An Advanced Obstetrical Safety Collaborative

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Learning Lab - Designing for Improved Maternal and Neonatal Health
IHI National Forum
Sunday – December 4, 2016
Our Hospital Clients

- Montefiore
- Mount Sinai Beth Israel
- Mount Sinai Brooklyn
- Mount Sinai Hospital
- Mount Sinai Queens
- Mount Sinai West
- Mount Sinai St. Luke’s
- New York Eye and Ear Infirmary of Mount Sinai
- Montefiore
- Mount Vernon
- New Rochelle
- Nyack
- St. Luke’s Cornwall Hospital
- Maimonides Medical Center
- White Plains Hospital
- Burke Rehabilitation & Research
- FOJP

Mount Sinai Health System

- A Member of the Mount Sinai Health System
Our Role

• Financial Support
  ✓ Faculty time
  ✓ Equipment – new technology

• Joint collaboration with all hospitals
  ✓ Data
  ✓ Internal
  ✓ External
Frequency - Open & Closed Claims
2004-2013

- Surgery: 37%
- Medical Specialties: 11%
- Obstetrics: 7%
- Internal/Family Medicine: 9%
- Emergency Medicine: 7%
- Gynecology: 5%
- Radiology: 4%
- Anesthesiology: 3%
- Other: 17%
Cost-Open & Closed Claims
2004-2013

- Surgery: 36%
- Obstetrics: 16%
- Medical Specialties: 10%
- Internal/Family Medicine: 8%
- Emergency Medicine: 7%
- Gynecology: 5%
- Radiology: 4%
- Anesthesiology: 2%
- Other: 12%
Obstetrics - Best practices

• Created by Chairman consensus- 2008
• Adopted and implemented over 2 years
• Audited by HIC patient safety analysts
  • 22% of deliveries
  • 100% Shoulder Dystocia & Vacuum Deliveries
• Quarterly feedback given to Chairman
• Fetal heart monitoring course
• Team training
• Simulation
OB Audit: Hospital Report

- Percent Admission Notes Complete
- Percent Admission Notes On Time
- Percent Progress Notes Complete
- Progress Note Compliance
- Composite Note (CN) Score
- Operative Vaginal Deliveries including Note Score
- Shoulder Dystocia Cases and Follow-up
- Pre-Oxytocin Checklist
- TOLAC/VBAC
- Adverse Outcome Index (AOI); Weighted Adverse Outcome Index (WAOI)
OB Audit: Physician Report Card

**% Admission Notes Complete**
- Provider: 81%
- Hospital: 77%
- Collaborative: 67%

**% Progress Notes Complete**
- Provider: 73%
- Hospital: 39%
- Collaborative: 52%

**% Admission Notes On Time**
- Yellow Alert Cutoff: 75%
- Yellow Score Alert: 63%
- Yes

**CN Score (Average of 8 Elements Below)**
- Yellow Alert Cutoff: 50%
- Yellow Score Alert: 94%
- No

**Element Completeness**
- History: 100%
- Exam: 100%
- Fetal Assessment: 88%
- Estimated Fetal Weight: 94%
- Admit Plan of Care: 100%
- Fetal Heart Rate Assessment: 100%
- Progress of Labor: 82%
- Progress Plan of Care: 91%
**OB Best Practices Review & Response Plan**

**Red Events**
- Two instruments used during OVD (excluding C-sections)
- Vacuum pop-offs >3 or no descent with >3 pulls or forceps used after no descent after initial pull (excluding C-section)
- Vacuum used < 34 weeks (excluding C-section)
- Oxytocin use with Cat III FHRT
- Demonstrated reckless behavior that could endanger patients

**Yellow Events**
- OVD initiated with NO attending EFW documentation
- OVD initiated with EFW > 4000 grams (diabetic) or >4500 grams (non-diabetic) AND NO attending documentation of rationale or maternal request for trial of labor
- No documentation of recommendation for C-section for EFW >=4500 (diabetic) >5000 (non-diabetic)
- Inadequate 2nd stage documentation
- Induction/C-section at <39 weeks WITHOUT approved medical indication.
- Composite note score < 60
- Timely admission note score < 75%

*Loss of insurance applies to physicians insured through FOJP hospitals. For those who are not, notification will be made to the physician's malpractice insurance carrier.
Obstetrics - Best practices

• Measuring outcomes based on quality
• Giving feedback about teamwork skills
• Addressing attending skills using simulation
Measuring Quality in Obstetrics – The Missing Link

Fouad Atallah, MD, FACOG
Director of Patient Safety/OBGYN
Maimonides Medical Center, Brooklyn, NY
Measuring Quality in Obstetrics

Quality vs Safety

- Best possible outcome
  - Health
  - Satisfaction

- Improving quality of care

- Bottom of acceptable

- Unsafe care

Baillit 2016
Measuring Quality in Obstetrics

- Quality measures issues
- Is it under our control?
- Process versus outcome measures
- Risk adjustment or case-mix
- Patient vs Provider vs System factors
- Accuracy
- Feasibility
- Level
- Use
Measuring Quality in Obstetrics

• Inpatient measures relevant to OBGYNs:
  • NQF – JC – Leapfrog – CMS
  • May 2016
  • Elective deliveries before 39 weeks (PC-01, LF, CMS)
  • Episiotomy rate (LF)
  • Cesarean rate for low-risk births (PC-02, LF, CMS)
  • Rate of antenatal steroids for under 34 week births (PC-03, LF, CMS)
  • Exclusive breastfeeding at hospital discharge (PC-05)
<table>
<thead>
<tr>
<th>Adverse Outcome</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal death</td>
<td>750</td>
</tr>
<tr>
<td>Intrapartum or neonatal death (&lt; 2500 g)</td>
<td>400</td>
</tr>
<tr>
<td>Uterine rupture</td>
<td>100</td>
</tr>
<tr>
<td>Maternal admission to ICU</td>
<td>65</td>
</tr>
<tr>
<td>Birth trauma</td>
<td>60</td>
</tr>
<tr>
<td>Return to OR/ Labor and delivery</td>
<td>40</td>
</tr>
<tr>
<td>Admission to NICU (greater than 2500 g for over 24 hours)</td>
<td>35</td>
</tr>
<tr>
<td>APGAR score &lt;7 at 5 minutes</td>
<td>25</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>20</td>
</tr>
<tr>
<td>Third or fourth degree perineal tear</td>
<td>5</td>
</tr>
</tbody>
</table>

Mann 2006
Measuring Quality in Obstetrics

Goffman 2014
Measuring Quality in Obstetrics

AOI and WAOS by Year

- AOI Collaborative
- WAOS Collaborative

<table>
<thead>
<tr>
<th>Year</th>
<th>AOI</th>
<th>WAOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>10.5%</td>
<td>8.2%</td>
</tr>
<tr>
<td>2010</td>
<td>8.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>2011</td>
<td>7.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>2012</td>
<td>7.8%</td>
<td>2.7%</td>
</tr>
<tr>
<td>2013</td>
<td>7.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>2014</td>
<td>8.7%</td>
<td>3.0%</td>
</tr>
<tr>
<td>2015</td>
<td>7.8%</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

Measuring Quality in Obstetrics
# Measuring Quality in Obstetrics

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Postpartum hemorrhage</th>
<th>Peripartum infection</th>
<th>Severe perineal laceration at SVD</th>
<th>Composite neonatal adverse outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>17</td>
<td>20</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>B</td>
<td>18</td>
<td>17</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>C</td>
<td>15</td>
<td>23</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>D</td>
<td>16</td>
<td>21</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>E</td>
<td>6</td>
<td>2</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>F</td>
<td>12</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>G</td>
<td>21</td>
<td>12</td>
<td>6</td>
<td>5</td>
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<td>H</td>
<td>20</td>
<td>4</td>
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<td>I</td>
<td>3</td>
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<td>16</td>
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<td>J</td>
<td>22</td>
<td>19</td>
<td>5</td>
<td>9</td>
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<tr>
<td>K</td>
<td>2</td>
<td>11</td>
<td>13</td>
<td>23</td>
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<tr>
<td>L</td>
<td>8</td>
<td>1</td>
<td>25</td>
<td>21</td>
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<tr>
<td>M</td>
<td>13</td>
<td>18</td>
<td>7</td>
<td>25</td>
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<tr>
<td>N</td>
<td>24</td>
<td>10</td>
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<td>18</td>
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<td>O</td>
<td>5</td>
<td>14</td>
<td>14</td>
<td>10</td>
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<tr>
<td>P</td>
<td>1</td>
<td>7</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Q</td>
<td>9</td>
<td>9</td>
<td>2</td>
<td>13</td>
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<td>R</td>
<td>7</td>
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<td>17</td>
<td>14</td>
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<td>S</td>
<td>19</td>
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<td>10</td>
<td>15</td>
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<td>25</td>
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<td>12</td>
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<td>4</td>
<td>13</td>
<td>19</td>
<td>3</td>
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<td>V</td>
<td>14</td>
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<td>W</td>
<td>23</td>
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<tr>
<td>X</td>
<td>11</td>
<td>15</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Y</td>
<td>10</td>
<td>5</td>
<td>16</td>
<td>20</td>
</tr>
</tbody>
</table>

Baillit 2013
Measuring Quality in Obstetrics

• Up 40% of variation in outcomes was related to differences in patient populations. 50-100% of inter-hospital variation in outcomes was unexplained.

Grobman 2014
Measuring Quality in Obstetrics

• Adjudication: the missing link in quality
• SOQRATES: Selective Obstetrical Quality Review and Adjudication of Trigger Events Scale
  • Selective triggers based on the AOI
  • Initial local adjudication: A, E, Q
  • Secondary adjudication for A and E
Measuring Quality in Obstetrics

- **Trigger events**
  - **Maternal:**
    - In-hospital maternal death
    - Unanticipated operative procedure or interventional radiology (OR/IR) procedure
    - Unplanned maternal intubation/ICU admission/transfer to another hospital
    - Transfusion ≥4 PRBCs
    - Eclampsia/Stroke/Coma
    - Venous thrombo-embolism
    - Sepsis
  - **Neonatal:**
    - In-hospital neonatal death ≥2500 grams or more than 37 weeks of gestation (died within 7 days of birth, excluded: congenital anomalies, hydrops, and dwarfism)
    - Apgar score less than 7 at 5 minutes in a term neonate ≥2500 grams or more than 37 weeks of gestation (excluded: congenital anomalies, hydrops, and dwarfism)
    - Cord gas pH less than 7 or base deficit less than 12
    - Birth trauma [BT-1] - shoulder dystocia with palsy, or fractures (clavicle excluded)
    - Birth trauma [BT-2] - cephalhematoma, subgaleal hematoma, intra-cranial hemorrhage (with operative vaginal delivery)
Measuring Quality in Obstetrics

• Adjudication
  – By local QA committee
  – Scale:
    • A = Definitely or probably no quality issue/(definitely or probably) unavoidable outcome (multiply by 0)
    • E = Cannot determine if there is a quality issue or if outcome could have been different with different care (multiply by 1)
    • Q = Definitely or probably a quality issue/Outcome could definitely or probably have been avoided with better care (multiply by 2)
    • NA = More information needed/can’t score case (in which case, information should be sought and then case re-adjudicated)
Measuring Quality in Obstetrics

• Adjudication
  – If a case is assigned “E” or “A”, it is referred to another institution for final adjudication.

• Scoring system and quality profile:
  – In-hospital maternal death: 1000 points
  – In-hospital neonatal death: 500 points
  – For each morbidity: 100 points
  – Within each morbidity, loss of organ or loss of function 100 points (to be added before the multiplication by the weight)
## Measuring Quality in Obstetrics

<table>
<thead>
<tr>
<th>Adverse event</th>
<th>Q1</th>
<th>Quality score</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality</td>
<td>0</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Neonatal mortality</td>
<td>1</td>
<td>Q</td>
<td>1000</td>
</tr>
<tr>
<td>Trigger events - Maternal</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR/IR</td>
<td>1</td>
<td>Q</td>
<td>200</td>
</tr>
<tr>
<td>ICU</td>
<td>1</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>4 PRBCs or more</td>
<td>2</td>
<td>A*</td>
<td>0</td>
</tr>
<tr>
<td>Eclampsia/Stroke/Coma</td>
<td>1</td>
<td>A</td>
<td>0</td>
</tr>
<tr>
<td>Sepsis</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>VTE</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Trigger events - Neonatal</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apgar &lt;7 at 5 minutes</td>
<td>1</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Low pH or base deficit</td>
<td>0</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>BT-1</td>
<td>2</td>
<td>A*</td>
<td>0</td>
</tr>
<tr>
<td>BT-2</td>
<td>0</td>
<td>-</td>
<td>400</td>
</tr>
<tr>
<td>Number of patients</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of adverse events</td>
<td>9</td>
<td></td>
<td></td>
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<tr>
<td>Score</td>
<td></td>
<td>1600</td>
<td></td>
</tr>
<tr>
<td>Quality profile</td>
<td>A*, A, A*, Q, Q, Q*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOQRATES</td>
<td></td>
<td>1600 [A*, A, A*, Q, Q, Q*]</td>
<td></td>
</tr>
</tbody>
</table>
# Measuring Quality in Obstetrics

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calibri</td>
<td>AANQQQ*</td>
<td>AQQ*Q</td>
<td>AAAQQ</td>
<td>AAAQ</td>
</tr>
<tr>
<td>Courier</td>
<td>AAQQQQ</td>
<td>AAQQ</td>
<td>AANNQ*</td>
<td>AANN</td>
</tr>
<tr>
<td>Georgia</td>
<td>AAANN</td>
<td>AAANQ</td>
<td>AANQ</td>
<td>ANQQ*</td>
</tr>
<tr>
<td>Palatino</td>
<td>AANQQQ*Q</td>
<td>AAANQ</td>
<td>AANN</td>
<td>AANN</td>
</tr>
<tr>
<td>Verdana</td>
<td>AAQQ*</td>
<td>ANQQ*</td>
<td>QQQQ</td>
<td>ANNN</td>
</tr>
<tr>
<td>HIC</td>
<td>12Q***</td>
<td>9Q**</td>
<td>8Q*</td>
<td>4Q*</td>
</tr>
</tbody>
</table>
Measuring Quality in Obstetrics

• **SOQRATES** (Selective Obstetrical Quality Review and Adjudication of Trigger Events Scale):

• **Pros:** reflects quality, collects most of the preventable outcomes, allows a comparison overtime and between institutions of preventable outcomes, allows identification and action against poor quality root causes.

• **Cons:** may be labor-intensive in the beginning, still based on a sample, quality issues may be different each time.
# Measuring Quality in Obstetrics

## TABLE 3

Frequency of opportunities for improvement by factor, N = 66

<table>
<thead>
<tr>
<th>Factor</th>
<th>Specific opportunities for improvement</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider, N = 52</td>
<td>Inappropriate choice of treatment</td>
<td>24</td>
<td>46.2</td>
</tr>
<tr>
<td></td>
<td>Delay in diagnosis or treatment</td>
<td>19</td>
<td>36.5</td>
</tr>
<tr>
<td></td>
<td>Management hierarchy</td>
<td>8</td>
<td>15.4</td>
</tr>
<tr>
<td></td>
<td>Poor/inadequate documentation</td>
<td>5</td>
<td>9.6</td>
</tr>
<tr>
<td></td>
<td>Team communication</td>
<td>4</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>Provider education</td>
<td>3</td>
<td>5.8</td>
</tr>
<tr>
<td></td>
<td>Referral to higher level of care</td>
<td>3</td>
<td>5.8</td>
</tr>
<tr>
<td>Patient, N = 19</td>
<td>Patient delay in seeking health care or adhering to medical advice</td>
<td>13</td>
<td>68.4</td>
</tr>
<tr>
<td></td>
<td>Suboptimally controlled prepregnancy underlying medical or physical condition</td>
<td>8</td>
<td>42.1</td>
</tr>
<tr>
<td></td>
<td>Complications due to conditions of pregnancy</td>
<td>7</td>
<td>36.8</td>
</tr>
<tr>
<td></td>
<td>Nonobstetric medical complication that occurred during pregnancy</td>
<td>5</td>
<td>26.3</td>
</tr>
<tr>
<td></td>
<td>Significant social conditions</td>
<td>3</td>
<td>15.8</td>
</tr>
<tr>
<td></td>
<td>Barriers to health care access</td>
<td>1</td>
<td>5.3</td>
</tr>
<tr>
<td>System, N = 9</td>
<td>Policies and procedures affecting outcome</td>
<td>5</td>
<td>56.6</td>
</tr>
<tr>
<td></td>
<td>Delay in transfer to higher level of care</td>
<td>2</td>
<td>22.2</td>
</tr>
<tr>
<td></td>
<td>Communication</td>
<td>2</td>
<td>22.2</td>
</tr>
</tbody>
</table>

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*Defined as lack of consultation with appropriate services available for assistance, eg. In-house or attending obstetrics physician, maternal-fetal medicine.*

*Defined as failure to communicate due to system error, eg. Contact information for consulting service not available.

As an active clinician, administrator, and researcher in health care quality, I am often amusingly reminded of Robert Pirsig’s *Zen and the Art of Motorcycle Maintenance* (1974) as I search for what defines quality in medicine and obstetrics. In this book, the protagonist takes a 17-day health care spending. Regulatory bodies, credentialing boards, government and third party payers, hospitals, and, of course, our patients demand improved outcomes, better value, and fewer instances of harm. For over 10 years, obstetric researchers and clinicians have proposed, and in many cases
TeamSTEPPS Observations

Loraine O’Neill MPH, RN
System Chief Patient Safety Officer,
Dept of OB/GYN
Mount Sinai Health System
Situation:

Need to assess the frequency and use of selected team work elements

Daily use and embedding into daily practices in L&Ds

Accountability
Background

OR experience, training, incorporating TS

Terminology into our guidelines/ policies/ simulation

Other team observation tools
When to do
Who to do
Pilot
<table>
<thead>
<tr>
<th>Outcome Category</th>
<th>Source</th>
<th>Primary Outcome Metric</th>
<th>Effect of Preoperative Briefing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes</td>
<td>Allard et al, 2011</td>
<td>Safety Attitude Questionnaires</td>
<td>Perception of better safety climate</td>
</tr>
<tr>
<td></td>
<td>Bandari et al, 2012</td>
<td>Perceived effectiveness in revealing surgical defects</td>
<td>Agreement of 87% that briefings were effective for identifying defects (most commonly instrument and communication defects)</td>
</tr>
<tr>
<td>Communication and surgical flow</td>
<td>Lingard et al, 2008</td>
<td>No. of communication failures per procedure</td>
<td>Significant decrease in communication failures per procedure (3.95 before briefing vs 1.31 after)</td>
</tr>
<tr>
<td></td>
<td>Nundy et al, 2008</td>
<td>Percentage of unexpected delays and of communication breakdowns per procedure</td>
<td>Reduction of 31% for unexpected delays and 19% for communication breakdowns</td>
</tr>
<tr>
<td></td>
<td>Henrickson et al, 2009</td>
<td>No. of surgical flow disruptions per procedure</td>
<td>Significant decrease in surgical flow disruptions per procedure (5.4 before briefing vs 2.8 after)</td>
</tr>
<tr>
<td></td>
<td>Ali et al, 2011</td>
<td>Operating start times</td>
<td>No statistical difference in operating start time after introduction of preoperative briefings</td>
</tr>
<tr>
<td>Prophylaxis compliance</td>
<td>Lingard et al, 2011</td>
<td>Prophylactic antibiotic administration timing</td>
<td>Improved physician compliance with antibiotic administration guidelines (77.6% before briefing vs 87.6% after)</td>
</tr>
<tr>
<td></td>
<td>Paull et al, 2010</td>
<td>Antibiotic and deep venous thrombosis prophylaxis compliance rates</td>
<td>Increased compliance rates for antibiotic (97% vs 92%) and deep venous thrombosis (96% vs 85%) prophylaxis</td>
</tr>
<tr>
<td>Morbidity and mortality</td>
<td>Neily et al, 2011</td>
<td>No. of adverse events per month</td>
<td>Adverse events decreased from 3.21 to 2.4 per month with use of medical team training</td>
</tr>
<tr>
<td></td>
<td>Young-Xu et al, 2011</td>
<td>Annual surgical morbidity rates</td>
<td>Annual surgical morbidity rates declined 20% more with team training vs without</td>
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<td></td>
<td>Mazzocco et al, 2009</td>
<td>ASA-adjusted OR of complication or death</td>
<td>Increased teamwork (information sharing and briefing) reduced odds of complication or death (OR, 0.21)</td>
</tr>
<tr>
<td></td>
<td>Neily et al, 2010</td>
<td>Annual mortality rate</td>
<td>Risk-adjusted surgical mortality rate was reduced more in programs that used preoperative briefing (RR, 1.49)</td>
</tr>
</tbody>
</table>

Abbreviations: ASA, American Society of Anesthesiologists; physical status classification; OR, odds ratio; RR, risk ratio.
# Team Performance Observation Tool

**Date:** ____________________________  
**Unit:** ____________________________  
**Team:** ____________________________  
**Shift:** ____________________________  

| Rating Scale | 1 = Very Poor  
| 2 = Poor  
| 3 = Acceptable  
| 4 = Good  
| 5 = Excellent  

<table>
<thead>
<tr>
<th>1. Team Structure</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Assembles a team</td>
<td></td>
</tr>
<tr>
<td>b. Establishes a leader</td>
<td></td>
</tr>
<tr>
<td>c. Identifies team goals and vision</td>
<td></td>
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<tr>
<td>d. Assigns roles and responsibilities</td>
<td></td>
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<tr>
<td>e. Holds team members accountable</td>
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<tr>
<td>f. Actively shares information among team members</td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Overall Rating – Team Structure</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Leadership</th>
<th>Rating</th>
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<tbody>
<tr>
<td>a. Utilizes resources efficiently to maximize team performance</td>
<td></td>
</tr>
<tr>
<td>b. Balances workload within the team</td>
<td></td>
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<tr>
<td>c. Delegates tasks or assignments, as appropriate</td>
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<tr>
<td>d. Conducts briefs, huddles, and debriefs</td>
<td></td>
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<tr>
<td>e. Empowers team members to speak freely and ask questions</td>
<td></td>
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<tr>
<td>Comments:</td>
<td></td>
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<tr>
<td>Overall Rating – Leadership</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Situation Monitoring</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Includes patient/family in communication</td>
<td></td>
</tr>
<tr>
<td>b. Cross monitors fellow team members</td>
<td></td>
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<tr>
<td>c. Applies the STEP process when monitoring the situation</td>
<td></td>
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<tr>
<td>d. Fosters communication to ensure team members have a shared mental model</td>
<td></td>
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<tr>
<td>Comments:</td>
<td></td>
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<tr>
<td>Overall Rating – Situation Monitoring</td>
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</table>

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<tr>
<th>4. Mutual Support</th>
<th>Rating</th>
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<tbody>
<tr>
<td>a. Provides task-related support</td>
<td></td>
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<tr>
<td>b. Provides timely and constructive feedback to team members</td>
<td></td>
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<tr>
<td>c. Effectively advocates for the patient</td>
<td></td>
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<tr>
<td>d. Uses the Two-Challenge rule, CUS, and DESC script to resolve conflict</td>
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<tr>
<td>e. Collaborates with team members</td>
<td></td>
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<tr>
<td>Comments:</td>
<td></td>
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<tr>
<td>Overall Rating – Mutual Support</td>
<td></td>
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</table>

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<thead>
<tr>
<th>5. Communication</th>
<th>Rating</th>
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<tbody>
<tr>
<td>a. Coaching feedback routinely provided to team members, when appropriate</td>
<td></td>
</tr>
<tr>
<td>b. Provides brief, clear, specific and timely information to team members</td>
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<tr>
<td>c. Seeks information from all available sources</td>
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<tr>
<td>d. Verifies information that is communicated</td>
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<tr>
<td>e. Uses SBAR, call-outs, check-backs and handoff techniques to communicate effectively with team members</td>
<td></td>
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<tr>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>Overall Rating – Communication</td>
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</table>

**TEAM PERFORMANCE RATING**
# ASSESSMENT

*Type of Observation:*
- Briefing
- Huddle

*Date:*

*Time:*
(Military/24hr format)

*Observer Name:*

*Number of L&D Patients:*

*Miscellaneous Urgent Concerns on L&D:*
- Yes
- No

*Category III tracing
- Critically ill patient
- Shoulder Dystocia
- Eclampsia/Seizure/Hypertensive Emergency
- PPH/STAT cesarean/hysterectomy
- Staffing Issue
- High risk neonate/neonatal compromise/Code
- C-section/multiple C-section
- Multiple birth delivery
- Other:
b. Rating: Check off team members present for the safety rounds:

- [ ] OB Provider
- [ ] OB Residents
- [ ] Neonatology Provider
- [ ] Charge Nurse
- [ ] Anesthesiology Provider
- [ ] Triage Representative

*OB Provider:
- [ ] OB Attending
- [ ] MFM

*Anesthesiology Provider:
- [ ] Anesthesiology Attending
- [ ] Anesthesiology Resident (Must be second year resident or higher)
- [ ] CRNA

*Neonatology Provider:
- [ ] Neonatology Attending
- [ ] Physician's Assistant
- [ ] Neonatology Resident (Must be second year resident or higher)
- [ ] Nurse Manager
- [ ] Nurse Practitioner
- [ ] Charge Nurse

*Triage Representative:
- [ ] Triage Attending
- [ ] NP
- [ ] Triage Nurse
- [ ] PA
- [ ] CNM
- [ ] Resident (Must be second year resident or higher)

Comments:
2. A Leader is established and Safety Rounds Called: Leadership (L):

a. Performance Criteria: An individual must call the safety rounds, and use the leadership skills below.
   Minimum leadership skills:
   1. identify him/herself as the leader
   2. team introduction
   3. discuss plan of care

b. **Rating** on a three point scale. Did the leader meet performance criteria?
   
   ☐ Yes  ☐ Partial  ☐ No

Comments:

---

3. SBAR, Check Back: Communication (C):

a. Performance Criteria: Multiple opportunities to demonstrate
   1. SBAR is concise/precise (Yes - ALL PATIENTS) (Partial - SOME PATIENTS)
   2. Check back may be present including but not limited to discussion of plan of care and/or management, use of medications, patient disposition.

b. **Rating** on a three point scale. Did the team meet performance criteria?
   
   ☐ Yes  ☐ Partial  ☐ No

Comments:

4. Active engagement of all Team Members: Mutual Support (MS):
   a. Performance Criteria: Team members discuss/assess roles

   b. Rating on a two point scale. Did the team meet performance criteria?
      - [ ] Yes
      - [ ] No

   Comments:

5. Active engagement of all Team Members: Mutual Support (MS):
   a. Performance Criteria: Team members discuss
      1. equipment issues
      2. staffing (e.g. obstetrical provider, nursing support, other)
      3. room availability

   b. Rating on a three point scale. Did the team meet performance criteria?
      - [ ] Yes
      - [ ] Partial
      - [ ] No

   Comments:
6. Active engagement of all Team Members: Mutual Support (MS):
   a. Performance Criteria: Team members discuss the acuity on L & D

   b. Rating on a two point scale. Did the team meet performance criteria?
      ○ Yes  ○ No

Comments:
All Hospitals OB TeamSTEPPS Observation

n = 339

Q#1 – Team Assembly: Team Structure
Q#2 – A leader is Established and Safety Rounds Called
Q#3 – SBAR, Check Back
Q#4 – Active Engagement of All Team Members: Team members discuss/assess roles
Q#5 – Active Engagement of All Team Members: Team members discuss equipment issues, staffing, room availability
Q#6 – Active Engagement of All Team Members: Team members discuss the acuity on L&D

*Cases compliant with all 6 questions
Recommendation

More data-change tool

Drilldown to local variance

Establish best practices
Thanks to:
Our OB teams back in NYC
Our data group at FOJP HIC


• Schmutz J. and Manser T. Do team processes really have an effect on clinical performance? A systematic literature review Br. J. Anaesth. first published online March 1, 2013 doi:10.1093/bja/aes513
Technical Skills Training for Attending Obstetricians: Unchartered Territory

Colleen A. Lee MS, RN
Project Manager, Division of Quality and Patient Safety
New York-Presbyterian Hospital
Simulation in Obstetrics

• Traditionally focused on trainees and/or multidisciplinary teams

• Few opportunities exist beyond residency and fellowship training for providers to practice and maintain the technical skills needed to safely perform high stakes, low frequency events such as shoulder dystocia and urgently indicated vacuum-assisted vaginal delivery (VAVD)

• Difficult to focus on attending technical skill within multidisciplinary team simulations
SAFEST

• **Skills for Attendings** Facilitated by **Education using Simulation Training**
  
  • Mandatory, standardized attending technical skills training for shoulder dystocia and operative vaginal delivery beginning in 2016
  • Program developed by the Obstetric Simulation work group of the Hospitals Insurance Company (HIC)
  • Supported (equipment and faculty time) by HIC
SAFEST

• **Background:**
  – Obstetrics: several high risk, low frequency emergent events capable of producing devastating outcomes
  – HIC: ongoing audit of shoulder dystocia and VAVD across the collaborative

• **Program:**
  – Focus on SD and VAVD
    • evidence based algorithms known to decrease risks if performed correctly
  – Multi-center (5 sites) study
    • 350 Attending physicians to be trained over 4 quarters
  – Skills assessed in simulation:
    • Baseline
    • Immediately post-training
    • Retraining at 6, 12, 18 and 24 month intervals

<table>
<thead>
<tr>
<th>Step</th>
<th>Pre</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Post</th>
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</table>
Aims of SAFEST

• **Outcomes monitored:**
  – Occurrence of newborn injury (brachial plexus injury and/or birth trauma after SD or VAVD)
  – Additional newborn outcomes: admission to NICU >24 hours, Apgar <7 at 5 minutes, and no complication

• **Potential to link simulation with outcomes**
  – Focus on Attending technical skills in a large multi-center trial
  – Standardized, reproducible curriculum
  – Retention data
*Hand positioning for LOA hold
Progress to Date

- Prework (curriculum development, validation of tools, equipment, IRB approvals) completed as of March 2016
- Faculty handbook developed to ensure standardization across all sites
- Training commenced April 1, 2016
- Over 170 Attending Obstetricians trained to date across all 5 sites in the collaborative
Thank You

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  dfeldman@fojp.com