ABSTRACT: Since publication of the Institute of Medicine’s landmark report To Err is Human: Building a Safer Health System, emphasis on patient safety has steadily increased. Obstetrician–gynecologists should continuously incorporate elements of patient safety into their practices and also encourage others to use these practices.

The American College of Obstetricians and Gynecologists (ACOG) is committed to improving quality and safety in women’s health care. The Institute of Medicine report, To Err Is Human: Building a Safer Health System, notes that errors in health care are a significant cause of death and injury (1). Despite disagreements over the actual numbers cited, all health care professionals agree that patient safety is extremely important and should be addressed by the overall health care system. The American College of Obstetricians and Gynecologists continues to emphasize its long-standing commitment to quality and patient safety by codifying a set of objectives that should be adopted by obstetrician–gynecologists in their practices. Obstetrician–gynecologists are encouraged to promulgate these principles in the hospitals and other settings where they practice.

Patient Safety Objectives

I. Develop a commitment to encourage a culture of patient safety

Safety should be viewed as an essential component of a broader commitment to the provision of optimal health care for women. Promoting safety requires that all those in the health care environment recognize that the potential for errors exists systemically. Women’s health care should be delivered in a learning environment that encourages disclosure and exchange of information in the event of errors, near misses, and adverse outcomes.

A culture of safety should be the framework for any effort to reduce medical errors. According to the Agency for Healthcare Research and Quality (AHRQ), a safety culture refers to “a commitment to safety that permeates all levels of an organization, from frontline personnel to executive management” (2). Associated with a safety culture is the concept of a “just culture,” which recognizes that competent professionals make mistakes and acknowledges that even competent professionals may develop unhealthy norms, such as shortcuts or routine rule violations, but has zero tolerance for reckless behavior (2). “Frontline personnel feel comfortable disclosing errors—including their own—while maintaining professional accountability” (2). A just culture recognizes that some rate of human error is inevitable, especially in complex endeavors such as the delivery of health care. Therefore, the first step in the delivery of safe health care should be to identify and study the patterns and causes of error occurrence within delivery systems. Obstetrician–gynecologists should adopt and develop those safe practices that reduce the likelihood of system failures that can cause adverse outcomes. Just culture also recognizes the responsibility of all health care providers to follow these safe practices once established, and to avoid behaviors that would be characterized as “at-risk behavior” or “reckless behavior.” At-risk behavior is the type of rule bending that tends to naturally occur over time in systems where the rate of
adverse outcomes is very low. Reckless behavior is the type of behavior that clearly puts patients at significant risk of harm and shows a conscious disregard of unreasonable risk. In a just culture, instances of adverse outcomes or failure to follow safety protocols are investigated fairly and openly. The general principle when dealing with these situations is summarized as “console the human error; coach the at-risk behavior; and punish the reckless behavior” (3).

Institution of these principles establishes an atmosphere where all caregivers feel safe in reporting errors, near misses, and at-risk behaviors by themselves and others. This will promote and increase error reporting and identify potentially hidden problems, as well as motivate health care providers to find system problems and collaborate to resolve system failures.

The role of leadership, whether in the inpatient or outpatient setting, is essential in facilitating an effective patient safety program. Strong leadership within obstetrics and gynecology is necessary to advocate for the provision of both financial and human resources to achieve patient safety goals. Efforts devoted to optimizing communication and collaboration among the various members of the health care team are equally important in promoting these principles of patient safety.

II. Implement recommended safe medication practices
Most medical errors are caused by problems associated with the use of medications; therefore, efforts to reduce the occurrence of these errors should be ongoing. Although computerized physician order entry systems can be effective in reducing prescribing errors, they are costly and may not collect data that support quality improvement activities (4, 5). In the absence of computerized physician order entry systems, the following steps should be adopted to reduce errors in prescribing and administering medications (6):

- Improve legibility of handwriting
- Avoid use of nonstandard abbreviations
- Check for drug allergies and sensitivities
- Always use a leading 0 for doses of less than 1 unit (eg, 0.1 mg, not .1 mg), and never use a trailing 0 after a decimal (eg, 1 mg, not 1.0 mg): “always lead, never follow”
- All verbal orders should be written down by the individual receiving the order and read back to the prescriber verbatim to ensure accuracy

III. Reduce the likelihood of surgical errors
Surgical errors may involve the performance of the incorrect operation or a procedure on the wrong site or wrong patient. Although these errors occur much less frequently than medication errors, the consequences of these errors are always significant. The attending obstetrician–gynecologist who is ultimately responsible for the patient’s care should work with other operating room personnel, such as nurses and anesthesiologists, to be certain that systems are in place to ensure proper patient and procedure identification. The obstetrician–gynecologist also should use a preoperative verification process to confirm, with the patient, the intended procedure to be performed.

There are several resources available to promote this verification process. The Joint Commission developed the Universal Protocol and associated “Speak Up” program to address this issue. It is designed to ensure correct person, correct site, and correct procedure through the elements of a preprocedure verification process, marking the procedure site, and performing a “time-out” before starting the procedure. The World Health Organization’s Safe Surgery Saves Lives program, endorsed by the International Federation of Gynecology and Obstetrics (FIGO), has recently been shown to significantly reduce surgical morbidity and mortality in multiple settings (7). It is a 19-item safe surgery checklist that includes a sign-in procedure before induction of anesthesia, a time-out procedure before skin incision, and a sign-out procedure before the patient leaves the operating room. Universal application of these techniques should be strongly advocated for and practiced by all obstetrician–gynecologists as proven methods to improve the safety of our patients in the operating room.

IV. Improve communication with health care providers
Communication between all members of the health care team is a crucial element in patient safety. In its analysis of sentinel events, the Joint Commission found that almost two thirds of the events involved communication failure as a root cause (8). Training in teamwork and communication techniques is increasingly being recognized as a cornerstone of a robust patient safety program; AHRQ developed the TeamSTEPPSTM program to address this issue (9).

One key communication tool that it advocates is SBAR—Situation, Background, Assessment, and Recommendation or Request. It is a structured system to communicate critical information clearly and efficiently. It allows caregivers to provide information on what is happening to the patient, what the clinical background is, what they think the problem is, and what they would recommend or what action is being requested. This information can then be appropriately understood and acted upon.

A time of great potential for miscommunication is during patient handoffs. This occurs during shift changes for nurses, laborists, or practice partners. The Joint Commission states: “The primary objec-
tive of a handoff is to provide accurate information about a patient’s care, treatment and services, current condition, and any recent or anticipated changes. The information communicated during a handoff must be accurate to meet patient safety goals” (10). TeamSTEPPS™ includes a structured technique for handoffs, which may facilitate the transmission of clinical and patient safety information in a way that prevents the omission of critical aspects of the treatment plan.

An increased awareness of the importance of clear communication between all members of the health care team will measurably enhance the safety of the care delivered by obstetrician–gynecologists. Training around these issues for all health care providers is highly recommended.

V. Improve communication with patients

Communication is a core element of the physician–patient relationship and is essential for the delivery of high quality, safe patient care. According to the Code of Professional Ethics of the American College of Obstetricians and Gynecologists, “the patient–physician relationship has an ethical basis and is built on confidentiality, trust, and honesty” (11). It also states “the obstetrician–gynecologist should deal honestly with patients and colleagues. Communication should be complete, clear, concise, and timely” (12). To be prepared for occurrences of adverse events, ACOG encourages the development and use of written policies that address the timing, content, communication, and documentation of disclosure. The American College of Obstetricians and Gynecologists believes that it is the moral obligation of every physician to communicate honestly with patients, particularly those who experience an adverse outcome. Open communication and transparency in health care will increase trust, improve patient satisfaction, and may decrease liability exposure (13).

VI. Establish a partnership with patients to improve safety

Patients who are involved in making their health care decisions have better outcomes than those who are not (14). According to the ACOG Committee Opinion, Informed Consent, the “involvement of patients in decisions about their own medical care” is good for their health—not only because it is a protection against treatment that patients might consider harmful, but because it contributes positively to their well-being” (15). Patients should be encouraged to ask questions about medical procedures, the medications they are taking, and any other aspect of their care. Patient education materials developed by ACOG and other organizations are available.

VII. Make safety a priority in every aspect of practice

The discipline of obstetrics and gynecology has a long tradition of leadership in quality assessment activities, which have been associated with an increase in patient safety. The quest for patient safety is an ongoing, continuously refined process incorporating information sharing and collaboration into daily practice. Emphasizing compassion, communication, and patient-focused care will aid in creating a culture of excellence. Opportunities to improve patient safety should be used whenever identified.

References


**Additional Resources**


