Question 1:

You and others have suggested teamwork strategies as a method to improve safety. How do you suggest dealing with disagreements over protocol among different members of a team?

Response from Dr. Pettker:

Disagreements within a team are common and when they occur it is often between a nurse and a physician with regard to lack of clarity or differences of opinion in the care being given. There are two approaches for dealing with these disagreements. The first is to use structured tools that allow team members to communicate directly and clearly. Crew resource management programs often suggest specific communication techniques, like the “CUS” words (concerned, uncomfortable, safety/scared), the two-challenge rule (when a concern is repeated to ensure it is heard), and “stopping the line” when someone “needs clarity.” The second approach is implementing a chain of command or consultation that designates who should be contacted, typically a nurse–physician dyad higher in the administrative chain, and how they should be contacted to review the situation and settle differences. The approach at Yale mandates that at every level in the chain of command a nurse–physician team is involved so that all sides feel equally and fairly represented. We also emphasize the expectation that all links in the chain are easily contacted and available, at all times. These two strategies work best in concert. Each time the problem ascends the chain of command, the question should be asked, “What team training tools have you already used to try to resolve your disagreement?”

Question 2:

For physicians, quality improvement projects are often mandatory as opposed to traditional research, which is voluntary. How do you motivate physicians to adhere to changes in clinical protocols that may not yet be evidence-based?
Often our quality improvement projects are generated from the identification of a gap or latency in care that needs improvement. When these gaps are identified or perceived by specific physicians or midwives, we involve them in solving the problem. Involving those who are working at the bedside is very important to developing the right protocols. It is true that many of the protocols and guidelines we develop may not be entirely evidence-based. In developing protocols and guidelines, the work must be as evidence-based as possible, with the next step being to make it consensus-based. We work our guidelines and protocols through several committees for comment before they are put into place. We give many opportunities for open comment. Giving all stakeholders (physicians, midwives, nurses, managers, ancillary staff, or departments) a voice in the review process is critical. In the end, our providers find that practicing one way, even if it lacks a firm foundation of clear evidence, is better than having many different and confusing approaches to a problem. Over time, the benefits of adherence to protocols become evident to even the most skeptical, and buy-in progresses.

Question 3:

You use reducing non-indicated deliveries prior to 39 weeks of gestation as an example of quality improvement. For many of us who lived through this, there was a long period of uncertainty when we were trying to determine what a non-indicated delivery is and what isn’t, largely because the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal and Fetal Medicine (SMFM) did not come out with definitions of medically indicated deliveries until 2013. How can this be better addressed for future quality improvement projects?

Response from Dr. Pettker:

Luckily, ACOG has addressed very well the timing of medically indicated late-preterm and early-term deliveries in a Committee Opinion of the same name (no. 560; see Obstet Gynecol 2013;121:908–10). As we suggest in the article, The Joint Commission list of “approved” indications is imperfect. Work must continue to ensure that The Joint Commission criteria align with those recommendations by ACOG. Further, we advocate continued research on the optimum timing for deliveries and recommend timely adaptation of recommendations and regulations by professional organizations like ACOG and SMFM and oversight by regulatory bodies like The Joint Commission.

Question 4:

An article was recently published on the association between third-degree and fourth-degree lacerations and operative delivery and shoulder dystocia (see Obstet Gynecol 2015;125:927–37). The authors suggested that attempting to reduce this adverse outcome might increase the rate of cesarean deliveries. How should physicians balance this trade-off, or other similar trade-offs, when developing quality improvement protocols?

Response from Dr. Pettker:

The use of third- and fourth-degree laceration rates as a quality measure is controversial and is a good example of how measures should be used with good judgment. They are an undesired outcome of childbirth, but they are often unplanned and some of the measures that prevent them, like cesarean delivery, are probably not reasonable. The conclusion you point out is important: in striving to improve one quality measure, we should avoid transferring the harm to other procedures or outcomes. We should always be guided by doing the right thing and avoiding harm, as well as an approach that weighs the risks and benefits of one therapy or technique.
Question 5:

You mentioned that sentinel events typically result in conveyance of formal corrective action plans to regulatory agencies. Hospitals may be pressured to come up with a plan without evidence to support the plan. What suggestions do you have for managing these potentially competing interests?

Response from Dr. Pettker:

Corrective action plans that come from sentinel events are typically formed after identifying institutional and systemic gaps in care. While there may not be an evidence-base in the literature for the action plan, the evidence to support the plan comes from the careful review of the event and the conclusions made from that review. Systematic approaches to analyzing the failures leading to the event, such as failure modes and effects analysis and safety event classification systems, emphasize logical approaches to the problems that led to harm. This can reduce what might be viewed as exaggerated or unfair reactions to a problem.

Question 6:

You mention that safety and quality solutions may not be the same across different patient populations and settings. How should leaders of hospital conglomerates address this? Should the quality improvement process be developed centrally or locally?

Response from Dr. Pettker:

Many hospitals are joining forces into clinically integrated networks or are being incorporated into larger health care organizations. Quality improvement processes become very challenging when these organizations combine units of different acuity (ie, a birth center and a tertiary care center); but, the expectations for care delivery are standardized. In one way, the ability to openly share experiences and approaches to common problems is an asset. In looking at quality improvement, the similarities should be emphasized as much as the differences. To paraphrase a popular political quote, however, in the end all quality improvement is local. The process of developing quality improvement projects must deliberately respect the differences of each unit. Teams should be formed within individual hospitals that report out to a larger oversight group. These teams should be allowed to form their own approaches, but should be held accountable for reporting progress. A good example of this is the Ohio Perinatal Quality Collaborative to reduce unnecessary early-term birth, as reported in the article.

Question 7:

You mention that organizational safety culture needs to shift to a fair and nonjudgmental approach to adverse outcomes and event reviews. What role, if any, do often public and judgmental morbidity and mortality conferences play in this initiative?
Much of the work of reviewing adverse outcomes and safety events is done by designated departmental leaders who are trained in safety and quality principles and respect the confidentiality of the individuals involved. However, open and honest morbidity and mortality conferences are a critical additional part of departmental quality assurance activities. This transparency reinforces an open safety culture that is preoccupied with failure. Structuring these activities into a process that takes a systematic approach emphasizing safety and quality principles is critical. This would include developing a set of departmental guidelines for what is and is not appropriate for discussion and, when applicable, a methodology (i.e., root cause analysis or failure modes and effects analysis). Further, these conferences should be coordinated and moderated by individuals with experience in these principles. Departmental leadership should emphasize the “just culture” approach to these reviews and should openly call out the harm done in finger pointing and judgment.

Question 8:

Although safety and quality improvement may improve the medico-legal climate, there are times when projects might increase exposure to professional liability litigation. For example, decreasing the cesarean delivery rate may increase the risk of litigation for adverse outcomes associated with a Category 2 tracing or an operative vaginal delivery. How should these potential consequences be accounted for in the development and execution of a local quality improvement project?

Response from Dr. Pettker:

This is the challenge of our work. Every time we improve quality or safety our task is to find ways to use new approaches while ensuring that we do not add harm. Certainly, in developing a project, teams should be wary of how it might adversely affect other aspects of care. This points to the importance of prospective assessment of multiple quality measures instead of a measure in isolation.