

# Improving Patient Safety in Perinatal Services

Catholic Healthcare West Has Instituted a Four-Phase, Systemwide Program

BY BARBARA PELLETREAU, HILLERY TRIPPE, & ELAINE ZIEMBA

**C**ontinually improving patient safety is the first priority of Catholic Healthcare West, San Francisco. Nowhere is this more true than in one of the highest risk areas in health care—perinatal services (delivery of the baby and the care of the mother and newborn). Studies have shown that patients and newborns can be harmed when a basic element—communication—is missing from the care of these most vulnerable of patients. When one reviews reported events and studies professional liability claims, one sees that effective communication between health care practitioners, including doctors and nurses, is often the missing component. Its absence can result in unnecessary and even tragic outcomes, including death, as well as costly professional liability claims.

CHW has taken an uncompromising approach in improving communication concerning patient safety. The system began its effort with neither a pilot project sited at a few representative facilities nor a single initiative. Instead, CHW's Corporate Risk Services (CRS) spearheaded a four-phase approach that involved every one of CHW's 41 hospitals.

## FOUR PHASES

### Events Reporting System

The first critical step was providing the means to capture all adverse (or potentially adverse) events that might impact patient safety. Toward this end, in the late spring of 2005, CHW launched its Events Reporting System (ERS). Within a

year, the ERS had captured more than 100,000 events and made them available for each hospital to analyze and shape into meaningful information that would serve as a basis for action plans.

Using the new system, employees could electronically enter an event in from three to five minutes and have it routed directly to the department managers and risk manager for review. In addition, all medication events were routed to a pharmacist for his or her immediate review and analysis. Hillery Trippe, a CHW executive (and one of this article's authors), said, "We want to encourage all the reporting of events because then facilities know where their opportunities are to improve patient safety. If we don't know, we cannot fix it."

### Reading Fetal Monitoring Strips

Meanwhile, another safety program focused on improving communications in perinatal services themselves. Physicians and nurses received training in reading fetal strips, their goal being to pass a National Certification Corporation test. Having a common terminology and understanding of interpretation of fetal monitoring strips is key if a nurse and physician are to communicate clearly about the patients' status, note any early signs of fetal distress, and then determine appropriate actions. This year, approximately 1,500 employees and physicians will receive this training and testing across CHW's facilities.

### MedTeam Training

The program's third component was MedTeam training, which CHW launched for every person working in perinatal services, including physicians, nurses, assistants, pharmacists, clerks, and anyone else whose work involved the obstetrics department. MedTeams training is based on research in the field of aviation—a field, like medicine, that involves high stress, high risk, and dire consequences should team members fail to communicate.\* Teaching teams of people new ways to communicate, share information, solve problems, and manage workloads has improved safety in aviation—and it should improve perinatal safety at CHW as well.

At each CHW hospital, two key individuals have been cho-



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\*For information on MedTeam training, contact the Agency for Healthcare Research and Quality, Washington, DC, at [www.ahrq.gov](http://www.ahrq.gov).



sen to participate in two and a half days of extensive MedTeam training. After they complete their sessions, they will return to their facilities and, in the following five months, train everyone in perinatal services (the training will include practice and feedback sessions).

### Executive "WalkRounds"

The fourth step was (almost literally) Executive WalkRounds (EWR), intended to engage senior management at each hospital in a minimum of at least one scheduled visit a month to the facility's perinatal service area.\* For this purpose, "senior management" can include the chief operating officer, chief nurse executive, patient safety officer, chief financial officer, and risk manager—but the hospital president *must* attend the monthly meeting held after the EWR to solicit issues and ideas from the front line staff on improving patient safety. A designated scribe also attends the EWR to note all identified issues. After the meeting, the EWR team meets to determine action plans and assign accountability. The scribe enters all information into a simple access data base and at the month's end sends results to CRS to track closure of issues, attendance of hospital president, and the number of participants.

\*The WalkRounds concept was developed by Allan Frankel, MD. For information on it, contact the Health Research & Education Trust, Chicago, at [www.hret.org/hret/walkrounds](http://www.hret.org/hret/walkrounds).

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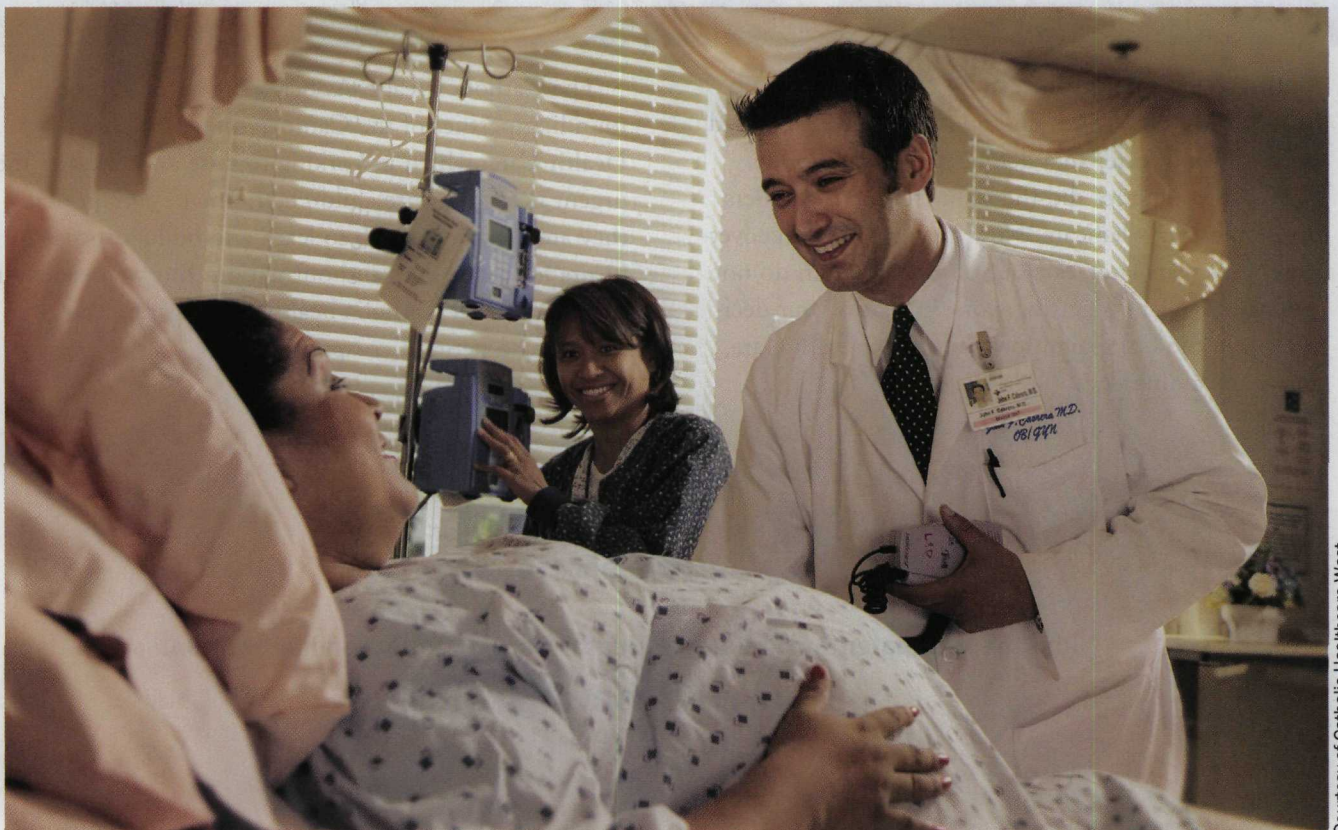
At each CHW hospital, two key individuals will train everyone in perinatal services.

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### TRACKING EFFECTIVENESS

CHW is measuring the effectiveness of its perinatal services safety program through its Safety Attitude Questionnaire, a widely accepted tool that scores the employees' perception of safety in their units. An independent, external agency will score the results. In each of the next two years, CHW hospitals will be evaluated for their ability to improve their scores in their perinatal services over and above their baseline. In addition, CRS will be tracking the insurance claims in these areas over the next few years, to see whether the number of claims filed and their overall cost decreases. CHW believes that its uncompromising approach will yield positive tangible results in the years ahead and, most importantly, new levels of excellence in patient safety.

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