Maternal Safety Bundle
Support for Patients, Families, Staff

Bereavement Resources for Patients, Families, Staff

A Mother's Memory, Bereavement and Advanced Care Planning Services:
www.bereavementservices.org/maternaldeath
www.amazon.co.uk/Mothers-Memory-Book-Record-Family/dp/184786547X#reader_184786547X

Rights of the Bereaved Tip Sheet:

"Resolve Through Sharing":
www.bereavementservices.org

University of Missouri Second Victim Provider Support Program:
www.muhealth.org/secondvictim

Resources from AHRQ Website:

Toolkit for Staff Support (Link from AHRQ Website):
www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html

"Taking Its Toll": The Challenges of Working in Fetal Medicine
Author(s): Melody A. Menezes, PhD; Jan M. Hodgson, PhD; Margaret Sahhar, BA; Sylvia A. Metcalfe, PhD

Acute Grief and Mourning: One Obstetrician’s Experience
Author(s): Ronald A. Chez, MD
Maternal Safety Bundle
Tool for Staff after Severe Morbidity or Maternal Death

Step 1 Clinical Care:
- Assure patient stability
- Call for support for care of other patients & provider support (colleagues and leadership)
- Call for patient/family support and comfort (social worker, clergy, other staff member)

Step 2a Plan Initial Patient/Family Meeting:

Gather the Facts and Debrief:
- Review all medical records
- Review with other health care providers who were involved
- Clarify and understand the facts
- Avoid speculation and blame
- Assess cultural/religious practices and prep team

Who Should Attend the Meeting:
- Patient and patient approved family members
- Other health care providers directly involved
- Skilled communicators, if needed
- Non-family member translator
- Meet any special needs of your patient
- Decide who will lead the discussion

Location of Meeting:
- Set the time and place for the meeting as soon as possible
- Choose a setting where you can meet face to face, seated
- Find a comfortable environment with confidentiality/privacy
MATERNAL SAFETY BUNDLE

Tool for Staff after Severe Morbidity or Maternal Death

STEP 2b PLANNING WHAT TO SAY:

ORGANIZE YOUR THOUGHTS AND CONSIDER HOW YOU WILL:

☐ Manage your own emotions (but don’t be afraid to show sorrow)
☐ Acknowledge that something unexpected has happened
☐ Express your concern and regret
☐ Respond to your patient’s emotional reactions
☐ Respond to questions your patient is likely to ask
☐ Explain the process for any analysis of the adverse event

STEP 3 INITIAL PATIENT/FAMILY MEETING:

DURING MEETING:

☐ Find out what your patient/family already knows
☐ Acknowledge patient suffering and convey empathy
☐ Set agenda for the meeting
☐ Present the existing facts
☐ Describe clinical condition as it now exists
☐ Describe any future care requirements
☐ Express your concern and regret as appropriate
☐ Try not to overload with too much information
☐ Repeat key aspects, if needed
☐ Communicate in a clear, sensitive, and empathetic manner
☐ Welcome note taking, support persons, and questions
☐ Discuss how seriously you are taking the situation

END OF MEETING:

☐ Confirm the clinical next steps
☐ Summarize the discussion
☐ Test for understanding of information with open-ended questions
☐ Define what the next steps will be in process
☐ Answer any questions about how/why the event occurred
☐ Provide contact information
☐ Arrange a follow-up meeting
MATERNAL SAFETY BUNDLE

Tool for Staff after Severe Morbidity or Maternal Death

STEP 4 FOLLOW UP AND RECOVERY:

PATIENT/FAMILY:
- Keep patient and family aware of patient condition
- Continue to provide clinical and emotional support
- Ask what resources patient/family is using
- Provide resources for patient/family (religious, social, cultural as needed)
- Convey newly uncovered facts to your patient
- Discuss what steps have been taken to prevent similar harm
- Provide a further expression of regret

PROVIDERS:
- Inform Risk Management
- Inform primary providers of patient condition
- Arrange appropriate emotional support for all those involved
- Document the clinical care and discussions in a factual way

Modified from:
- Obstetric Communication Response Team (OCRT) Checklist, Montefiore Medical Center, 2014