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VP 2016 ISSUE 2

Perinatal Injuries: Toward an Integrated Safety Program

Perinatal safety programs (PSPs) play an important role in minimizing risks to mothers and infants. Such programs enhance the delivery of care by reinforcing adherence to evidence-based practice recommendations and standardized clinical protocols.

By improving outcomes and reducing lawsuits stemming from maternal complications, an effective PSP can produce significant cost savings for institutions, payors and providers. In addition, PSPs are advantageous from an accountable care organization (ACO) standpoint, as they offer a sound approach to managing the health of a vulnerable, at-risk patient population, making hospitals more attractive partners for prospective ACO partners.

The need for improvement in this area is clear. According to the CNA *Hospital Professional Liability Claim Report 2015: Stepping Up to Quality Healthcare and Patient Safety*, 30 percent of the hospital malpractice claims with a $1 million indemnity payment related to perinatal care. And of the 48 perinatal closed claims included in the study, 58.4 percent involved permanent injury, while one-third resulted in death.[1] (For additional loss-related statistics, see the box at right.)

The Cost of Maternal Complications

- Maternal stays with pregnancy- and delivery-related complications have an overall cost of $17.4 billion, *accounting for nearly 5 percent of overall hospital costs in the U.S.*
- On average, maternal hospital stays with complications are approximately 50 percent more costly than delivery stays without complications, *i.e., $4,100 for non-delivery stays and $3,900 for delivery stays with complications versus $2,600 for delivery stays without complications.*
- Hospital stays for pregnancy-related complications are longer, on average, than are delivery stays without complications, *i.e., 2.9 days for maternal non-delivery stays and 2.7 days for delivery stays with complications versus 1.9 days for delivery stays without complications.*

Source: "How-to Guide: Prevent Obstetrical Adverse Events." Cambridge, Mass.: Institute for Healthcare Improvement, 2012.

1 The study examined a total of 591 professional liability claims involving perinatal, inpatient medical, surgical and emergency care that closed between January 1, 2005 and December 31, 2014.

This edition of *Vantage Point*® explores CNA obstetric-related claims data, revealing critical gaps in perinatal safety preparedness. Also presented are a variety of PSP-based strategies, including compliance with national practice bundles, implementation of safe delivery protocols, escalation strategies for high-risk situations and crisis simulation. Finally, a self-assessment tool on page 8 helps hospitals and healthcare systems evaluate their degree of perinatal safety.

LOSS FREQUENCY AND SEVERITY

Failure to intervene is cited in 70.8 percent of the 48 perinatal claims reviewed. (See Figure 1.) Within this category, mismanagement of labor constitutes the most common cluster of allegations, accounting for 33.3 percent of the claims reviewed, followed by delay in delivery of a fetus at 10.3 percent. However, lawsuits alleging mismanagement of labor rank fourth in terms of severity, averaging $441,833 in total paid (i.e., indemnity plus legal and related expenses). Delay in the treatment of a neonate has the highest total paid, with an average of $1,015,416. This particular allegation is relatively rare, accounting for just 2.1 percent of the perinatal allegations in the dataset. (See Figures 2 and 3.)

Figure 1 – Frequency of Closed Claims by Category of Perinatal Allegations

Percentage of 48 Perinatal Closed Claims

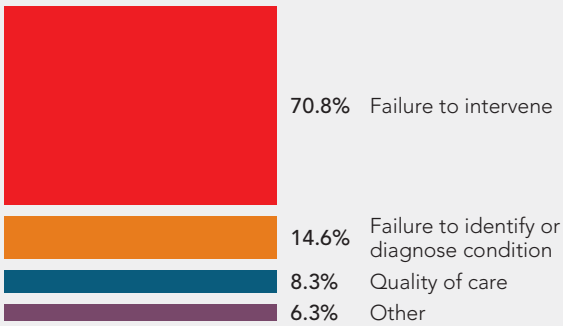

Figure 2 – Types and Frequency of Allegations Within the 'Failure to Intervene' Category

Allegation	Percentage of 48 perinatal closed claims
Mismanagement of labor - other	33.3%
Delay in delivery of fetus	10.3%
Improper/untimely management of obstetrical patient	8.3%
Failure to timely report complication of pregnancy/labor	4.2%
Treatment/care - other	4.2%
Failure to maintain infection control	4.2%
Failure to invoke chain of command	2.1%
Delay in treatment of neonate	2.1%
Delay in managing change in maternal condition	2.1%
Category total	70.8%

Figure 3 – Average Total Paid for Closed Claims Alleging 'Failure to Intervene'

Allegation	Average paid expense	Average paid indemnity	Average total paid
Delay in treatment of neonate	$15,416	$1,000,000	$1,015,416
Failure to timely report complication of pregnancy/labor	$30,686	$725,000	$755,686
Delay in delivery of fetus	$194,686	$426,038	$620,724
Mismanagement of labor - other	$133,395	$308,438	$441,833
Failure to invoke chain of command	$94,834	$325,000	$419,834
Improper/untimely management of obstetrical patient	$138,268	$195,417	$333,684
Treatment/care - other	$49,142	$187,750	$236,892
Delay in managing change in maternal condition	$38,569	$125,000	$163,569
Failure to maintain infection control	$4,728	$17,506	$22,233
Category overall	$117,022	$328,158	$445,180

The second most frequent allegation category is failure to identify or diagnose a condition, accounting for 14.6 percent of the perinatal claims reviewed. These allegations are costlier to defend and indemnify than are failure to intervene allegations, averaging $626,640 total paid as compared to $445,180. (See Figure 4.) Delay in identifying fetal distress is the most common allegation within the failure to identify category, accounting for 8.3 percent of the perinatal closed claims. It also tops the list in terms of cost in this category, averaging $764,011 in total payment. Delay in diagnosis of placental abruption is the second most frequent allegation (4.2 percent of the perinatal closed claims) within this category, and is alleged half as frequently as delay in identifying fetal distress. It also has high severity, averaging $635,218 in total paid. (See Figures 5 and 6.)

Figure 4 – Average Total Paid for Closed Claims by Allegation Category

Allegation category	Average paid expense	Average paid indemnity	Average total paid
Failure to identify or diagnose condition	$70,925	$555,714	$626,640
Failure to intervene	$117,022	$328,158	$445,180
Quality of care	$25,562	$53,750	$79,312
Other	$285	$34,103	$34,388
Overall	$95,382	$320,097	$415,479

Figure 5 – Types and Frequency of Allegations Within the 'Failure to Identify or Diagnose Condition' Category

Allegation	Percentage of 48 perinatal closed claims
Delay in identification of fetal distress	8.3%
Delay in diagnosis of placental abruption	4.2%
Failure to diagnose or misdiagnosis	2.1%
Category total	14.6%

Figure 6 – Average Total Paid for Closed Claims Alleging 'Failure to Identify or Diagnose Condition'

Allegation	Average paid expense	Average paid indemnity	Average total paid
Delay in identification of fetal distress	$106,511	$657,500	$764,011
Delay in diagnosis of placental abruption	$35,218	$600,000	$635,218
Failure to diagnose or misdiagnosis	$0	$60,000	$60,000
Category overall	$70,925	$555,714	$626,640

COMMON PROCESS FAILURES

Many of the closed claims involve serious and lifelong consequences to mothers and infants, including birth trauma and infant asphyxia, iatrogenic prematurity, sepsis and maternal hemorrhage. Despite the severity of these complications, there is a troubling recurrence of certain perinatal safety lapses, including the following:

- *Failure to standardize practice guidelines for high-frequency clinical interventions*, such as:
  - Administration of labor-inducing agents, e.g., oxytocin, misoprostol, magnesium sulfate.
  - Intrauterine resuscitation during non-reassuring fetal heart rate tracings.
  - Early-term birth.
  - Vacuum or forceps delivery.
  - Shoulder dystocia.
  - Prophylaxis for venous thromboembolism.
  - Treatment of uterine tachysystole.
  - Management of postpartum hemorrhage.
  - Repair of severe perineum/perianal lacerations (third and fourth degree).
- *Noncompliance with electronic fetal monitoring (EFM) certification*, which promotes enterprise-wide standardization of interpretation and communication of fetal status.
- *Absence of a safe Cesarean delivery program*, with safeguards such as centrally located obstetrical whiteboards, time-out checklists and surgical instrument counts.
- *Lack of safety checklists for high-risk clinical situations*, including maternal hemorrhage, shoulder dystocia, preeclampsia, cord prolapse and fetal tachysystole.
- *Insufficient training and simulation drills for high-risk events*, such as emergency Cesarean delivery, maternal hemorrhage, vacuum forceps extraction, shoulder dystocia and neonatal resuscitation.
- *Failure to enforce an escalation algorithm for non-code changes in patient condition*, such as worrisome EFM tracings and maternal distress.
- *Lack of maternal/fetal safety and quality assurance discussions* designed to improve perinatal performance and clinical outcomes.
- *Inadequate or poor clinical documentation practices*, compromising both patient care and legal defensibility.

CLOSING SAFETY GAPS

Enhancing perinatal safety requires a combination of technical initiatives, such as computer-embedded practice guidelines and documentation tools, and procedural measures, including communication protocols, clinical competency evaluation and team crisis training. The following strategies can significantly raise the level of perinatal safety preparedness:

Utilize electronic record systems to enhance consistency of care. More and more hospitals are utilizing electronic health record (EHR) systems to reinforce compliance with obstetrical practice bundles, which are evidence-based protocols designed to improve care processes and patient outcomes. (See box on page 5 for a listing of commonly used practice bundles.) By embedding checklists, pop-up queries, alerts and automated report triggers within daily workflow, EHRs help hospitals align their clinical processes with established practice bundles, thus enhancing patient care and documentation in the following areas, among others:

- Ongoing monitoring of eclamptic patients, which is defined by the American College of Obstetricians and Gynecologists (ACOG) as patients having a blood pressure greater than or equal to 160/110.
- Detection and treatment of placental abruption.
- Interventions to prevent maternal hemorrhage.
- Fetal heart tone assessment and treatment of fetal tachysystole.
- Detection of shoulder dystocia and/or cord prolapse, and associated interventions to prevent birth trauma or asphyxia.
- Clinical interventions in response to maternal and fetal symptoms.
- Interdisciplinary communication.
- Use of the chain-of-command in crisis situations.

Suggested Practice Bundles and Tools

- ***Elective Induction Bundle, Augmentation Bundle and Vacuum Bundle**, from the Institute for Healthcare Improvement, 2010. (Scroll down to pages 9-20.)*
- ***Maternal Hemorrhage Toolkit 2.0.**, from the California Maternal Quality Care Collaborative, March 2015.*
- ***Maternal Venous Thromboembolism Prevention Bundle**, from the Council on Patient Safety in Women's Health Care, October 2015. (Click on the drop-down bar marked "Patient Safety Bundles and Tools." Login access required.)*
- ***Obstetric Hemorrhage Bundle**, from the American College of Obstetricians and Gynecologists, November 2015.*
- ***Obstetric Hemorrhage Bundle**, from the Council on Patient Safety in Women's Health Care, May 2015.*
- ***Patient, Family, and Staff Support after a Severe Maternal Event Bundle**, from the Council on Patient Safety in Women's Health Care, October 2015. (Click on the drop-down bar marked "Patient Safety Bundles and Tools." Login access required.)*
- ***Severe Hypertension Bundle**, from the Council on Patient Safety in Women's Health Care, May 2015. (Click on the drop-down bar marked "Patient Safety Bundles and Tools." Login access required.)*

Institute a "hard-stop" protocol against early elective deliveries. The ACOG issued elective induction guidelines in 2009, reinforcing the preferability of full-term vaginal delivery in the absence of maternal or fetal indications for Cesarean delivery. Consequently, an increasing number of hospitals have adopted hard-stop policies, prohibiting doctors from performing elective inductions prior to 39 weeks without the documented approval of an obstetrics chief, based on established criteria.[2]

A hard-stop policy should:

- *Reflect ACOG and other national quality criteria* for early elective deliveries.
- *Be approved by the governing body* of the hospital or health system.
- *Establish a single system for determining gestational age*, and ensure that this system is utilized by all providers.
- *Mandate documentation of induction criteria*, as well as the mother's informed consent to early delivery.
- *Require written documentation*, using a specially designed scheduling form.
- *Delineate the steps to be taken, and by whom, in the chain of command* when a delivery is scheduled that does not meet the sanctioned criteria. (For tips on how to overcome potential barriers to provider compliance, see "Elimination of Elective Deliveries at Prior to 39 Weeks Gestation.")

To access a sample policy statement, including an induction documentation checklist and sample informed consent and scheduling forms, see the Midwest Health Initiative's Policy Toolkit to Support Reduction of Early Elective Delivery.

Implement an escalation policy whenever patient safety is in jeopardy. Escalation (i.e., chain of command) policies ensure timely, appropriate communication among nursing staff and medical providers when "non-code" changes occur in maternal/fetal conditions. Unlike rapid response teams, which deploy when patient harm is imminent, escalation policies permit staff members, including agency staff, to obtain needed assistance when:

- *A patient's condition is worsening* and the nurse cannot contact a designated provider in a timely manner.
- *A provider responds, but is reluctant to take necessary action* to address reported concerns.
- *A provider responds inappropriately*, e.g., in a hostile or distracted manner.
- *A provider's orders are unsafe* or deviate from the recognized standard of care.
- *A staff member has concerns about patient or personal safety*, including dangerous staffing levels or violent behavior.

Escalation procedures generally involve making an initial call to an immediate supervisor if a provider does not respond promptly. However, the process should not stop there if the problem remains. Written policy must authorize and indeed require moving up the chain of command until the situation is resolved safely and appropriately. (See "Sample Documentation: Provider Unavailability" on page 6.)

2 Studies have shown that hard-stop policies improve outcomes and significantly reduce admissions to neonatal intensive care units.

In the event of a worsening maternal/fetal condition, documentation should *objectively* note the clinical observations and findings that prompted the call to a provider, including the name of the responding provider, the time of the response and the interventions rendered. (See "OB Crisis: Utilizing the 'SBAR' Model of Communication" on page 7.) Reporting protocols should be followed by staff, but the incident report should not be noted in the patient health information record.

Require simulated crisis training for all levels of obstetrical-neonatal staff, including physicians and nurses. Regularly scheduled drills that realistically imitate obstetrical and neonatal emergencies have been shown to enhance the ability of staff to respond to and mitigate adverse outcomes in high-pressure situations, such as:

- Placental abruption.
- Fetal bradycardia.
- Shoulder dystocia.
- Postpartum hemorrhage.
- Eclamptic seizure/magnesium toxicity.
- Urgent Cesarean section.
- Maternal collapse.
- Infant code.

Simulations should reinforce the principles of accurate documentation, swift response time, teamwork and communication, as described in the Agency for Healthcare Research and Quality's TeamSTEPPS platform. Always document staff participation in crisis training, including individual emergency skill competency levels.

Perinatal harm remains a significant exposure for hospitals. By developing and implementing an effective perinatal safety program, leaders can reduce the likelihood of potentially grave injuries to mothers and newborns, as well as consequent liability. For additional obstetrical safety initiatives designed to reduce maternal/fetal injuries, see *Vantage Point*®, 2010 – Issue 3, "Perinatal Care: Creating and Maintaining a High-reliability Unit."

Sample Documentation: Provider Unavailability

2030 *Dr. Delivery paged regarding patient's condition: BP 160/110, restless, moist skin. Nancy Nurse, RN*

2035 *Ann Assistant, RN from the doctor's office returned call. Dr. Delivery is out of town. Given phone number of covering physician, Dr. Untimely. Nancy Nurse, RN*

2045 *Dr. Untimely summoned to bedside at 2039, but failed to come to unit. Sally Supervisor, RN, notified of situation. Instructed to go up the chain of command and call the OB department chair. Nancy Nurse, RN*

2048 *Dr. Good, Chairperson of OB, called to discuss patient's condition. BP 154/106, RR 18, Pulse 108. Reinforced urgency of patient's condition and asked MD to evaluate patient. Nancy Nurse, RN*

2051 *Dr. Good arrived. At bedside evaluating patient. See progress checklist for status. Nancy Nurse, RN*

For additional communication strategies, see Dingley, C. et al. ***"Improving Patient Safety Through Provider Communication Strategy Enhancements."***

OB Crisis: Utilizing the 'SBAR' Model of Communication

Patient name: _____ Staff member initiating: _____

Patient identification number: _____ Staff member's position: _____

Date: _____ Unit/floor/ward: _____

Time: _____ Responding provider/consultant name: _____

SITUATION: WHAT HAS OCCURRED?

Vital statistics:

Blood pressure: _____ Respiratory rate: _____ Pulse: _____ Temperature: _____

Saturated O2: _____ Oxygen rate and delivery (if applicable): _____ Urine output: _____

Pain level (1-10): _____ Fetal heart rate: _____ Fetal movement: _____ Non-stress test: _____

Level of consciousness: ☐ Alert ☐ Verbal ☐ Lethargic

Skin: ☐ Warm and dry ☐ Pale and clammy ☐ Sweaty ☐ Extremities cold ☐ Extremities warm

BACKGROUND

Note history, including fetal assessment, antenatal risks, labor progression, postnatal status, clinical treatment, etc.

_____

_____

_____

ASSESSMENT

I am concerned about:

☐ Systolic pressure > 160 mmHg ☐ Systolic pressure < 90 mmHg ☐ Diastolic pressure > 100 mmHg

☐ Pulse rate > 100 bpm ☐ Pulse rate < 40 bpm ☐ Pulse rate > systolic BP

☐ Respiration rate > 30 breaths per minute ☐ Respiration rate < 10 breaths per minute

☐ Urine output: < 100 ml over last four hours ☐ Significant protein uria

☐ Fetal well-being ☐ Maternal hemorrhage antepartum/postpartum

☐ Other _____

I think the problem is _____

☐ I believe delivery should be expedited. ☐ I believe the patient should be transferred.
☐ I am not sure what the problem is, but the mother or baby is deteriorating.

RECOMMENDATION

What step should be taken next? _____

When will the provider/consultant review the patient? _____

What tests, treatments or actions should be completed in the interim? _____

This sample form is for illustrative purposes only. Your clinical procedures and risks may be different than those described. We encourage you to modify the form to suit your practice and patient needs. As each clinical practice presents unique situations and statutes may vary by state, we recommend that you consult with legal counsel prior to use of this or similar forms in your organization.

Creating a Culture of Perinatal Safety: A Self-assessment Tool

MAJOR AREAS OF CONCERN	YES	NO	COMMENTS
PROGRAM LEADERSHIP			
1. *Has leadership established a perinatal safety program (PSP)*, articulated program goals and allocated sufficient resources?	○	○	
2. *Is the program properly overseen* by an executive-level leader?	○	○	
3. *Is the program reviewed at the executive level on a quarterly basis*, and is the governing board apprised of PSP goals, results, issues and changes under consideration?	○	○	
STAFFING AND SUPERVISION			
1. *Do supervisors adhere to the* staffing and supervision requirements *promulgated by the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)* and other national organizations?	○	○	
2. *Does the organization sanction the use of midwives, laborists, obstetrical hospitalists and perinatal safety nurses*, in order to bolster perinatal staffing?	○	○	
3. *Is there a designated perinatal safety coordinator,* who receives daily briefings and is responsible for monitoring staffing levels, patient census and resource availability?	○	○	
4. *Are expectations and performance standards explained to everyone involved in the PSP*, including direct-care staff, environmental services (e.g., for maintaining infection control standards), supply chain vendors (e.g., for providing safe materials and equipment) and facilities management (e.g., for keeping elevators running smoothly)?	○	○	
PERINATAL SAFETY COMMITTEE			
1. *Is there a perinatal safety committee (PSC)* that includes:			
- Physicians/providers knowledgeable in obstetrics and neonatal medicine?	○	○	
- Pediatricians, anesthesiologists/CRNAs, surgeons, hospitalists and intensivists?	○	○	
- Perinatal nurse specialists?	○	○	
- Obstetrical surgical staff?	○	○	
- Representatives from risk management, performance improvement and quality assurance?	○	○	
- Clinicians from the blood bank, laboratory services and pharmacy?	○	○	
2. *Does the PSC review the perinatal safety program annually*, in order to ensure that policies and protocols are aligned with the quality metrics and professional standards of the American College of Obstetricians and Gynecologists, American Academy of Pediatrics and AWHONN, among other professional associations?	○	○	
3. *Has the PSC launched a "zero birth injury" initiative*, which uses evidence-based care bundles to guide management of obstetric/neonatal services?	○	○	
4. *Does the PSC formally review perinatal data on a quarterly basis*, in order to identify strengths and opportunities for improvement?	○	○	
5. *Are subcommittees convened as needed* to address high-risk issues that may require external consultants, such as system failures and staff training deficits?	○	○	

PROGRAM COMPONENTS	YES	NO	COMMENTS
FETAL/UTERINE ASSESSMENT GUIDELINES			
1. *Does the organization require electronic fetal monitoring training and certification* for perinatal staff at all levels?	○	○	
2. *Are fetal heart rate assessments and uterine activity documented* in accordance with the terminology developed by the National Institute of Child Health and Human Development?	○	○	
3. *Are estimated fetal size and vaginal exam assessment findings documented* prior to delivery and/or induction?	○	○	
4. *Is there a standard practice for safely administering uterotonics* and managing abnormal uterine contractions?	○	○	
POLICY STATEMENTS AND COMPLIANCE			
1. *Are there written policy statements regarding the appropriate and safe performance of the following obstetrical activities*, among others:			
- Elective deliveries?	○	○	
- Operative vaginal deliveries (e.g., forceps and vacuum extractions)?	○	○	
- Cesarean deliveries?	○	○	
- Vaginal birth following previous Cesarean delivery (i.e., VBAC delivery)?	○	○	
- Multiple gestation deliveries?	○	○	
- Prophylactic antibiotic administration for Cesarean deliveries?	○	○	
- Patient handoffs during shift changes, between departments and to other facilities?	○	○	
2. *Do the written policies include documentation parameters* to help ensure consistent and thorough notation in all cases?	○	○	
3. *Is there a "hard-stop" policy* empowering staff to act when clinical practice runs contrary to prescribed policy, and does it include an escalation algorithm to facilitate going up the chain of command when maternal/fetal safety is in jeopardy?	○	○	
4. *Does the organization have a quality improvement process* to monitor compliance with treatment and documentation policies and requirements?	○	○	
5. *Does the PSC review perinatal situations* that fall outside of standard practice?	○	○	

PROGRAM COMPONENTS (CONTINUED)	YES	NO	COMMENTS
PROTOCOLS FOR HIGH-RISK PRESENTATIONS			
1. *Are there written protocols for assessing and managing high-morbidity and mortality presentations*, including:			
- Hypertensive emergencies?	○	○	
- Postpartum hemorrhage?	○	○	
- Venous thromboembolism?	○	○	
- Uterine tachysystole?	○	○	
- Shoulder dystocia?	○	○	
- Prolapsed cord?	○	○	
- Newborn resuscitation?	○	○	
2. *Do written protocols include maternal/fetal assessment requirements, alternative strategies, and communication and documentation parameters*, as well as exit strategies if the maternal/fetal condition deteriorates?	○	○	
3. *Are standardized checklists available on the unit/floor/ward for high-risk presentations*, in order to enhance consistency and strengthen documentation of assessment findings, interventions and outcomes?	○	○	
4. *Are team "huddles" required for high-risk presentations*, and are debriefings conducted post-event?	○	○	
RAPID RESPONSE/CRISIS SIMULATION			
1. *Does the organization have an obstetrical early warning system* for impending emergencies?	○	○	
2. *Is there a dedicated rapid response team* that deploys in emergencies?	○	○	
3. *Does the organization utilize a common, structured communication and documentation method for perinatal care*, e.g. Situation, Background, Assessment, Recommendation (SBAR)?	○	○	
4. *Is there a clinical decision guide to help staff know when to trigger a rapid response*, and are there rules in regard to response times?	○	○	
5. *Do all perinatal staff members receive crisis training*, with an emphasis on individual communication skills and team collaboration (e.g., TeamSTEPPS training)?	○	○	
6. *Are all perinatal care staff required to participate in regularly scheduled simulation drills*, in order to improve unit response to obstetrical emergencies?	○	○	
7. *Is participation in simulation drills documented*, and is degree of competence recorded?	○	○	
8. *Are data from both real and simulated emergencies reviewed*, in order to identify improvement opportunities?	○	○	

QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT	YES	NO	COMMENTS
DATA GATHERING AND TRACKING			
1. *Are patient record audits performed on a regular basis*, utilizing standard perinatal criteria?	○	○	
2. *Are quality reviews conducted frequently*, based on perinatal care and safety information captured by the organization's electronic record system?	○	○	
3. *Are outcomes data tracked for all higher-risk cases*, including but not limited to:			
- Early elective deliveries that do not meet the exclusion criteria?	○	○	
- Hypertensive emergencies?	○	○	
- Postpartum hemorrhage requiring four or more blood transfusions?	○	○	
- Venous thromboembolism?	○	○	
- Uterine tachysystole?	○	○	
- Shoulder dystocia?	○	○	
- Prolapsed cord?	○	○	
- Newborn resuscitation?	○	○	
ANALYSIS AND REPORTING OBLIGATIONS			
1. *Are perinatal care processes and outcomes routinely reviewed and analyzed* for quality improvement purposes?	○	○	
2. *When defects are identified, are performance improvement methodologies (such as Plan-Do-Study-Act) utilized* to clarify goals and manage improvement efforts?	○	○	
3. *Is progress effectively tracked* via dashboards, control charts and/or scorecards?	○	○	
4. *Are data and findings obtained through the PSP shared with the following areas*, among others:			
- Perinatal units/departments?	○	○	
- Executive leadership?	○	○	
- Medical staff?	○	○	
- Nursing leadership?	○	○	
- Governing board?	○	○	
5. *Is there an ongoing quality assurance and performance improvement program* that safeguards patient confidentiality and gives the work product protected status?	○	○	
PEER REVIEW			
1. *Is the performance of physicians and other providers reviewed regularly*, using evidence-based perinatal safety and quality criteria?	○	○	
2. *Are providers rewarded* for positive safety outcomes?	○	○	
3. *Do medical staff consider availability of resources* when making practice choices?	○	○	
4. *Is feedback from direct-care staff solicited* during the performance review of physicians and other providers?	○	○	

ADVERSE EVENT MANAGEMENT	YES	NO	COMMENTS
INCIDENT REPORTING			
1. *Is there a formal process for reporting adverse incidents and occurrences* in a thorough, timely manner?	○	○	
2. *Is a special incident report format utilized* when reporting perinatal situations?	○	○	
3. *Does the organization permit anonymous reporting when necessary* to avoid potential retaliation?	○	○	
EVENT DISCLOSURE			
1. *Is there a formal protocol for disclosing unanticipated perinatal outcomes* to the patient/family?	○	○	
2. *Does the policy designate one individual to speak to the patient/family* about the event and/or outcome?	○	○	
3. *Are the hospital risk manager and legal counsel contacted* prior to disclosure?	○	○	
4. *Is the patient/family continually updated* as the event is investigated and reviewed?	○	○	
5. *Are supportive measures made available* to the patient/family and involved staff members?	○	○	

EDUCATION AND TRAINING	YES	NO	COMMENTS
STAFF			
1. *Do perinatal staff members receive orientation and training* in regard to duties, rules and evaluation criteria?	○	○	
2. *Are new hires and medical staff apprised of perinatal performance expectations* as part of the orientation process?	○	○	
3. *Is PSP education provided to perinatal care staff* on an annual basis?	○	○	
4. *Are perinatal staff members included in all relevant educational activities*, including sessions dealing with quality assurance and performance improvement?	○	○	
5. *Are staff members trained how to identify adverse incidents*, as well as how to report them?	○	○	
PATIENTS/FAMILY			
1. *Are patients/families told what to expect from staff and providers* during their stay in the perinatal setting?	○	○	
2. *Do staff explain to patients their role in the perinatal safety process* and assess and document their degree of understanding?	○	○	
3. *Are patients/families instructed to report any concerns they have* about institutional polices and staff or provider practices that may increase the risk of perinatal harm?	○	○	

This tool serves as a reference for organizations seeking to evaluate perinatal risk exposures. The content is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel given after a thorough examination of the individual situation, as well as a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

QUICK LINKS

- Eliminating Harm Checklists, from the American Hospital Association and the Health Research & Educational Trust.
- Fausett, M. et al. "How to Develop an Effective Obstetric Checklist." *American Journal of Obstetrics & Gynecology*, September 2011, volume 205:3, pages 165-70.
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