New strategy helps reduce errors in obstetrical care

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Researchers at Yale School of Medicine have implemented patient safety enhancements to dramatically reduce errors and improve the staff's own perception of the safety climate in obstetrical care.

Edmund F. Funai, M.D., associate professor in the Department of Obstetrics, Gynecology & Reproductive Sciences at Yale, will present preliminary results from this research at the Society for Maternal Fetal Medicine Annual Meeting on February 2 in Dallas, Texas.

An estimated 44,000 to 98,000 Americans die in hospitals each year as a result of errors. About half of medical errors are linked to communication errors and system failures. Obstetrics has lagged behind other specialties in attempts to improve safety because perinatal adverse events are both relatively uncommon and usually unexpected, occurring in previously healthy patients who are anticipating good outcomes.

"There is a crisis of confidence in American healthcare right now," said Funai.
"Reports in the media about patient injury in the hospital setting were causing concern, and we sought to apply some basic principles to obstetric care to make it a great deal safer than it is right now."

Funai and his team designed and implemented clinical patient safety interventions at Yale-New Haven Hospital. These included communication training, standardizing interpretation of fetal monitoring, and creating a novel staff role—the patient safety nurse. In tracking and

analyzing 14 markers for adverse outcomes, the team found that the rate of adverse events decreased by about 60 percent over 2.5 years, while the staff's own perception of the overall safety climate increased by 30 percent, according to a survey given by a third party.

Funai said that the main cause of adverse events and patient injury is a breakdown in communication, usually involving failure to recognize the severity of a given situation or condition, often involving a newborn's status.

"Communication issues are only going to increase as a result of restrictions on resident work hours," he said. "Patients are increasingly handed off from shift to shift and more attending physicians are practicing shift medicine. There is just more opportunity for errors in patient care. Everything we can do to standardize care and facilitate communication will make a big difference."

Funai said, "After taking these surprisingly simple steps to address safety, both patients and staff report that the care is much more seamless and better organized," he said. "The staff is more comfortable and empowered to communicate their concerns about a patient. A comfortable staff often leads to more successful patient outcomes."

Source: Yale University