A critical look at all available protocols is a key component of a safety initiative. Simplifying and standardizing the oxytocin order set, for instance, was something we did early on.

It’s important to ensure that everyone is speaking the same language. We were particularly struck by the importance of common language and common understanding in fetal heart rate monitoring. For example, early on we surveyed EVMS residents and labor and delivery nurses about how they defined uterine tachysystole. Responses were all over the board, with more than 20 different definitions.

Without a common definition, we realized, we would have not only varying recognition of the problem at labor and delivery, but also poor communication among health team members and the potential for harming the patient.

To prevent errors of missing fetal heart rate for maternal heart rate during labor, we adopted the National Institute for Child Health and Human Development’s definitions of uterine tachysystole and fetal heart rate patterns. This was an important precursor to the development of protocols for addressing tachysystole and enhancing communication among providers.

We also established universal monitoring of maternal and fetal heart rates. The maternal heart rate is continuously displayed on the fetal heart rate monitor, which substantially reduces the chance for error.

In addition, we studied our cesarean section response time and developed new response time guidelines that enabled us to clearly and efficiently communicate with anesthesiologists regarding the various levels of urgency involved. Ultimately, we created four cesarean section categories that provided clear communication among health care teams and allowed for data collection and review. (See box above.)

To significantly reduce unnecessary prematurity and its associated morbidity, we implemented elective induction and cesarean section bundles that require either a gestational age of at least 39 weeks or documented fetal lung maturity.

These criteria are currently part of the national voluntary consensus standards for perinatal care in 2008 that were developed by a committee of the National Quality Forum.

Following much debate, we also implemented, at both hospitals, the universal collection of arterial and venous cord pH with every delivery. We have found this practice to be cost effective and to provide objective documentation of fetal intrapartum oxygenation. It also identifies neonates for targeted resuscitation and is a mechanism for continuous quality improvement. Given its potential controversy, however, this practice should not be at the top of the list for safety initiatives at labor and delivery.

Plans in the immediate future include a focus on shoulder dystocia, operative delivery, and triage of patients at labor and delivery. Given the early success of OB Right, we decided to expand this program to the five other Sentara Healthcare hospitals that provide obstetric services in southeastern Virginia.

In order to achieve this goal, we have created a Clinical Effectiveness Council with physician/nurse team representatives from each of the hospitals. The council meets monthly and is currently in the process of implementing key components of the OB Right program.

**Keys to Success**

We have learned that “buy-in” is key to an effective patient safety initiative. Hospital administration must devote the resources necessary for the success of the program, and both physicians and nurses must be at the table together and be involved as a team with a common safety goal.

A clinical safety coordinator is also essential to the success of a program. This person provides the consistency required and plays a critical role in communicating with the staff in the trenches.

Additionally, it is important to establish methods of communication early on, and to deliver and communicate tangible successes as soon as possible.

The OB Right program communicates with the health care team through posters on labor and delivery, and a newsletter that reports every 3 months on the issues and successes of the program. It also has a Web site with educational modules, near-miss reporting, meeting schedules and minutes, and other interactive tools.

Since OB Right began, we’ve almost eliminated elective deliveries at less than 39 weeks’ gestation, and have achieved an almost-universal compliance with simultaneous maternal and fetal heart rate tracing and measurement of arterial and venous cord pH at both hospitals.

One of the major liability insurance companies sends a representative to the OB Right steering committee meetings and provides premium discounts for physician participation in the OB Right program.

As reported in the Institute of Medicine report “Crossing the Quality Chasm: A New Health System for the 21st Century,” the biggest challenge to moving from one to the other is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures but as opportunities to improve the system and prevent harm.