Continuing Education Webinar
Improving Safety through Collaboration:
The Interdisciplinary Perinatal Practice Committee

This webinar will be recorded and available on the NPIC/QAS website www.npic.org.
Nurse Planner:
Carolyn L. Wood, PhD, RN, Clinical Nurse Consultant

Purpose/Goal(s) of this Education Activity:
The purpose/goal(s) of this activity is to enable the learner to expand knowledge on the benefits and process of an interdisciplinary perinatal practice committee.

1.0 Contact Hour:
This continuing nursing education activity was approved by the Northeast Multistate Division (NE-MSD), an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.
Disclosures and Successful Completion of this Activity

No commercial support has been provided for this activity.

No one involved in planning or presenting this program has a conflict of interest.

There will be no discussion of off-label usage of any products.

In order to successfully complete this activity and receive 1.0 Contact Hour(s) or 1.0 AMA PRA Category 1 Credit™, you must attend/watch the webinar and return the completed post-test/evaluation to NPIC/QAS.
Improving Safety through Collaboration: The Perinatal Practice Committee

February 24, 2016
Jean Salera-Vieira, MS, PNS, APRN-CNS

Jean Salera-Vieira is the Perinatal Clinical Nurse Specialist/Advanced Nurse Clinician at Kent Hospital (Warwick, RI), working with nursing and medical providers in LDR, Mother/Baby and Level II nursery. She holds Bachelor’s degrees in Social Work (from the University of New Hampshire) and Nursing (from Rhode Island College), Masters of Science in nursing from the University of Rhode Island, as well as a Post-Masters Certificate as a Perinatal Nurse Specialist from the University of Washington, Seattle. Jean is certified in Inpatient Obstetrics and holds a certificate of added qualification in Electronic Fetal Monitoring. She has presented and written on safety issues in the perinatal setting including color-coding for multiples, preparation for The Joint Commission visit, and discharge planning for the families of late preterm infants. Jean is currently the AWHONN RI Section Chair, Chair of the March of Dimes Mission Committee in RI and serves on the NCC Board of Directors.

Learning Objectives:
Upon completion of this activity, participants should be able to:
- Identify the professional standards citing the need for interprofessional communication to improve safety
- Describe strategies employed to organize and facilitate an interdisciplinary committee
- Discuss factors to sustain the work of the interdisciplinary committee

Media used for activity:
- Live event – webinar
- Archived event – electronic

Method of Participation:
- Participants are required to attend the live event through webinar format.

Estimate time required for completion:
- One hour

Date of original release:
- February 24, 2016

Activity termination date:
- 1 Year after date of original release

Scope of Practice:
- This activity is appropriate for the current and future scopes of practice for attending physicians and other clinicians and Allied Health professionals involved in perinatal care.

Core Competencies:
- Medical Knowledge and Patient Centered Care

Accreditation:
- Women & Infants Hospital is accredited by the Rhode Island Medical Society to sponsor intrastate continuing education for physicians. Women & Infants Hospital designates this online educational activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Disclosure:
- Jean Salera-Vieira, MS, PNS, APRN-CNS has no relevant financial relationships to disclose.
- No other persons responsible for the planning or implementation of this activity have any financial interests to disclose.

Policy on Privacy and Confidentiality:
To obtain the Women & Infants Continuing Medical Education Policy on Privacy and Confidentiality, call the WIH CME office at 401-274-1122, ext. 4-2383.

Further Information:
For more information regarding this program please email education@npie.org or call 401-274-0650.
Improving Safety Through Collaboration: The Interdisciplinary Perinatal Practice Committee

Jean Salera-Vieira, MS, PNS, APRN-CNS, RNC-OB, C-EFM
Kent Hospital
Warwick, Rhode Island
Polling question

• Does your facility have an interdisciplinary perinatal practice committee?

• If so, how long have you had this committee?
  • Less than 1 year
  • 1-3 years
  • 3-5 years
  • More than 5 years
Objectives

• Identify the professional standards citing the need for interprofessional communication to improve safety.

• Describe strategies employed to organize and facilitate an interdisciplinary committee.

• Discuss factors to sustain the work of the interdisciplinary committee.
Our mission statement

“The Interdisciplinary Perinatal Practice Committee (IPPC) will be an interdisciplinary committee that will examine scientific literature and evidence based guidelines about a particular topic. Recent literature, practice guidelines from ACOG, AWHONN, AAP, etc., as well as current Kent practice will be reviewed during the meetings. By examining the most recent scientific, peer reviewed literature and professional organization standards, we will be focusing on patient safety, risk reduction, and best practice at the bedside. Collaborative discussion will be held around the selected topic to obtain nursing and medical staff input into suggested practice changes. Practice guidelines/proposals may be developed based on the discussions of the meetings.”
Also known as...

Using the perinatal safety literature to guide practice change

Perinatal safety advocates and leaders among others, include –

• Debra Bingham
• Holly Kennedy
• Audrey Lyndon
• Lisa Miller
• Kathleen Rice Simpson
**Sentinel events**

- Sentinel event root causes –
  - May have multiple root causes

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http://www.jointcommission.org/sentinel_event_statistics/
Maternal and Perinatal Events

• For the years 2004-2015:
  • Maternal events –
  • Communication is number two

• Perinatal sentinel events –
  • Communication is number two

http://www.jointcommission.org/sentinel_event_statistics/
Professional organization recommendations

- Use of communication tools such as SBAR, huddles
- Collaboration and communication key to improving patient outcomes
- Optimal team performance incorporates effective communication and respect for input from all members
- Collegial relationships enhance quality care
ACOG, ACNM, AWHONN, SMFM:

“Effective communication among team members and with patients is a hallmark of safe and highly reliable patient care. Reluctance or inability to proactively identify and resolve problems in clinical care creates safety risks and undermines teamwork, resulting in poorer quality of care at best and patient harm at worst.”

Lyndon, Johnson, Bingham et al., 2015
Strategies for improving safety

• Enhanced communication in the perinatal setting
• Utilizing evidence based practice
• Team strategies - drills, simulations, debriefing
• Addressing practice changes
• Standardizing protocols - include shared decision making
• Collaboratively discuss differing points of view
Future of Nursing Recommendations:

• Nurses should practice to the full extent of their education and training.
• Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
• Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
• Effective workforce planning and policy making require better data collection and information infrastructure.

Potential barriers to practice or quality improvement change

- May include:
  - Environmental/cultural barriers
  - Clinician barriers
  - Leadership barriers
  - Lack of resources
  - Silos

Bingham & Main, 2010
Change management theory

• “Unfreezing”
  • Gather information
  • Getting ready to change
  • Preparing others for the change

• “Change what needs to be changed”
  • Identify gaps in current state
  • Clearly describe the future vision
  • Communicate the benefits of the change

• “Freezing/Refreeze”
  • Make the change permanent
  • Reinforce the change

Polling question

Has your hospital/unit/team participated in any team training?
Setting the stage

• Dedicated nurses and providers

• Want to provide the best care for patients

• Needed an opportunity for nursing and providers to come together

• Time to review current professional organization standards and scientific literature
Team purpose

• “Interdisciplinary Perinatal Practice Committee” structure and concept.

• The purpose of the committee is “to provide a routine process to monitor publication of practice statements from professional and regulatory agencies and include these publications as a standing agenda item.”

Simpson, Kortz & Knox, 2009
Campaigning for change

- Engagement of stakeholders
- Identify informal leaders
- Nursing -
  - Identify champions of change
  - Opportunity to have input into practice and policy

- Providers –
  - Identify champions of change
  - Benefits of interdisciplinary collaboration
  - Build on previous interdisciplinary committee work
Campaigning for change

- Engagement of stakeholders

- Formal leaders –
  - Nursing Leaders
  - Provider Leadership
  - Risk Management
  - Hospital Administration
Potential obstacles to establishing the IPPC

- Perception
  - “Already follow the standard of care.”
  - “I know what’s best for my patients.”

- Time constraints
  - Too many meetings on the calendar
  - Not enough time to fit another meeting into the schedule

- New untried idea
Committee membership

- Perinatal CNS
- Nursing
- Obstetric providers (MDs, DOs, CNMs)
- Neonatology providers (MDs, NNPs)
- Family practice resident
- Risk Management
- Medical Education
- Nursing Administration

Attendance at each meeting varies from 8 to 20 attendees.
Committee Expectations

• “Homework”
  • Current nursing and medical research
  • Updated professional reports and guidelines

• Environment and structure
  • Open discussion
  • Lively conversation
  • Invites learning
  • All opinions heard and respected
How do we get everyone there?
Benefits

PERCEIVED

• Improved communication
• Strengthening collaboration
• Use of research and EBP into practice
• Input into proposed changes on the unit
• Professional growth

TANGIBLE

• Nursing contact hours
• CME for Providers
• Risk Management credits

RISK REDUCTION
IMPROVED PATIENT SAFETY
Inaugural topic
Inaugural topic process

- Three meetings
- Created draft order sets
- Developed policy
- When new process developed, educated other staff
The work of the IPPC

- Standardization of oxytocin orders
  - Continued random audits show adherence to change

- Postpartum hemorrhage
  - Collaborative development of PPH algorithm
  - Creation of PPH kit
  - Quantification of blood loss

- Delayed Cord Clamping
  - Created algorithm for providers and nursing
The work of the IPPC

- Infant weight loss related to maternal intrapartum fluid intake
- Breastfeeding and marijuana
  - Consistent planning and education
- Hypertension in pregnancy
- TOLAC and Pitocin
Sustainment

- Leadership support
- Celebrate successes
- Follow-up on changes made at the IPPC
  - Conduct audits to show sustainment
  - Share IPPC work with team members who were not at the meeting
  - Relate policy changes back to IPPC meetings
  - Evaluate outcomes
Sustainment

• Support team members as change is implemented

• Monitor effectiveness of the change
  • Share results with team members

• Engage team members in the work of the committee
  • Educational posters/sessions
  • Presenting to colleagues
Hardwired into practice

• Nursing
  • reports improved communication at the bedside
  • now feels empowered to be part of the changes in practice on the unit
  • assists with development of policy and practice changes

• Providers using order sets, and following policies and algorithms created by the IPPC

• Members of IPPC discuss the work of the committee outside the committee meetings
The IPPC today -

• Culture of Safety
  • IPPC viewed as the format to discuss and vet practice changes
  • Created an environment that strives to decrease risk to patients with increased collaboration and communication
Next steps

• Bringing the IPPC to the hospital system level
  • System-wide interdisciplinary round table
AHRQ Resource -

• Comprehensive Unit-based Safety Program (CUSP) Toolkit
  • Includes model of a unit based team

Thank you

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References


References


Questions & Comments

Participants are encouraged to ask questions and share comments.

- Please use the chat box for questions or comments.
- Questions and comments are visible only to presenters.
- Questions will be answered in the order in which they are submitted.
- Should there not be enough time to address your question(s), please email education@npic.org so we may follow-up with you.
Thank You for Attending!

ATTENTION:

For 1.0 Contact Hour or 1.0 AMA PRA Category 1 Credit™

*DO NOT CLOSE YOUR BROWSER WINDOW*

POST-TEST WILL AUTOMATICALLY APPEAR WHEN THE WEBINAR HAS ENDED

Please complete the post-test within 24 hours

Certificates of Attendance & Completion will be emailed within 14 business days