

OBSTETRICAL (OB) HARM TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current or initiate new interventions for OB-harm prevention in your facility

Reference: www.hret-hen.org

OB Harm Top Ten Checklist				
Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Implement policies and protocols that align with nationally recognized evidence based practices, such as the ones developed by the Council on Patient Safety in Women's Healthcare. (www.SafeHealthcareforEveryWoman.org)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Complete an intensive, multi-disciplinary review of all cases that meet the criteria of Severe Maternal Morbidity or Mortality, in an effort to address systems issues and improve outcomes for patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Develop protocols and policies to address specific support for patients, families AND staff following a significant adverse event in maternal health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Implement standardized language such as NICHD to describe changes in fetal heart rates and ensure a shared mental model about the condition of baby during labor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Utilize an obstetric early warning system such as the Modified Early Obstetric Warning System (MEOWS) as a trigger tool for an impending obstetric emergency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Develop an organization specific responses and clinical decision guide for triggers in the early warning system that includes expectations for response times for all team members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Utilize simulation drills to practice the response to obstetric emergencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use data from past adverse events, simulation drills and early warning trigger tools to identify opportunities for and drive improvement.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Include frontline maternal health staff members in quality improvement education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Consider the use of alternative staffing of clinicians through the use of nurse midwives, laborists, obstetric hospitalists, doulas or a dedicated obstetric emergency department as methods to increase patient safety.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

