

## **Maternal Safety**

## **Curated Library**

#### **Foundations**

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Marla Shauer, PhD(c), MSN, CNM; Amy Nichols, EdD, RN, CNS, CHSE, ANEF; Audrey Lyndon, RN, PhD, FAAN | January, 31 2024

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People of color experience disproportionately higher rates of maternal morbidity and mortality. As part of a larger quality improvement and patient safety initiative to reduce severe maternal morbidity from hemorrhage (SMM-H), this hospital analyzed...

## **Maternal Safety Event Identification and Definition and Analysis**

Use of maternal early warning trigger tool reduces maternal morbidity.

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A multidisciplinary model for reviewing severe maternal morbidity cases and teaching residents patient safety principles.

Ogunyemi D, Hage N, Kim SK, et al. Jt Comm J Qual Patient Saf. 2019;45:423-430.

The rise in maternal morbidity and mortality is one of the most pressing patient safety issues in the United States. Formal debriefing after adverse events is an important method for analyzing and improving safety. In this study, an academic hospital...

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Stanford, CA; California Maternal Quality Care Collaborative: July 1, 2022.

This toolkit focuses on identification of, and rapid response to, sepsis in obstetric patients. It includes screening, evaluation and monitoring, and antibiotic use recommendations for maternal sepsis patient.

Distinguishing high-performing from low-performing hospitals for severe maternal morbidity: a focus on quality and equity.

Howell EA, Sofaer S, Balbierz A, et al. Obstet Gynecol. 2022;139:1061-1069.

Health equity in maternal safety is a major patient safety goal. Researchers interviewed health care professionals, including frontline nurses and physicians, chief medical officers, and quality and safety officers, from high- and low-performing...

## **Patient Engagement**

Thematic analysis of women's perspectives on the meaning of safety during hospital-based birth.

Lyndon A, Malana J, Hedli LC, et al. J Obstet Gynecol Neonatal Nurs. 2018;47:324-332.

A vital component of engaging patients in safety is eliciting their perspective on how they experience both routine care and adverse events. Researchers interviewed women who gave birth in hospitals about what contributed to their sense of safety....

The impact of patient-physician alliance on trust following an adverse event.

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Maternal morbidity has garnered increasing attention as a patient safety issue. This survey of postpartum women elicited reports of adverse events, unanticipated procedures, and sense of betrayal in health care institutions. Patients' reports of...

#### **HEAR Her Concerns.**

National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health; Centers for Disease Control and Prevention.

Maternal harm during and after pregnancy is a sentinel event. This campaign encourages women, families, and health providers to identify and speak up with concerns about maternal care and act on them. The program seeks to inform the design of support...

## Value of Teamwork in Maternal Safety

#### Team training for safer birth.

Cornthwaite K, Alvarez M, Siassakos D. Best Pract Res Clin Obstet Gynaecol. 2015;29:1044-1057. Obstetric care is considered a high-risk environment. Highlighting the importance of coordinated teamwork during obstetric emergencies, this review discusses strategies to augment clinical outcomes in this setting, including team training,...

Integrated approach to reduce perinatal adverse events: standardized processes, interdisciplinary teamwork training, and performance feedback.

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Prior research has shown that reducing preventable perinatal harm leads to a decrease in malpractice claims. In this prospective study involving the perinatal units across 14 hospitals from 12 states and accounting for almost 350,000 deliveries,...

Delivering high reliability in maternity care: in situ simulation as a source of organisational resilience. Macrae C, Draycott T. Safety Sci. 2019;117:490-500.

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## **All Library Content**

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