Crisis Teams for Obstetric Patients

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KEYWORDS

• Rapid response systems • Obstetric care • Crisis team • Medical emergencies

KEY POINTS

- Obstetrical care of mothers and their unborn children, involves emergencies that necessitate rapid coordination of multidisciplinary group of medical care providers efficiently. This group of providers is an obstetrical rapid response team.
- Obstetrical rapid response teams can be divided into 4 components: an afferent arm of activators, an efferent arm of responders, quality improvement personnel who track and analyze the response, and administrators that coordinate and perpetuate the efforts
- A commonly utilized training venue for obstetrical rapid response teams involves multidisciplinary simulation training. This chapter discusses simulation training and the evolution of obstetrical crisis responses over a ten year period.

Rapid response systems (RRSs) for medical emergencies, especially to avoid full cardiopulmonary arrest and facilitate trauma care, have been in existence for more than 2 decades. Continuous quality-improvement inpatient RRS teams for obstetric care involve periodic maternal and or fetal crisis situations. During events, such as fetal bradycardia, shoulder dystocia, anaphylaxis, and maternal hemorrhage, patient care needs greatly and often exceed the resources allocated to routine care. Unfortunately, these emergencies in the past decades have led to increases in maternal morbidity in the United States, especially in cases of maternal hemorrhage.[1] Many of these crises require rapid, coordinated intervention of a multidisciplinary team to optimize outcome. Increasingly, hospitals have incorporated obstetric teams into their RRSs to address these recurring but unpredictable maternal and/or fetal events. Rapid response teams focused on obstetric events differ from medical or trauma rapid response teams in that the population that they are designed to treat (pregnant women) are usually younger and healthier and the outcome of the treatment affects

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2 patients (mother and fetus). Proper institution of rapid care often prevents major morbidity to both individuals.[2]

The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion, "Preparing for Clinical Emergencies in Obstetrics and Gynecology," emphasizes the importance of crisis response teams for clinical emergencies relevant to obstetric patients.[3] The US Department of Health and Human Services along with the American Hospital Association and the Health Research & Educational Trust updated the Obstetrical Harm Care Change Package entitled, "2014 Update: Recognition and Prevention of Obstetrical Related Events and Harm," in which the use of obstetric RRSs were advocated.[4] Global initiatives developed recently to improve the quality of maternal and newborn care, use basic indicators of care, and advocate a coordinated obstetric care team response to emergency care. These global initiatives are based on recommendations partially spurred by the United Nations Commission on Information and Accountability for Women and Children's Health that working through the World Health Organization millennial goals program, and the Global Alliance for Surgery, Obstetric, Trauma, and Anaesthesia Care (G4 Alliance).[5,6]

Many institutions established obstetric-specific crisis teams as local quality-improvement initiatives. Recently, more reports on such teams have appeared in the published global literature.[7–13]

This article describes the implementation, training, and maintenance of an obstetric-specific crisis team at the University of Pittsburgh Medical Center (UPMC) Magee-Women's Hospital (MWH) from 2005 through 2016, including descriptions of alternate obstetric team approaches chosen by other institutions. This information was solicited through query of several medical associations (Council of Women's and Infants' Specialty Hospitals, Society for Obstetric Anesthesia and Perinatology, and Society for Simulation in Healthcare), and the Institute for Healthcare Improvement.

A current literature search of the state of art, growth and evolution, and logistics of training personnel for participation in obstetric RRS also is discussed. For many institutions, simulation training is the backbone of maintaining systemic responses and educating new providers about the RRS response. In simulation, training teams can develop a coordinated approach and communication skills required for the situations that an obstetric RRS encounter. Recent developments in simulation training specific to obstetric rapid response teams are also described. In addition, the efficacy and sustainability of obstetric RRS, with supporting data, are discussed before the conclusion of this article.

BACKGROUND AND JUSTIFICATION

The authors' institution, MWH, added an obstetric-specific team response to its RRS for multiple reasons:

1. The single call system was the most rapid way to bring multidisciplinary providers to a patient who needed care urgently. One call assembled the necessary personnel and expertise to provide optimal evaluation and intervention. After calling, the bedside provider could focus on immediate crisis care of the patient rather than making multiple sequential phone calls.
2. The multidisciplinary response facilitated interdisciplinary communication, as team responders arrived and received a briefing about the patient at nearly the same time. Poor communication was the number one root cause identified in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Sentinel Event Alert, "Preventing Infant Death and Injury During Delivery."[14]

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