Safety Bundles for Harassment and Discrimination: One pragmatic approach.

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Positionality & Lenses.

- I am a white, able- and lean-bodied, cisgender heterosexual Christian woman living in the American South. I identify most strongly as a mother, physician, teacher, and feminist.

- I practice Maternal-Fetal Medicine.

- I serve as Chair of the Department of Obstetrics & Gynecology.

Collaboration.

Dr Laura Riley

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AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

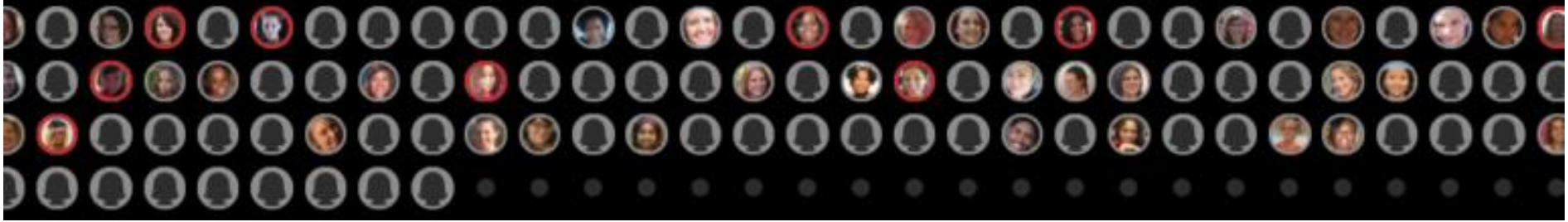
ACOG
The American College of Obstetricians and Gynecologists

Health Resources & Services Administration
HRSA
Maternal & Child Health

Lost Mothers

An estimated 700 to 900 women in the U.S. died from pregnancy-related causes in 2016. We have identified 134 of them so far.

by Nina Martin, ProPublica, Emma Cillekens and Alessandra Freitas, special to ProPublica
July 17, 2017



Why America's Black Mothers and Babies Are in a Life-or-Death Crisis

The answer to the disparity in death rates has everything to do with the lived experience of being a black woman in America.

By LINDA VILLAROSA APRIL 11, 2018

Clinical Practice: *Current Commentary*

Bias in Obstetrician–Gynecologists' Workplaces

Nancy C. Chescheir, MD, and Rebecca S. Benner, MPS

Obstetrician–gynecologists (ob-gyns) face similar types of biases in the workplace as any people in society. In this first of three articles exploring this issue, we present the stories from ob-gyns who describe their experiences dealing with these biases. These stories serve to personalize the issue and to encourage us to personally face bias in the workplace to build our own resilience and strength, to support those who are personally attacked or diminished, and to develop workplace cultures that are inclusive, diverse, and strong.

(Obstet Gynecol 2018;132:813–9)

gyns requires that we build a trusting relationship with our patients, but if some characteristic we have prevents a patient from accepting us as a health care provider, the delivery of health care breaks down. Our work is hard enough without feeling dismissed and disrespected by patients, coworkers, and peers.

A 2017 survey conducted by WebMD–Medscape and STAT[2,3] of almost 1,200 health care professionals (including approximately 800 doctors) suggests that almost 60% of doctors experience bias from their patients (Figs. 1–3). Although it is not possible to deter-

Clinical Practice: *Current Commentary*

Beyond Silence and Inaction

Changing the Response to Experiences of Racism in the Health Care Workforce

Ashish Premkumar, MD, Sara Whetstone, MD, MHS, and Andrea V. Jackson, MD, MAS

The issue of race and ethnicity within obstetrics and gynecology has come to the forefront in the current social and political climate. Understanding the ill effects of racism within the clinical space requires an acknowledgment of both the ongoing problem and current limitations in the state of knowledge and praxis among clinicians, trainees, and educators alike. In this commentary, the issue of race and racism within obstetrics and gynecology is discussed through a case of discrimination experienced by an intern

During her first inpatient rotation of her intern year, N.M. was assigned a patient who was being admitted to the hospital. Before N.M. interviewed the patient, she was informed by her co-intern, who also identified as a black physician, that the patient's husband had stated, "Black people are normally not smart." When N.M. walked into the room to meet the patient, the husband said, "I saw you earlier," mistaking N.M. for her co-intern. As N.M. interviewed

Institutional Responses to Harassment and Discrimination in Obstetrics and Gynecology

Kacey Y. Eichelberger, MD, *Nancy C. Chescheir,* MD, *and Laura E. Riley,* MD

Institutional harassment and discrimination are prevalent in the field of medicine and are detrimental to the well-being of individuals, teams, and the work environment. The familiar framework of an obstetric safety bundle is used here to propose 11 practical steps a health care team or institution may take to prepare for and respond to workplace harassment and discrimination in a systematic fashion.

(Obstet Gynecol 2018;132:828–32)
DOI: 10.1097/AOG.0000000000002867

The first of this trilogy of articles highlights stories of some of our peers who have faced harassment or discrimination while at work and demonstrates the need for obstetrician–gynecologists to build professional environments that embrace inclusion and diversity.[1] The second article uses the example of organization, or institution can use to foster a culture in which individuals are supported to combat harassment, discrimination events, or both in the workplace. In these articles, as outlined by the U.S. Equal Employment Opportunity Commission, harassment is unwelcome conduct that is based on race, color, religion, sex (including pregnancy), national origin, age, disability, or genetic information.[3] We define discrimination as treating someone less favorably because of a personal characteristic protected by law.[4]

Although overt bigotry about any characteristic is relatively easy to identify by most witnesses, these instances tend to occur rarely in the health care environment. Far more common and insidious, microaggressive behavior can contribute to poor health out-

Eichelberger KY, Chescheir NC, Riley LE. Obstet Gynecol. 2018 Oct;132(4):828-832. doi: 10.1097/AOG.0000000000002867.PMID: 30204692

Confession.

We are by no means experts in this field.

Confession.

We weren't really looking

to be innovative.

But we did …

… know our audience.

Simple, Straightforward, Standardized, Practical.

What are we trained to do really well?

Deal with acute, unexpected, highly morbid events.
"Severe adverse events"

Find a **tool** that works for you:
For us - The Obstetric Patient Safety Bundle

The Institute for Healthcare Improvement describes patient safety bundles as, "...a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidence-based practices — generally three to five — that, when performed collectively and reliably, have been proven to improve patient outcomes." The bundle structure does not introduce new practice guidelines or concepts, but offers a standardized approach for delivering well-established, evidence-based practices to be implemented with complete consistency, for every patient, every time – resulting in improved patient outcomes.

"Small, Straightforward"
"Standardized approach"
"Every patient, Every time"

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

READINESS

Every unit

- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION

Every patient

- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE

Every hemorrhage

- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women's Health Care disseminates patient safety bundles to help facilitate the standardization process. This bundle reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Although the components of a particular bundle may be adapted to local resources, standardization within an institution is strongly encouraged.

The Council on Patient Safety in Women's Health Care is a broad consortium of organizations across the spectrum of women's health for the promotion of safe health care for every woman.

May 2015

For more information visit the Council's website at www.safehealthcareforeverywoman.org

- Obstetric Hemorrhage
- Severe Hypertension in Pregnancy
- Safe Reduction of Primary Cesarean Birth
- Obstetric Care for Women with Opioid Use Disorder
- Cardiac Conditions in Obstetrical Care-In Development
- Postpartum Discharge Transition Bundle-In Development

Recognition & Prevention

1. Assess your unit's risk for events before they occur.

   Discrimination and harassment surveys, focus groups

   eg, Diversity Engagement Survey (AAMC)

2. Take the pulse of your unit with implicit bias testing.
3. Establish, communicate and enforce patient and guest responsibility to treat all people in your facility with respect and without threat.

Recognition & Prevention

1. Assess your unit's risk for events before they occur.
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3. Establish, communicate and enforce patient and guest responsibility to treat all people in your facility with respect and without threat.

Develop a unit- or facility-wide policy that is communicated to all patients with early patient exposure.

Eg, Patient Rights Policy from Penn State Health Milton S Hershey Medical Center

PATIENT RESPONSIBILITIES

The following patient responsibilities are presented to the patient and family in the spirit of mutual trust and respect.

Demonstrate Respect and Consideration

Patients, as well as their family members, representatives and visitors, are expected to recognize and respect the rights of our other patients, visitors, and staff. Threats, violence, disrespectful communication or harassment of other patients or of any medical center staff member, for any reason, including because of an individual's age, ancestry, color, culture, disability (physical or intellectual), ethnicity, gender, gender identity or expression, genetic information, language, military/veteran status, national origin, race, religion, sexual orientation, or other aspect of difference will not be tolerated. This prohibition applies to the patient as well as their family members, representatives, and visitors.

In addition, requests for changes of provider or other medical staff based on that individual's race, ethnicity, religion, sexual orientation or gender identity will not be honored. Requests for provider or medical staff changes based on gender will be considered on a case by case basis and only based on extenuating circumstances.

https://cancer.psu.edu/documents/11396232/11459793/Patient+Rights+Policy+PC-33-HAM/b4f54eb1-7183-43cb-a606-640be66a84c8

Readiness

4. Build a team that is diverse and inclusive.

   Partner with diverse groups to increase talent pool. Critically evaluate your residency rank list process. AAMC's Diversity and Inclusion Strategic Planning Tool kit.

5. Train your team to identify and respond to microaggressions.

6. Practice your team's response plan to harassment and discrimination events.

Readiness

4. Build a team that is diverse and inclusive.

5. Train your team to identify and respond to microaggressions.

6. Practice your team's response plan to harassment and discrimination events.

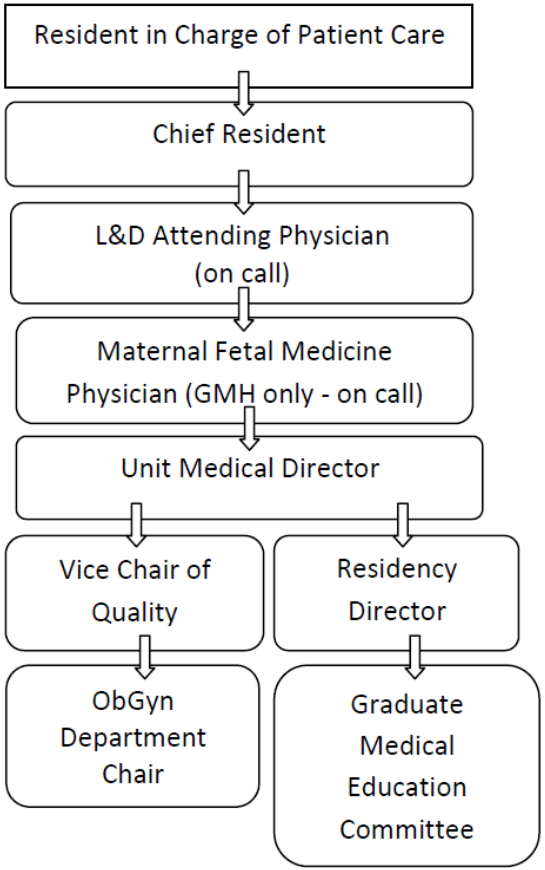
Simulations and drills. Scripting. Book or journal club as a tool – *Small Great Things* (Jodi Picault)

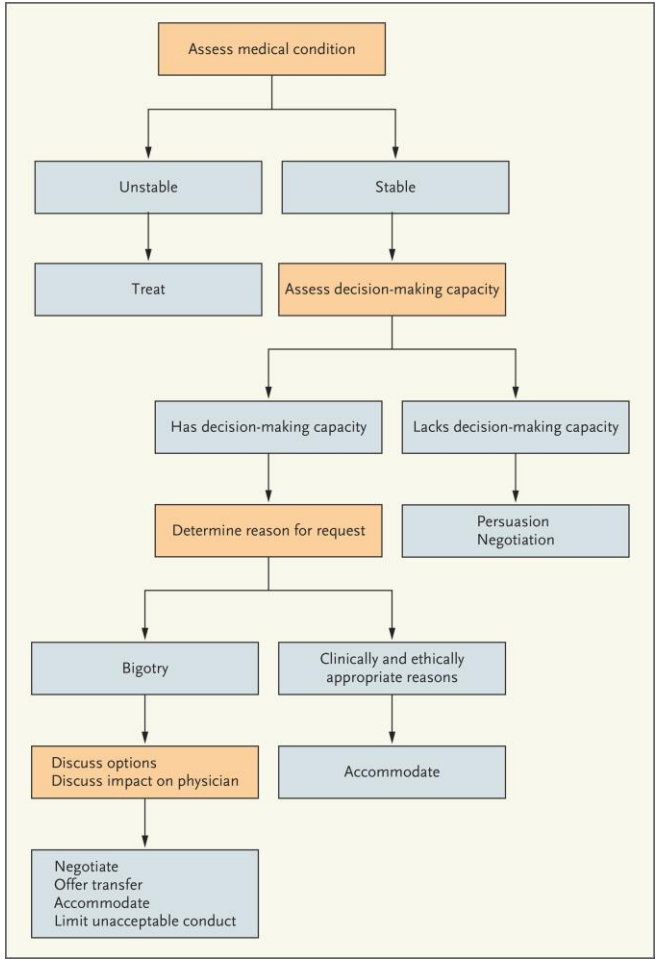
Response

7. Codify the expected responses and ladder of responsibility to activate when a team member experiences bigoted or discriminatory behavior.

Standard checklist with step-by-step instructions, backup options, etc. Online portal with confirmed output. Contextual framework from Paul-Emile, “Dealing with Racist Patients” (NEJM).

Appendix E: Obstetrics Teaching Service Physician's Notification Sequence





Considering a Patient's Request for Physician Reassignment Based on Race or Ethnic Background in an Emergency Setting.

N Engl J Med 2016; 374:708-711 DOI: 10.1056/NEJMp1514939

Response

8. Debrief the event.

Anger, frustration, shame, and victimization after an event. Have a facilitator not involved in the incident discuss with those involved and offer support. ** This skill will require professional development. A short-standardized instrument (such as the debrief checklist from TeamSTEPPS) may be helpful.

TeamSTEPPS Debrief Checklist

The team should address the following questions during a debrief

- ☐ Was communication clear?
- ☐ Were roles and responsibilities understood?
- ☐ Was situation awareness maintained?
- ☐ Was workload distribution equitable?
- ☐ Was task assistance requested or offered?
- ☐ Were errors made or avoided?
- ☐ Were resources available?
- ☐ What went well?
- ☐ What should improve?

https://www.une.edu/sites/default/files/teamstepps_debrief_checklist.pdf

Reporting & Systems Learning

9. Track data on harassment and discrimination events as you would any other quality measure.

Dashboard for D&I metrics and Dashboard tracking reported harassment and discrimination events. Feed info back to department with other quality data at quarterly intervals.

10. Ask to be graded.

Exit interviews. Periodic surveys. Focus groups. *“What are our institutional blind spots? What can we do to create a healthier work environment? If you were in charge, …”*

11. Share best practices.

Commit to national dissemination.

What we don’t know.

- In vivo effect?
- Fidelity across disciplines?

cpsi Canadian Patient Safety Institute

SURGICAL SAFETY CHECKLIST

www.safesurgerysaveslives.ca

BRIEFING—Before induction of anesthesia

Hand-off from ER, Nursing Unit or ICU

- ☐ Anesthesia equipment safety check completed
- ☐ Patient information confirmed
  - Identity (2 identifiers)
  - Consent(s)
  - Site and procedure
  - Site, side and level marked
  - Clinical documentation
  - History, physical, labs, biopsy and x-rays
- ☐ Review final test results
- ☐ Confirm essential imaging displayed
- ☐ ASA Class
- ☐ Allergies
- ☐ Medications
  - Antibiotic prophylaxis: double dose?
  - Glycemic control
  - Beta blockers
  - Anticoagulant therapy (e.g., Warfarin)?
- ☐ VTE Prophylaxis
  - Anticoagulant
  - Mechanical
- ☐ Difficult Airway / Aspiration Risk
  - Confirm equipment and assistance available
- ☐ Monitoring
  - Pulse oximetry, ECG, BP, arterial line, CVP, temperature and urine catheter
- ☐ Blood loss
  - Anticipated to be more than 500 ml (adult) or more than 7 ml/kg (child)
  - Blood products required and available
- Patient grouped, screened and cross matched

BRIEFING *(continued)*

- ☐ Surgeon(s) review(s)
  - Specific patient concerns, critical steps, and special instruments or implants
- ☐ Anesthesiologist(s) review(s)
  - Specific patient concerns and critical resuscitation plans
- ☐ Nurses(s) review(s)
  - Specific patient concerns, sterility indicator results and equipment / implant issues
- ☐ Patient positioning and support / Warming devices
- ☐ Special precautions
- ☐ Expected procedure time / Postoperative destination

TIME OUT—Before skin incision

- ☐ All team members introduce themselves by name and role
- ☐ Surgeon, Anesthesiologist, and Nurse verbally confirm
  - Patient
  - Site, side and level
  - Procedure
  - Antibiotic prophylaxis: repeat dose?
  - Final optimal positioning of patient
- ☐ "Does anyone have any other questions or concerns before proceeding?"

DEBRIEFING—Before patient leaves OR

- ☐ Surgeon reviews with entire team
  - Procedure
  - Important intra-operative events
  - Fluid balance / management
- ☐ Anesthesiologist reviews with entire team
  - Important intra-operative events
  - Recovery plans (including postoperative ventilation, pain management, glucose and temperature)
- ☐ Nurse(s) review(s) with entire team
  - Instrument / sponge / needle counts
  - Specimen labeling and management
  - Important intraoperative events (including equipment malfunction)
- ☐ Changes to post-operative destination?
- ☐ What are the KEY concerns for this patient's recovery and management?
- ☐ Could anything have been done to make this case safer or more efficient?

Hand-off to PACU / RR, Nursing Unit or ICU

PATIENT INFORMATION

Surgical Safety Checklist: Canada—Version 1, January 9, 2009

Megacode Testing Checklist: Scenarios 4/7/10
Tachycardia → VF → PEA → PCAC

American Heart Association®
life is why™

Student Name _____ Date of Test _____

Critical Performance Steps	✓ if done correctly		
Team Leader			
Ensures high-quality CPR at all times			
Assigns team member roles			
Ensures that team members perform well			
Tachycardia Management			
Starts oxygen if needed, places monitor, starts IV			
Places monitor leads in proper position			
Recognizes unstable tachycardia			
Recognizes symptoms due to tachycardia			
Performs immediate synchronized cardioversion			
VF Management			
Recognizes VF			
Clears before analyze and shock			
Immediately resumes CPR after shocks			
Appropriate airway management			
Appropriate cycles of drug–rhythm check/shock–CPR			
Administers appropriate drug(s) and doses			
PEA Management			
Recognizes PEA			
Verbalizes potential reversible causes of PEA (H's and T's)			
Administers appropriate drug(s) and doses			
Immediately resumes CPR after rhythm checks			
Post–Cardiac Arrest Care			
Identifies ROSC			
Ensures BP and 12-lead ECG are performed, O_2 saturation is monitored, verbalizes need for endotracheal intubation and waveform capnography, and orders laboratory tests			
Considers targeted temperature management			

STOP TEST

Test Results Check **PASS** or **NR** to indicate pass or needs remediation: **PASS** ☐ **NR** ☐

Instructor Initials _____ Instructor Number _____ Date _____

Learning Station Competency
☐ Cardiac Arrest ☐ Bradycardia ☐ Tachycardia ☐ Immediate Post–Cardiac Arrest Care ☐ Megacode Practice

Your airline | NORMAL CHECKLIST

Boeing 737-800 | SOP 5.1. 02.06.17

PREFLIGHT		
Voice Recorder	ON	CM1
Oxygen	TESTED, 100%	BOTH
NAVIGATION & DISPLAY Switches	NORMAL, AUTO	CM2
Window Heat	ON	CM2
Pressurization Mode Selector	AUTO	CM2
Flight Instruments	HDG_, Altimeter_	BOTH
Parking Brake	SET, Pressure Normal	CM1
Engine Start Levers	CUTOFF	CM1

BEFORE START		
Papers	ABOARD	CM1
Flight Deck Door	Closed and Locked	BOTH
Fuel	_KGS	CM1
	PUMPS ON	CM2
Passenger Signs	ON	CM2
Windows	LOCKED	BOTH
MCP	V2_, HDG_, ALT_	CM1
Takeoff Speeds	V1_, VR_, V2_	BOTH
CDU Preflight	COMPLETED	BOTH
Rudder and Aileron Trim	Free & Zero	CM1
Taxi and TO Briefing	COMPLETED	CM1
Anti Collision Light	ON	CM2

BEFORE TAXI		
Generators	ON	CM2
Probe Heat	ON	CM2
Anti-Ice	_	CM2
Isolation Valve	AUTO	CM2
Engine Start Switches	CONT	CM2
Recall	CHECKED	BOTH
Autobrake	RTO	CM2
Engine Start Levers	IDLE DETENT	CM1
Flight Controlls	CHECKED	BOTH
Flaps	_, GREEN LIGHT	BOTH
Ground Equipment	CLEAR	BOTH

BEFORE TAKEOFF		
Flaps	_, GREEN LIGHT	BOTH
Stabilizer Trim	_UNITS	CM2
Transponder	TA/RA	CM2

AFTER TAKEOFF		
Engine Bleeds	ON	PM
Packs	AUTO	PM
Landing Gear	UP and OFF	PM
Flaps	UP, NO LIGHTS	PM
Altimeters	STD, X-CHECKED	BOTH

DESCENT		
Pressurization	LAND ALT_	PF
Recall	CHECKED	PF
Autobrake	_	PF
Landing Data	Vref_, MINIMUMS_	BOTH
Approach Briefing	COMPLETED	PF

APPROACH		
Altimeters	hPa(In), X-CHECKED	BOTH

LANDING		
Engine Start Switches	CONT	PF
Speed Brake	ARMED	PF
Landing Gear	DOWN	PF
Flaps	_, GREEN LIGHT	PF

SHUTDOWN		
Fuel Pumps	As needed	CM2
Probe Heat	OFF	CM2
Hydraulic Panel	SET	CM2
Flaps	UP	CM2
Parking Brake	_	CM1
Engine Start Levers	CUTOFF	CM1
Weather Radar	OFF	BOTH
IRS Mode Selecors	OFF	CM2

SECURE		
Fuel Pumps	As required	CM2
Emergency Exit Lithts	OFF	CM2
Window Heat	OFF	CM2
Packs	OFF	CM2
APU Bleed	OFF	CM2
Lights	OFF	CM2
APU/EXT Power	As required	CM2
Battery Switch	As required	CM2

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Conclusion

In the absence of a perfect option, accept the imperfect and *do something.*

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