Safeguarding Against Never Events

Presented by

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AWHONN President

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Disclosure

- Employed by Henry Ford West Bloomfield Hospital
- Board member for the Association of Women's Health, Obstetric, and Neonatal Nurses
- No off-label usage of products will be discussed
- No commercial/sponsorship

Objectives

- Identify risk points for never events.
- List actions to mitigate occurrence of never events.
- Describe program called “through the patient’s eyes” to strengthen culture, approach and patient engagement.

The down & dirty of never events but certainly don't want to leave you feeling frazzled!

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Never Events

Definition-

serious incidents that are largely preventable

The What

- AWHONN's Draft Nursing Care Quality Measures
- TJC Perinatal Care Core Measures
- NQF National Voluntary Consensus Standards for Perinatal Care
- Medical errors are in the top 10 causes of death in US
  - Higher than mva, breast cancer, AIDs
  - Equivalent to 1 to 2 jet crashes per week

AWHONN's Draft Women's Health & Perinatal Nursing Care Quality Measures

- Triage is performed by a nurse in 10 minutes
- Spontaneous pushing
- Skin to skin
- 60 minutes uninterrupted skin to skin
- Elimination of supplementation of breast milk fed healthy term newborns
- Prioritizing maternal milk volume to ensure primary diet for premature babies in nicu
- Initial contact of mom with neonatal transport
- Grief support
- Women's health & wellness throughout lifespan
- Continuous/partial labor support
- Freedom of movement during labor

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TJC
Perinatal Care (PC) core measure set

- PC-01 Elective delivery
- PC-02 Cesarean birth
- PC-03 Antenatal steroids
- PC-04 Healthcare-associated bloodstream infections in newborns
- PC-05 Exclusive breast milk feeding

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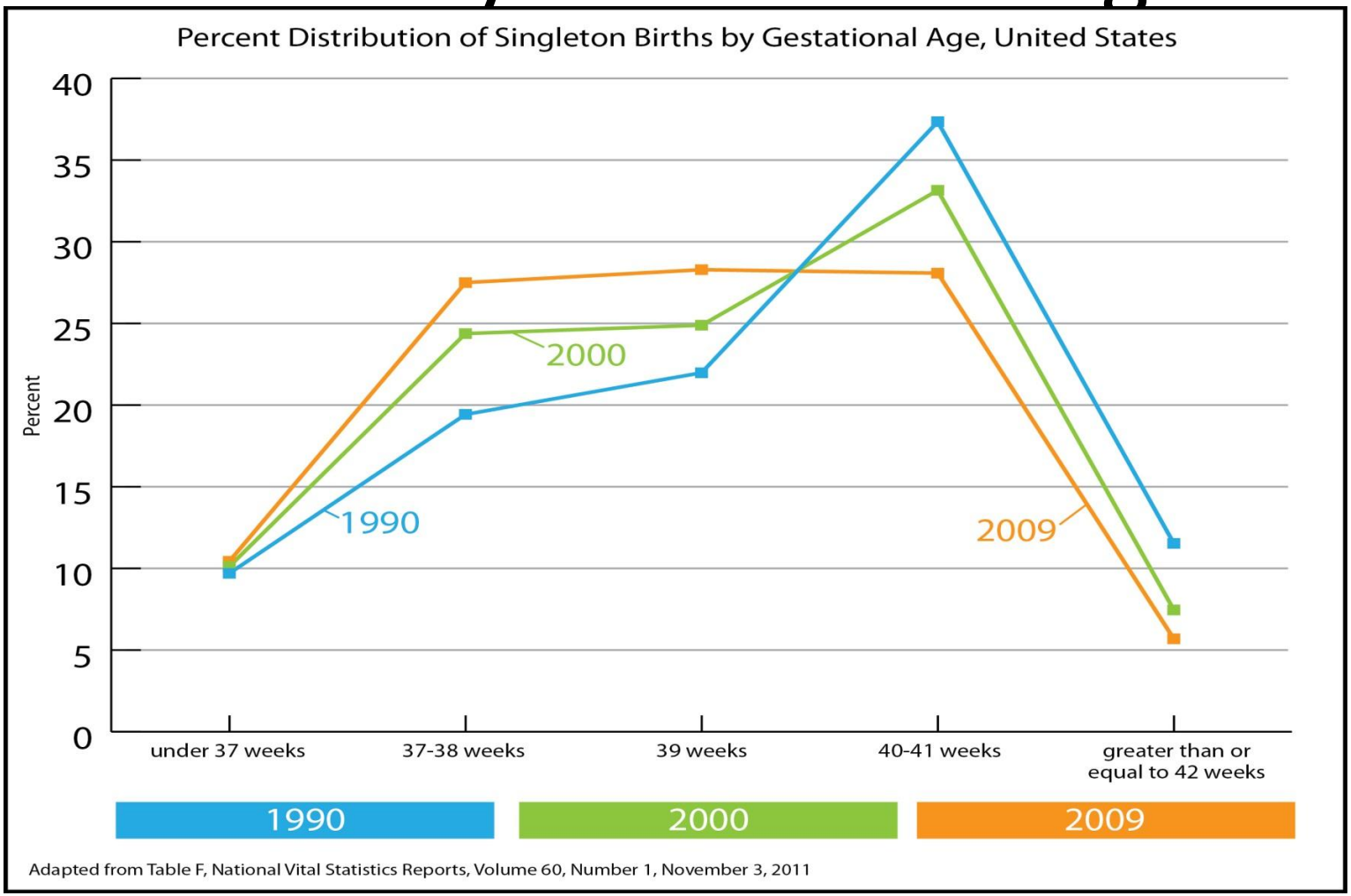
Elective Delivery

- Magnitude in 2007—33% electively delivered
- Effect upon cesarean birth rate
- Implications/adverse effects

Births by Gestational Age



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Cesarean Birth

- Rates
- Outcomes
- Implications

Joint Commission Sentinel Event Alert

- 47 perinatal deaths
- 34% had inadequate fetal monitoring as root cause
- 21% organizations created standardized fetal evaluation & monitoring processes
  - Interpretation
  - Education
  - Standard nomenclature
  - Guidelines
  - Escalation process
  - Medical record templates
- 21.9% of claims involved neurologically impaired children & 14.7% involved oxytocin

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- Christian, P. (2011). Standardization of intrapartum management and impact on adverse outcome. Clinical Obstetrics and Gynecology, 54(1), 8-15.

Never Events

- Retained foreign object
- Wrongly prepared high-risk injectable medication
- Intravenous administration of epidural medication
- Maladministration of insulin
- Transfusion of ABO incompatible blood components
- Misidentification of patients
- Maternal death due to postpartum hemorrhage after elective c/s

Retained foreign object

- Patient underwent gyn surgery & had vag. pack intentionally left in place with planned removal at 48 hours

- Patient needed suturing after an episiotomy during vaginal birth; to create clear view three swabs were placed in vagina, but 2 removed

Retained Sponges

- 2 hour training program
- Quiz
- Demonstrated standardized skill competency
- Sponge 4x8 in instead of 4x4 in
- 40 point audit & educational tool completed
- Observations
- Interviews
- Poster with checklist

Retained Surgical Items

- Lack of safety steps verification in medical record
- RSI missed on initial imaging
- Count not performed or documented
- Protocol followed incorrectly or disregarded
- Lack of protocol/safety procedure knowledge
- Team communication inadequate/deficient
- Inadequate device tracking

Symptoms of Retained Surgical Items

- Abdominal pain
- Abscess
- Nausea/vomiting
- Wound complication
- Mass
- Systemic inflammatory response syndrome
- Ileus
- Respiratory

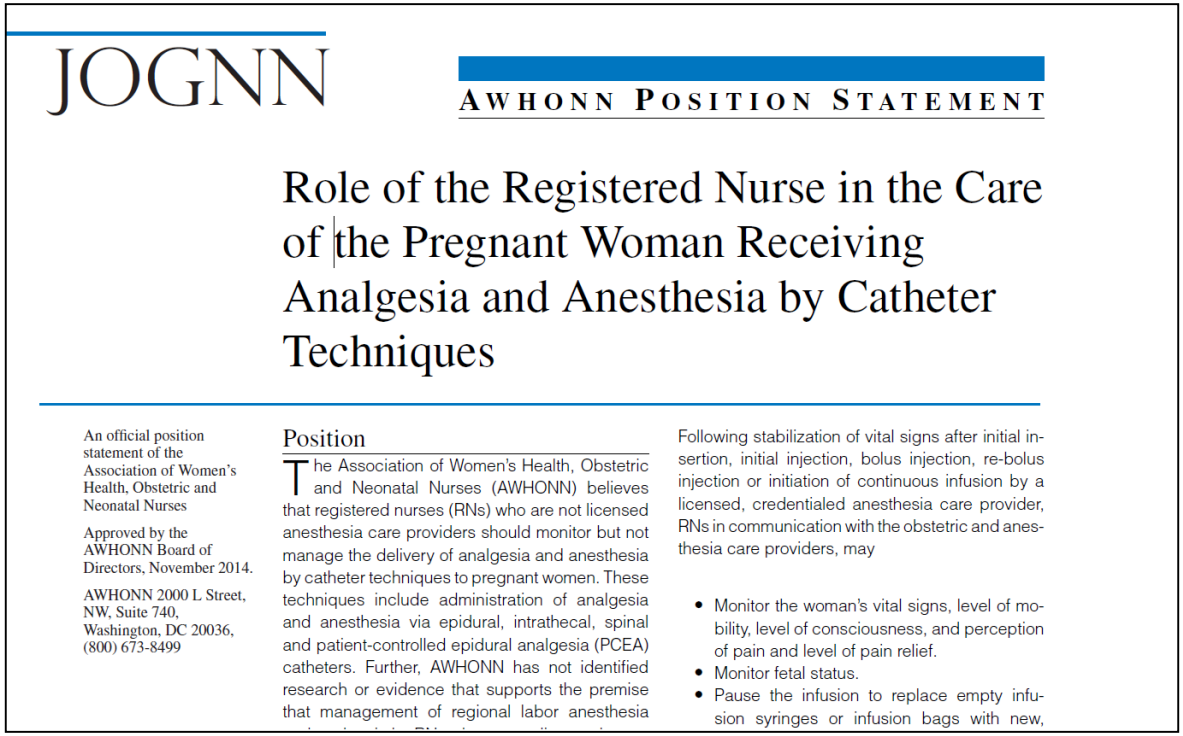
Wrongly prepared high risk injectable medication

- Heparin
- Magnesium sulfate
- Pitocin

Pitocin

- Routine
- Liability claims
- Tachysystole
- Standardized EBP
  - Mixture 30 units of oxytocin in 500 mL/h

Intravenous administration of epidural medication



JOGNN

AWHONN POSITION STATEMENT

Role of the Registered Nurse in the Care of the Pregnant Woman Receiving Analgesia and Anesthesia by Catheter Techniques

An official position statement of the Association of Women's Health, Obstetric and Neonatal Nurses

Approved by the AWHONN Board of Directors, November 2014.

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Position

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) believes that registered nurses (RNs) who are not licensed anesthesia care providers should monitor but not manage the delivery of analgesia and anesthesia by catheter techniques to pregnant women. These techniques include administration of analgesia and anesthesia via epidural, intrathecal, spinal and patient-controlled epidural analgesia (PCEA) catheters. Further, AWHONN has not identified research or evidence that supports the premise that management of regional labor anesthesia

Following stabilization of vital signs after initial insertion, initial injection, bolus injection, re-bolus injection or initiation of continuous infusion by a licensed, credentialed anesthesia care provider, RNs in communication with the obstetric and anesthesia care providers, may

- Monitor the woman's vital signs, level of mobility, level of consciousness, and perception of pain and level of pain relief.
- Monitor fetal status.
- Pause the infusion to replace empty infusion syringes or infusion bags with new,

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Maladministration of insulin

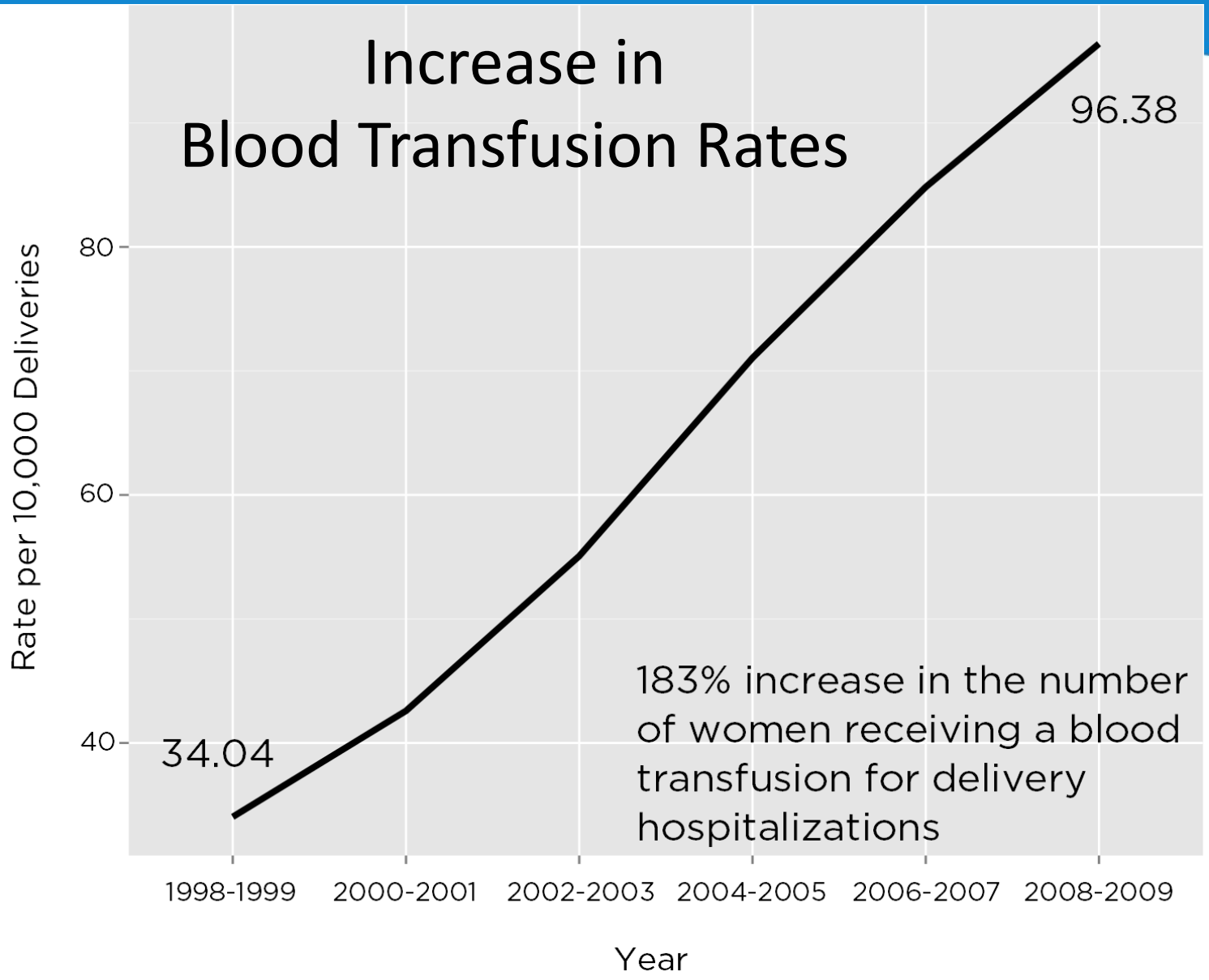
- Types of insulin
- Accurate testing to dosing

Medication Management

- 2 patient identifiers
- Automatic dispensing system
- Barcode medication administration
- Smart pumps
- Double checking high alert
- Pharmacy prepared meds
- Dosing regimens

Transfusion of ABO incompatible blood components

Increase in Blood Transfusion Rates



Source: Callaghan et al. (2010). Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States. *Obstetrics & Gynecology, 120.*

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Misidentification of Patients

- Scheduled for repeat C/S. Irregular menses, traveling internationally so US in 3rd trimester. Based on suspected date of conception, she presents at 39 weeks gestation. Amniocentesis is done(2nd of 2 amnios done today). Result is within mature range .

- Repeat C/S done for 6 pound boy who is cyanotic with respiratory distress. Apgar 4, 6, 7 at 1, 5, 10 min. To NICU, normal gases. RDS. After delivery realizes read the wrong chart & actually reviewed other amnio results. This pts result was immature fetal lungs.

Misidentification of patients

- Reasons for error
  - Complexity of activity
  - Lack of education & training
  - Perception that procedures not appropriate or efficient
  - Clinical detail missed
  - Test finding overlooked
  - Lab result attributed to

    wrong patient

Resolution to Misidentification

- Double checking
- Tracking
- Documenting every step
- Competence assessment
- Avoidance of excessive workload
- Avoidance of interruptions
- Implementing risk transfer policies

Key Factors to Human Errors

- Conscious automaticity
  - Environment too familiar& attention on next task
- Involuntary automaticity
  - Reduces working memory demand required for procedure
- Ambiguous accountability
  - Two people responsible for same task
- Stress
  - Heavy workload, distraction, fatigue

PATIENT/FAMILY MEMBERS TALK

WE TRULY LISTEN

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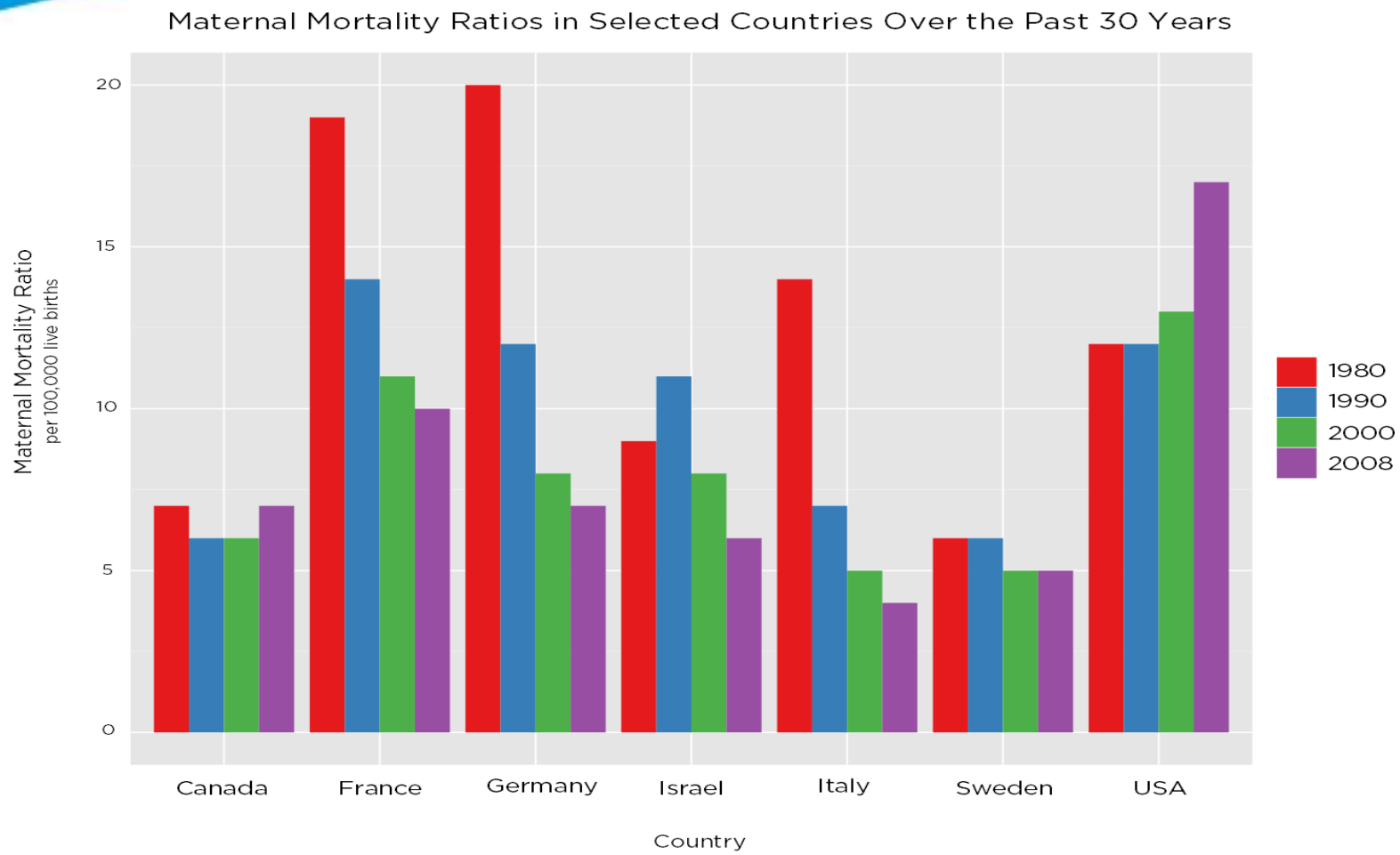
Maternal death

- or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility

- due to postpartum hemorrhage after elective c/s



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PREVALENCE OF MATERNAL DEATH

Women in the US have a greater risk of dying from pregnancy-related complications than women in *59* other countries.

- On average, 2-3 women die each day in the US
- African American women have a 3-4 fold higher risk of dying than Caucasian women.
- Maternal death rate in US is 21 per 100,000 live births
  - Has significantly increased over the last several years

CAUSES OF MATERNAL DEATH

- **The *spectrum* of cardiovascular disease is the leading cause, & includes**
  - Cardiomyopathy
  - Heart disease
  - Preeclampsia
- **Obstetric hemorrhage is one of the *leading single causes* of maternal death**
  - Considered preventable in the vast majority of cases

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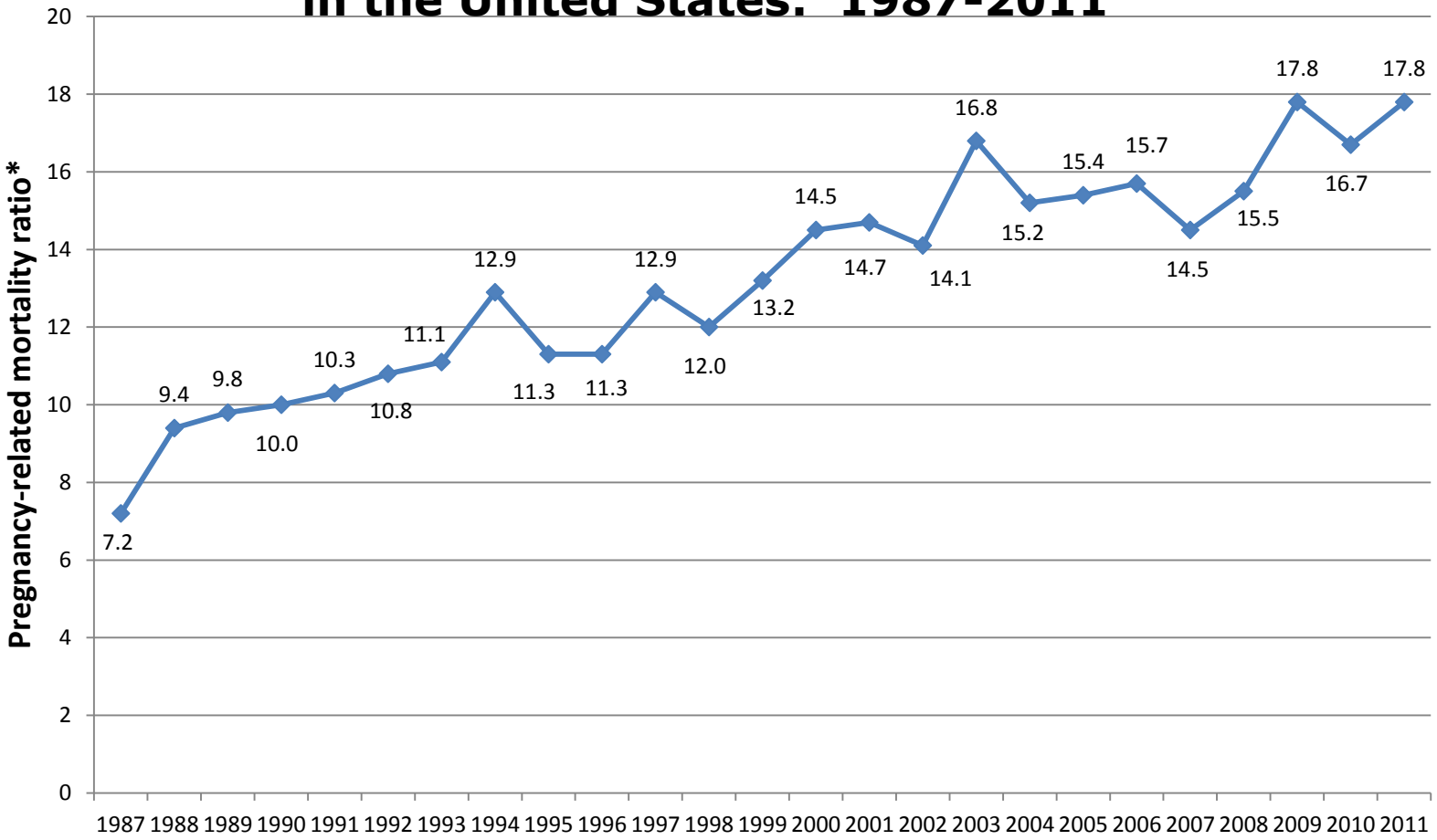
Trends in pregnancy-related mortality in the United States: 1987-2011



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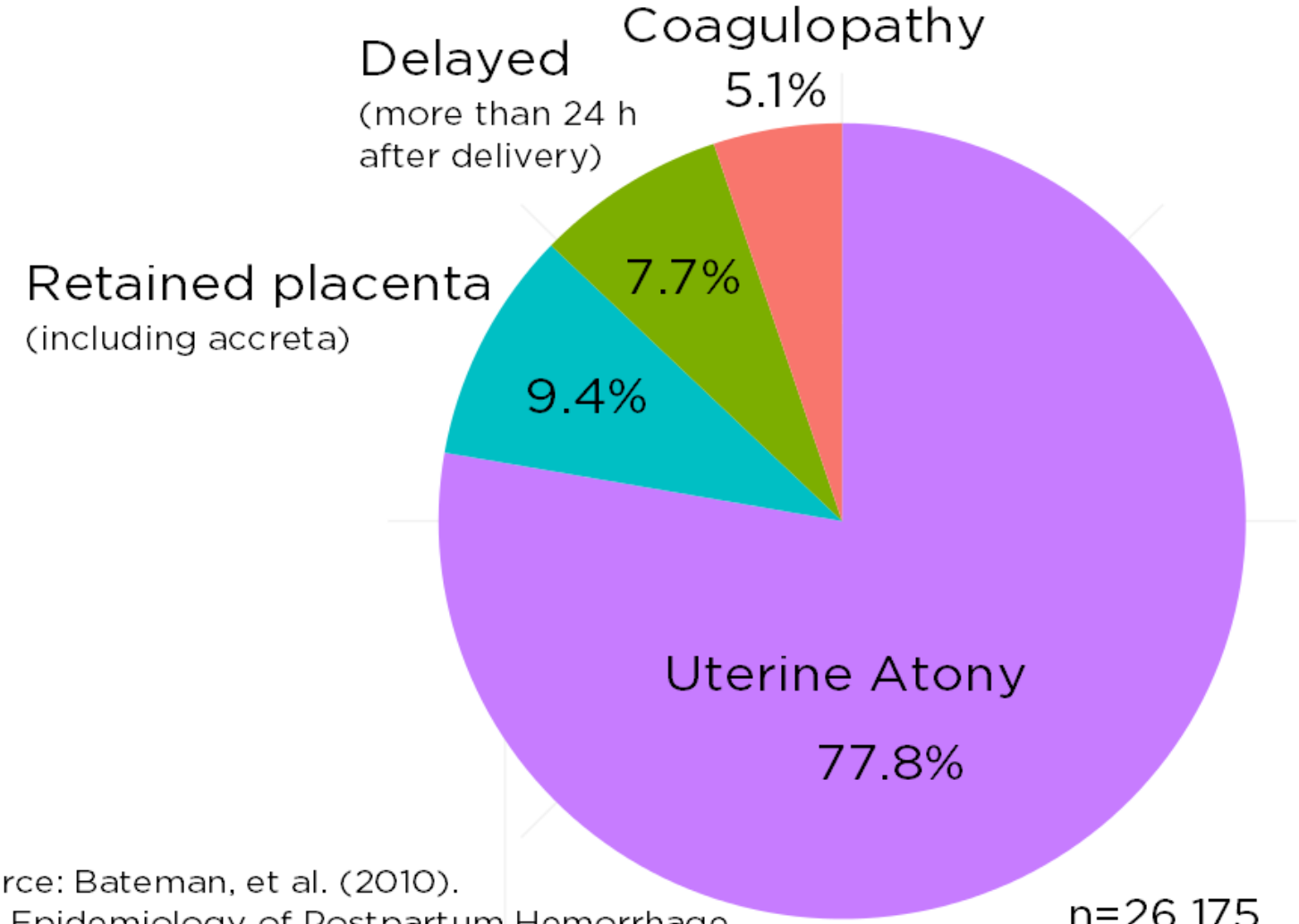
Patient Story

Etiology of Postpartum Hemorrhage



Source: Bateman, et al. (2010).
The Epidemiology of Postpartum Hemorrhage
in a Nationwide Sample. *Anesthesia Analgesia, 110.*

The Outcome

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The Why=The Risk Points

Communication about treatment

Availability of healthcare provider

Quality of care

Clinical management/referral

Telephone triage

Medication management

Safe Practices for Better Healthcare

Actions to Mitigate Occurrence of Never Events

- Leadership structures and systems
- Culture measurement, feedback, & intervention
- Teamwork training & skill building
- Identification and mitigation of risks & hazards
- Informed consent
- Disclosure
- Patient care information/documentation
- Nurse staffing plan

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Staffing Plan

Safe Practices for Better Healthcare

Actions to Mitigate Occurrence of Never Events

- VRBO & standardize list of do not use abbreviations
- Labeling
- CPOE & medication reconciliation
- Pharmacist leadership structures & systems
- Hand hygiene
- Surgical site infection prevention
- Venous thromboembolism prevention
- Perinatal collaborative

Guiding Perspective

Over 350,000 Registered Nurses care for women and newborns in the United States.
(Calculated from HRSA 2008 data)

Goal: Ensure that all women and newborns have equal access to evidence-based, high-quality care

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THROUGH THE PATIENT'S EYES - LESSONS LEARNED

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EVOLUTION

- *MULTIDISCIPLINARY PLANS WITH HIGH RISK PREGNANT MOMS*

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