Supporting Culture and Teamwork: Perinatal Collaborative

The aim of the Perinatal Collaborative is to reduce infant harm through the implementation and integration of systems improvements and team behaviors into maternal-fetal care.

When we think of labor and delivery today, we think of healthy women giving birth to a beautiful baby and everyone being happy, but when a bad outcome occurs it’s devastating to both the parents and the care team. When the Joint Commission on Accreditation of Healthcare Organizations analyzed 42 sentinel events involving infant death from 1999-2004, it revealed that communication was the leading root cause and culture as a barrier to communication and teamwork was an underlying cause. The Maryland Patient Safety Center Perinatal Collaborative seeks to address this fundamental process and by doing so reduce the risk of a poor outcome.

Changes Being Tested and Implemented

- Standardized electronic fetal heart rate (FHR) monitoring terminology with the adoption of terms from the National Institute of Child Health and Development (NICHD) for all professional communication about FHR patterns
- Applied the concepts of crew resource management/team training to labor & delivery
  - Implemented multidisciplinary team meetings (Board Rounds) on each shift
  - Improved effectiveness of SBAR communications
- Improved assertion for patient safety via TeamSTEPPS™ Two-Checklist Rule and CUS Techniques
- Created contingency teams to respond to emergency situations
- Improved situation monitoring through creation of shared mental models (e.g. call out and huddles)
- Improved situation monitoring through cross monitoring of team members
- Implemented routine emergency drills or critical events training with debriefings to evaluate team performance and identify opportunities for improvement
- Reviewed technique for vacuum-assisted deliveries
- Used and provided feedback on the Institute for Healthcare Improvement’s Perinatal Bundles (Elective Induction and Augmentation)

Summary of Results / Lessons Learned

In most cases, perinatal units in the region reported similar perceptions of patient safety culture to those facilities in AHRQ’s comparison group. Perceptions of Teamwork Within Units is high, while Teamwork Across Units remains an area with opportunities for improvement. Although teamwork within labor and delivery units was strong, it declined when the unit got busy. There were opportunities for improvement in all aspects of communication measured by the survey.

Since this project is in an early stage, improvement results are still being analyzed. However, we have already learned several lessons:

- Create an early and strong kick-off for the project to initiate momentum.
- Do what you can to do forward progress no matter what the circumstances.
- Assess the team’s progress in light of the circumstances to recognize efforts.
- Keep the senior leaders informed and excited about the project.

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Dimensions of Communication and Teamwork
AHRQ Hospital Patient Safety Survey, Maryland Perinatal Collaborative