ACOG, SMFM, and others address safety concerns in labor and delivery

4 specialty societies review safety risks in obstetrics and offer a range of strategies to overcome them

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At least half of all cases of maternal morbidity and mortality could be prevented, or so studies suggest.[1,2]

The main stumbling block?

Faulty communication.

That's the word from the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine, the American College of Nurse-Midwives, and the Association of Women's Health, Obstetric and Neonatal Nurses.[3]

In a joint "blueprint" to transform communication and enhance the safety culture in intrapartum care, these organizations, led by Audrey Lyndon, PhD, RN, from the University of California, San Francisco, School of Nursing, describe the extent of the problem, steps that various team members can take to improve safety, notable success stories, and communication strategies.[3] In this article, the joint blueprint is summarized, with a focus on steps obstetricians can take to improve the intrapartum safety culture.

Scope of the problem

A study of more than 3,282 physicians, midwives, and registered nurses produced a troubling statistic: More than 90% of respondents said that they had "witnessed shortcuts, missing competencies, disrespect, or performance problems" during the preceding year of practice.[4] Few of these clinicians reported that they had discussed their concerns with the parties involved.

A second study of 1,932 clinicians found that 34% of physicians, 40% of midwives, and 56% of registered nurses had witnessed patients being put at risk within the preceding 2 years by other team members' inattentiveness or lack of responsiveness.[5]

These findings suggest that health care providers often witness weak links in intrapartum safety but do not always address or report them. Among the reasons team members may be hesitant to speak up when they perceive a potential problem:

- feelings of resignation or inability to change the situation
- fear of retribution or ridicule
- fear of interpersonal or intrateam conflict.

Although Lyndon and colleagues acknowledge that it is impossible to eliminate adverse outcomes entirely or completely eradicate human error, they argue that significant improvements can be made by adopting a number of manageable strategies.[3]

Recommended strategies

Lyndon and colleagues describe some of the challenges of effective communication in a health care setting:

The communication of safety concerns involves more than

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FAST TRACK

Explicit elicitation of the patient's experience and concerns is recommended

> simply sending and receiving clinical data. Speaking up about safety concerns is a dynamic social process that is highly context-dependent and is influenced by multiple personal, group, and organizational factors…Highly reliable organizations have a generative safety culture in which everyone is proactively responsible for safety, expertise is valued over positional authority, and there is a clear understanding of how people in diverse roles are dependent on each other to achieve safe, high-quality care.[3]

Lyndon and colleagues go on to mention a number of strategies to improve communication, boost safety, and reduce medical errors.[3]

1. Remember that the patient is part of the team

The patient and her family play a key role in identifying the potential for harm during labor and delivery, Lyndon and colleagues assert. Patients should be considered members of the intrapartum team, care should be patient-focused, and any communications from the patient should not only be heard but fully considered. In fact, explicit elicitation of her experience and concerns is recommended.[3]

2. Consider that you might be part of the problem

It is human nature to attribute a communication problem to the other people involved, rather than take responsibility for it oneself. One potential solution to this mindset is team training, where all members are encouraged to communicate clearly and listen attentively. Organizations that have been successful at improving their culture of safety have implemented such training, as well as the use of checklists, training in fetal heart-rate monitoring, formation of a patient safety committee, external review of safety practices, and designation of a key clinician to lead the safety program and oversee team training.

3. Structure handoffs

The team should standardize handoffs so that they occur smoothly and all channels of communication remain open and clear.

"Having structured formats for debriefing and handoffs are steps in the right direction, but solving the problem of communication breakdowns is more complicated than standardizing the flow and format of information transfer," Lyndon and colleagues assert. "Indeed, solving communication breakdowns is a matter of individual, group, organizational, and professional responsibility for creating and sustaining an environment of mutual respect, curiosity, and accountability for behavior and performance."[3]

4. Learn to communicate responsibly

"Differences of opinion about clinical assessments, goals of care, and the pathway to optimal outcomes are bound to occur with some regularity in the dynamic environment of labor and delivery," note Lyndon and colleagues. "Every person has the responsibility to contribute to improving how we

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relate to and communicate with each other. Collectively, we must create environments in which every team member (woman, family member, physician, midwife, nurse, unit clerk, patient care assistant, or scrub tech) is comfortable expressing and discussing concerns about safety or performance, is encouraged to do so, and has the support of the team to articulate the rationale for and urgency of the concern without fear of put-downs, retribution, or receiving poor-quality care."[3]

5. Be persistent and proactive

When team members have differing expectations and communication styles, useful approaches include structured communication tools such as situation, background, assessment, recommendation (SBAR); structured handoffs; board rounds; huddles; attentive listening; and explicit elicitation of the patient's concerns and desires.[3]

If someone fails to pay attention to a concern you raise, be persistent about restating that concern until you elicit a response.

If someone exhibits disruptive behavior, point to or establish a code of conduct that clearly describes professional behavior.

If there is a difference of opinion on patient management, such as fetal monitoring and interpretation, conduct regular case reviews and standardize a plan for notification of complications.

6. If you're a team leader, set clear goals

Then ask team members what will be needed to achieve the outcomes desired.

"Team leaders need to develop outstanding skills for listening and eliciting feedback and cross-monitoring (being aware of each other's actions and performance) from other team members," note Lyndon and colleagues.[3]

7. Increase public awareness of safety concepts

When these concepts and best practices are made known to the public, women and families become "empowered" to speak up when they have concerns about care.

And when they do speak up, it pays to listen.

References

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