

# Perinatal Quality Collaborative of North Carolina

## North Carolina AIM Obstetric Hemorrhage (AIM OBH) Action Plan



### Global Aim:

The project aims to engage all obstetric units in North Carolina to improve response to obstetric hemorrhage (OBH) so that fewer mothers experience transfusions, major procedures, or serious medical complications.

### Specific Goal:

By July 2018, perinatal quality improvement teams in NC obstetrical units will utilize the AIM OBH bundle and other defined best practices for prevention, identification and management of hemorrhage to demonstrate 100% compliance with all of the AIM OBH structure metrics, 98% screening for hemorrhage risk done prior to giving birth, a 33% reduction in the total units of blood products transfused and a decrease of 25% in severe maternal morbidity (SMM) in hemorrhage cases.

### Measures/Goals:

- Defines the needed infrastructure to prevent, identify and manage OBH at each obstetrical unit
- Establishes the proper processes to prevent, identify and manage OBH at each obstetrical unit
- Demonstrates 100% compliance with the all AIM OBH structure metrics
- Demonstrates 98% percent of women who gave birth have a hemorrhage risk assessment recorded in the medical record prior to giving birth
- Decreases by 33% the total units of packed red blood cells transfused to patients who deliver
- Decreases by 25% the severe maternal morbidity (SMM) for hemorrhage at the state level



GOAL	PRIMARY DRIVER	INTERVENTIONS
<p>Demonstrates 100% compliance with all AIM OBH structure metrics</p>	<p>Standardize readiness for obstetric emergencies</p>	<ul style="list-style-type: none"> <li>• Have emergency supplies and medications readily available through the use of standardized hemorrhage carts or kits</li> <li>• Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)</li> <li>• Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)</li> <li>• Establish unit education on protocols, unit-based drills (with post-drill debriefs)</li> <li>• Integrate specific hemorrhage order sets in electronic medical record</li> </ul>
	<p>Patient and Family Engagement</p>	<ul style="list-style-type: none"> <li>• Develop OB specific resources and protocols to support patients and families through OB complications</li> <li>• Foster a culture that allows for patient and family involvement in plan of care</li> <li>• Complete quarterly assessment survey to measure current patient and family support and engagement</li> <li>• Provide information and emotional support resources to patients and families prior to discharge</li> </ul>



GOAL	PRIMARY DRIVER	INTERVENTIONS
<p>Demonstrates 98% percent of women who gave birth have a hemorrhage risk assessment recorded in the medical record prior to giving birth</p>	<p>Standardize readiness and recognition of obstetric emergencies</p>	<ul style="list-style-type: none"> <li>• Standardize assessment of hemorrhage risk at admission</li> <li>• Ensure appropriate preparedness based on level of risk</li> </ul>
<p>Decreases by 33% the total units of packed red blood cells transfused to patients who deliver</p>	<p>Standardize responses to obstetric emergency</p>	<ul style="list-style-type: none"> <li>• Utilize unit-standard, obstetric hemorrhage emergency management plan with checklists</li> <li>• Standardize measurement of cumulative blood loss (formal, as quantitative as possible)</li> <li>• Active management of the 3rd stage of labor (department-wide protocol)</li> <li>• Provide a unit-standard approach using a stage-based management plan with checklists</li> <li>• Support program for patients, families, and staff after all significant hemorrhages</li> </ul>
<p>Decreases by 25% the severe maternal morbidity (SMM) for hemorrhage at the state level</p>	<p>Standardize reporting of obstetric emergencies</p>	<ul style="list-style-type: none"> <li>• Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities</li> <li>• Monitor outcomes and process metrics in perinatal quality improvement (PQI) committee</li> <li>• Multidisciplinary review of serious hemorrhages for systems issues</li> </ul>



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