National Maternal Safety Initiative – A Primer

Background: the Need

Rates of severe maternal morbidity and maternal mortality in the United States are increasing and are now at levels at least twice as those seen in Western Europe. In recent years, there has been a steady rise in the number of women with chronic conditions, obesity, advanced maternal age, and medical interventions. Recent safety research demonstrates that when there is a lack of consistent protocols for diagnosis, management, consultation, or referral of complicated cases, less optimal patient outcomes may result. The most common preventable conditions resulting in severe maternal morbidity or mortality are obstetric hemorrhage, severe hypertension, and venous thromboembolism. In recent case reviews, a significant proportion of morbidity and mortality in these conditions has been found to be due to missed opportunities to improve outcomes. A major challenge in maternity care is effectively identifying women who are in need of advanced care while simultaneously recognizing and not over-intervening in lower risk cases. Surveys in the United States have also noted a lack of systems based internal case reviews to improve care for high risk women and a lack of support materials for women, families, and staff experiencing severe maternal complications.

Addressing the Need

To address these mounting issues, the National Maternal Safety Initiative was formed. The initiative is a multi-stakeholder consensus effort and is comprised of representatives from organizations in women’s health care and other provider, state, federal, and regulatory bodies. The primary work products of this initiative are Patient Safety Bundles – small, straightforward sets of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes. These Patient Safety Bundles are not meant to introduce new guidelines but rather organize existing evidence-based materials in ways that facilitate implementation within birthing facilities. The bundles will enumerate what a birth facility should have and provide examples to be modified for the circumstances of the facility. For example, this initiative will endorse that every hospital has “A” hemorrhage evaluation and management protocol but not establish “THE” national protocol.

The Council on Patient Safety in Women’s Health Care (the Council) proposes to support the further development and implementation of Patient Safety Bundles for obstetric hemorrhage, severe hypertension in pregnancy, and venous thromboembolism prevention in pregnancy.

Additionally, supporting documentation has been created to address the following areas of further concern related to maternal mortality and morbidity. These are supplemental bundles that facilities can choose to implement in addition to the core Patient Safety Bundles listed above.

- **Maternal Early Warning Criteria** – Criteria to identify maternal patients who require urgent bedside evaluation
- **Facility Review** – Case review packages for facility-based, mini-root cause analysis for use in all cases of severe maternal morbidity and mortality
- **Staff and Family Support** – Recommendations for support of patients, families, and staff who experience a severe maternal event

**Goal: Three Bundles, Three Years**

The goal of the National Maternal Safety Initiative is for every birthing facility in the United States to have the three designated core Patient Safety Bundles implemented within their facility within three
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years. The bundles will be rolled out consecutively, beginning with obstetric hemorrhage and advancing to the other areas. To support this national effort, publications are underway in peer reviewed journals. The first article, as an editorial call to action⁷, appears in the October 2013 issue of Obstetrics & Gynecology, the official publication of the American College of Obstetricians and Gynecologists.

Measuring Impact and Success

Success of the initiative will be measured in a variety of ways. Through the use of an interactive website the initiative will harness the ability to effectively track the implementation of the bundles at facilities throughout the United States. In addition, several large state-wide maternal quality improvement collaboratives will be tracking population-level severe maternal morbidity and mortality outcome metrics.

Organizational Asks: Endorsement

Stakeholder organizations engaged in the work of the Council and the National Maternal Safety Initiative are being asked to endorse the process, not an individual protocol or guideline. However, organizations will have input into the content contained within each of the Patient Safety Bundles.

Official endorsement of the process of the National Maternal Safety Initiative involves a commitment to perform the following functions:

- Review publications and informational materials of the initiative and add the endorsing organization’s logo to the work products of the initiative
- Publish the approved safety bundles and other appropriate key work products of the initiative in the endorsing organization’s peer reviewed journal
- Assist with the promotion and dissemination of the work of the initiative to the endorsing organization’s membership
- Maintain, as necessary, secure status of manuscripts prior to publication
- Provide timely feedback timely to the Council on work products of the initiative

⁴ Callaghan, W. Severe Maternal Morbidity Among Delivery and Postpartum Hospitalizations in the United States. Obstetrics & Gynecology 2012; 120: 1029-1037