Incorporating Team STEPPS into the Implementation of an Inter-professional Obstetric Hemorrhage Emergency Management Plan

Authors: Megan Flatley, BSN, RN, C-EFM, Nicole Kalinowski, BSN, RNC- MNN, CLC & Andrea Rebisch, BSN, RNC-OB, C-EFM

Objective

Discover how standardizing obstetric hemorrhage management with use of TeamSTEPPS communication tools increased staff's confidence in caring for a patient and communicating with providers.

Purpose

- The purpose of this project is to standardize hemorrhage management and to give nurses the autonomy to initiate the emergency plan.
- The goals were to enhance team communication between nurses and providers, increase team response time and increase confidence level of staff during a hemorrhage.

Relevance

- 17% of maternal deaths in the United States are from obstetric hemorrhage. With a >10% increase in patient volume in a two-year time span, the need to standardize hemorrhagic care was recognized.
- In addition, per a Joint Commission Sentinel Alert, most cases of perinatal death and injury are caused by an organization's culture/ communication failures.
- Team STEPPS was implemented in order to improve communication between nurses and providers.

Implementation

- This project first began with designing the obstetric hemorrhage emergency management plan. Nursing co-led the design process of the tool, obstetric hemorrhage risk assessment, and process for quantification of blood loss.
- TeamSTEPPS communication methods were taught to nursing staff and providers through in-services and modules, which explained the purpose and elements of the bundle in detail.
- Preparing the units for this bundle included: purchasing of scales, switching to calibrated drapes, designing obstetric hemorrhage carts, and creating a hemorrhage kit in our medication dispensing cabinet.
- Lastly, inter-professional drills in our hospital's simulation center were conducted.

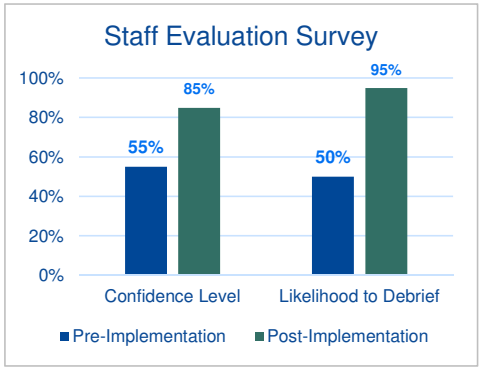
Evaluation

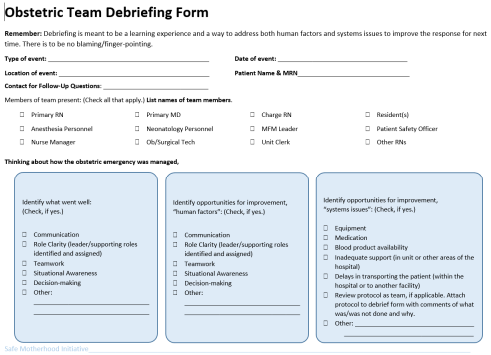
- Five months post-implementation, the inter-professional team was surveyed. The confidence level in treating a patient with obstetric hemorrhage increased from 55% to 85% of staff reporting being confident or very confident. None of the staff identified that they were not at all confident.
- In addition, 95% of the staff reported that they were likely to complete a debrief in comparison with only 50% prior to training. The increase in response supported our original purpose to appropriately train our team and improve confidence.
- The results from the survey also validated our goal of increasing communication between nurses and physicians using Team STEPPS communication tools.

Conclusion

Our project is unique in two ways.

- Primarily, nurses co-led the creation of a stage based hemorrhage plan. This tool gives nurses the autonomy to initiate and guide the team in appropriate interventions.
- Secondly, the addition of Team STEPPS tools is crucial to safe patient care and outcomes.





Obstetric Team Debriefing Form

Remember: Debriefing is meant to be a learning experience and a way to address both human factors and systems issues to improve the response for next time. There is to be no blaming/finger-pointing.

Type of event: _____ **Date of event:** _____

Location of event: _____ **Patient Name & MRN** _____

Contact for Follow-Up Questions: _____

Members of team present: (Check all that apply.) **List names of team members.**

☐ Primary RN ☐ Primary MD ☐ Charge RN ☐ Resident(s)
☐ Anesthesia Personnel ☐ Neonatology Personnel ☐ MFM Leader ☐ Patient Safety Officer
☐ Nurse Manager ☐ Ob/Surgical Tech ☐ Unit Clerk ☐ Other RNs

Thinking about how the obstetric emergency was managed,

Identify what went well: (Check, if yes.)

☐ Communication
☐ Role Clarity (leader/supporting roles identified and assigned)
☐ Teamwork
☐ Situational Awareness
☐ Decision-making
☐ Other: _____

Identify opportunities for improvement, "human factors": (Check, if yes.)

☐ Communication
☐ Role Clarity (leader/supporting roles identified and assigned)
☐ Teamwork
☐ Situational Awareness
☐ Decision-making
☐ Other: _____

Identify opportunities for improvement, "systems issues": (Check, if yes.)

☐ Equipment
☐ Medication
☐ Blood product availability
☐ Inadequate support (in unit or other areas of the hospital)
☐ Delays in transporting the patient (within the hospital or to another facility)
☐ Review protocol as team, if applicable. Attach protocol to debrief form with comments of what was/was not done and why.
☐ Other: _____

Safe Motherhood Initiative

Froedtert & Medical College of Wisconsin