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The Perinatal Patient Safety Nurse: A New Role to Promote Safe Care for Mothers and Babies

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Medical malpractice premiums and costs of obstetric claims, settlements, and jury awards are at an all-time high. This article describes one professional liability company's initiative to promote safer perinatal care and decrease costs of claims, including the development of the perinatal patient safety nurse role. The primary responsibility of the perinatal patient safety nurse is to promote safe care for mothers and babies by keeping patient safety as a focus of all unit operations and clinical practices. *JOGNN, 35,* 417-423; 2006. DOI: 10.1111/J.1552-6909.2006.00057.x

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A complex interrelationship of consumer, regulatory, and economic factors has resulted in a major focus on patient safety over the past several years. Popular media coverage of two Institute of Medicine reports, *To Err Is Human: Building a Safer Health System* (Kohn, Corrigan, & Donaldson, 1999) and *Crossing the Quality Chasm: A New Health System for the 21st Century* (Kohn et al., 2001), heightened public awareness of the prevalence and seriousness of medical errors and increased consumer expectations for safety and quality, especially in the inpatient setting.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has been involved in ongoing development of standards and programs to promote patient safety. The U.S. government increased funding for the Agency for Healthcare Research and Quality (AHRQ), which has promulgated patient safety indicators that can be used to monitor and evaluate quality of care (AHRQ, www.ahrq.gov).

Rising monetary awards in lawsuits over negative outcomes and resulting increases in liability insurance premiums are economic pressures forcing a concentration on safer care (Bovbjerg, 2005). Providers of medical liability insurance are in an untenable situation because of the litigious environment and increasingly large malpractice settlements and jury awards. Some companies have abandoned the medical malpractice business entirely, and in certain markets, it is difficult for health care providers to find coverage. The American College of Obstetricians and Gynecologists (ACOG, 2004) has identified 23 "red alert" states with medical liability insurance crises. Factors contributing to designation as a red alert state are a lack of available professional liability coverage for obstetricians, few carriers currently writing policies in the state, the number of carriers leaving the medical liability insurance market, and the cost and rate of increase of annual premiums based on reports from industry monitors.

These issues pose a challenge for care providers, institutions, and medical liability carriers as they work together to maintain a stable, cost-effective source of professional liability coverage that will allow health care delivery to remain financially viable while providing safe and quality care. This article describes one professional liability company's initiative to promote safer perinatal care, a program that led to the development of the perinatal patient safety nurse (PSN) role.

The MCIC Obstetric Patient Safety Initiative

MCIC Vermont, Inc. is a risk retention group that underwrites medical liability insurance for five academic medical centers. Insured shareholders include

Columbia University, Cornell University, Johns Hopkins University, the University of Rochester, and Yale University. The leadership team at MCIC Vermont critically evaluated the malpractice situation and decided to address the challenge through a proactive clinical initiative, in which an interdisciplinary leadership team from the five academic medical centers would identify and adopt evidence-based clinical practices to promote quality and minimize risk of patient harm. A colloquium would develop policy, strategies, and educational programs, with the goal of producing measurable improvements in the process of care and patient outcomes as well as changes in practitioner attitude and behavior. The ultimate long-term goal was a decrease in preventable adverse outcomes and malpractice claims losses.

The greatest potential for positive impact could be realized by identifying clinical areas that carried the highest claims costs and highest associated risk of preventable patient harm and injury; therefore, the initial step was analysis of past claims data and benchmark data. Review of company and national data from the previous 10 years revealed obstetrics to represent the highest financial risk, accounting for 24.5% of total claims dollars. Since obstetrics was identified as a high-risk clinical area, MCIC Vermont invited perinatal physician and nursing leaders from the five participating academic medical centers and their affiliated hospitals to partner with them in identifying, prioritizing, implementing, and evaluating clinical initiatives to promote patient safety.

A first step involved evaluation of existing practice at the participating medical centers and identification of areas of vulnerability. At the request of MCIC Vermont, a nationally recognized expert physician-nurse team completed an internal site review at all the participating facilities. Analysis of their reports revealed opportunities for performance improvement for the medical centers as a group, as well as areas for improvement unique to each facility.

The MCIC Vermont Patient Safety Subcommittee, the Claims & Risk Management Committee, and the Obstetric Clinical Leadership Group reviewed the recommendations and prioritized patient safety projects and implementation strategies. Initial safety projects identified as priorities included an evaluation of the safety culture in each obstetric department, promotion of interdisciplinary teamwork and a nonhierarchical clinical environment through team training programs, and standardization of key clinical policies and protocols based on current science, standards, and guidelines from professional associations and regulatory agencies.

They also planned to improve the accuracy and timeliness of fetal assessment by promoting a common language for electronic fetal monitoring (EFM), using terminology recommended by the National Institute of Child Health and Human Development Research Planning Workshop (NICHD, 1997), and a shared knowledge base on fetal heart rate (FHR) pattern interpretation and expected interventions for nonreassuring FHR patterns. This improvement would occur through ongoing education and national EFM certification for all members of the interdisciplinary team.

The leaders planned to create a forum for the obstetric (OB) leadership team to learn from each other by sharing successful practices and reviewing clinical cases in which opportunities for improvement were identified. They also would develop a set of evaluation criteria to monitor progress of the components of the initiative as well as maternal-fetal outcomes.

Development of the Patient Safety Nurse Role

The safety initiative leaders recognized that critical requirements for success of the obstetric patient safety initiative would be day-to-day on-site support for all program components, and ongoing monitoring and measurement of the impact of the project on patient safety and malpractice claims. The obstetric leaders saw the need for a designated perinatal practitioner at each site to take responsibility for the daily operation of the safety initiative. This practitioner would provide real-time review of patient care, while fostering an environment of safety and championing the goals of the initiative. These discussions led to the creation and implementation of the role of the PSN.

Role Description and Requirements

The ideal PSN is an advanced practice perinatal nurse with significant experience in clinical and administrative systems. Knowledge of national standards and guidelines and the principles and practice of safety science is essential. In addition to the advanced practice role experience of the PSN, national certification in inpatient obstetrics and EFM is expected.

Project management skills are required to formulate and execute patient-centered safety initiatives. Communication skills and ability to work collaboratively with the leadership team and staff members to promote teamwork among all care providers are critical to role success and to the success of all the obstetric safety program initiatives. Ability to coordinate and provide interdisciplinary educational programs requires an acute understanding of provider and system needs in the complex setting of an academic medical center.

The PSNs promote safe care for mothers and babies by keeping patient safety as a focus of all unit operations and clinical practices.