

Purpose of project

An obstetrical emergency occurs in approximately 1-2% of all pregnant patients (4)
Lack of communication, culture of safety, and teamwork have been linked to several significant patient injuries and/or deaths
Effective rapid response teams require a multidisciplinary approach (1-6)

Background/Significance

The Perinatal Quality Review Committee in July of 2017 meet and began reviewing current policies and data on emergent cesarean cases
2017 data demonstrated concern over the growing population of patients with comorbidities with subsequent impact on deliveries

There was no clearly defined way to have every team member's role clearly outlined every shift, this created gaps in care and delays

Simulated obstetrical emergencies result in improved decision to delivery times and subsequently improves maternal and fetal outcomes (1)

Sample and Setting

- Midwestern hospital with a separate women's pavilion with approximately 3500 live births per year, Level 3 Obstetrical Facility
- Women within childbearing years: 15 to 49
- 3450 total births in 2018
- Many of the OB Emergencies were women that had limited to no prenatal care

Methods/application to practice

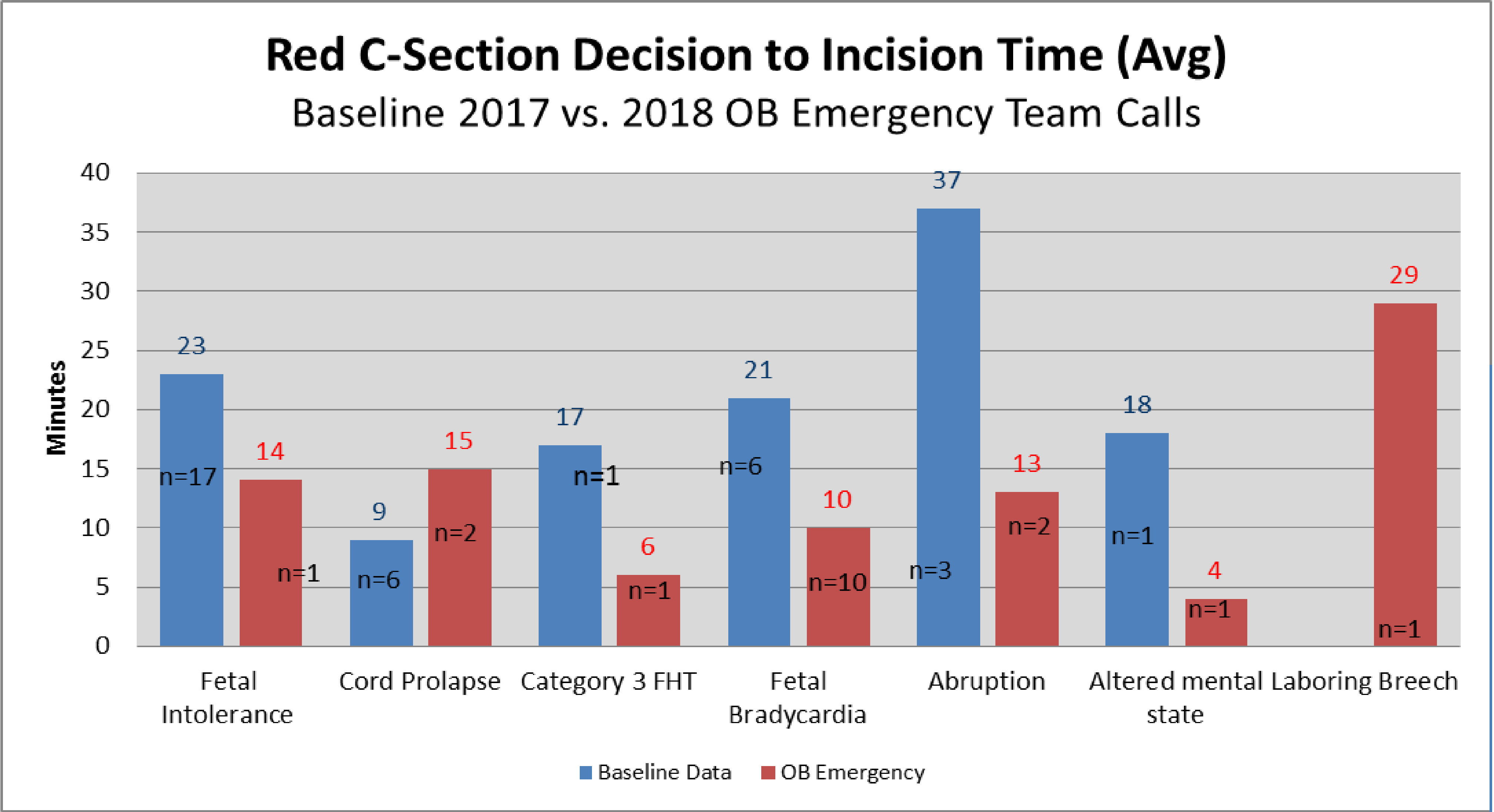
- Baseline data January 2017 through November 30, 2017 was collected
- Roles were clearly defined every shift to minimize confusion during deliveries
 - Cesarean surgeries involving an obstetrical rapid response team were tracked
 - All cases accompany a login sheet of attendees.
 - A flow sheet to document reason for call, pertinent happenings and vital signs
 - A debriefing form is completed
- Beginning December 1st 2017:
100 percent of OB Emergency team calls are tracked and cases are reviewed for
- response time
 - method of delivery
 - maternal and fetal outcomes.

Findings/Results/Outcomes

- 38 obstetrical rapid response calls in 2018 out of 3450 live births
- 18 patients required an emergent cesarean section
- Average decision to incision times have improved from 18 min to 9 minutes from 2017 to 2018.
- Reducing time to intervention by 49.6%
- Average of 4 calls/month

Implications

- Staff feel supported by increased communication and shared mental model
- Addition of the Neonatologist to the team
- Inclusion of postpartum hemorrhage immediate and delayed
- Room labeling of OB Emergency Department
- Inclusion of team member phone numbers on roll call sheet
- Conducting Monthly OB Cold Debriefs



Reference

1. American College of Obstetricians and Gynecologists. (2016). Preparing for clinical emergencies in obstetrics and gynecology. Committee Opinion No. 590. 123:722-5. Washington, DC: American
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4. Clements, C., Flohr-Rincon, S., Bombard, A., Catanzarite, V. (2007, April/May). OB Team Stat: Rapid Response to Obstetrical Emergencies. 11(2). (AWHONN, Ed.) AWHONN.
5. Lazzara, E., Benishek, BS., Sonesh, S., Patzer, B., Robinson, P., Wallace, R., Salas, E. (2014). THE 6 "Ws" of Rapid Response Systems. 37(2). (W. K. Wilkins, Ed.)
6. Spader, C. (2009). Speedy Delivery. pg.12-13. (N. Spectrum, Ed.) Nursing Spectrum. Retrieved 2017, fromwww.nursingspectrum.coAckno