patient risk and ensured the best outcomes possible.
The sustaining of patient-safety programs is therefore a dynamic process. Fundamental to sustainability is measuring effectiveness, sharing results, and accepting the fact that teams have to improve continuously.

So where are we now when we consider patient-safety strategies? Tools and training have been implemented across the nation, and the groundwork has been laid. Continuously improving our patient-safety strategies must become habit and part of the standard of care; only then will we sustain our successes. It is clear that such approaches no longer can be dismissed as the latest “flavor of the month” in health care. Our patients, the public, the government, and payers all expect us to work as a team and use all the tools at our disposal to provide the best of outcomes. We have developed patient-safety strategies that have enabled us to function as a team; it is now our responsibility to sustain and embrace them.

REFERENCES


