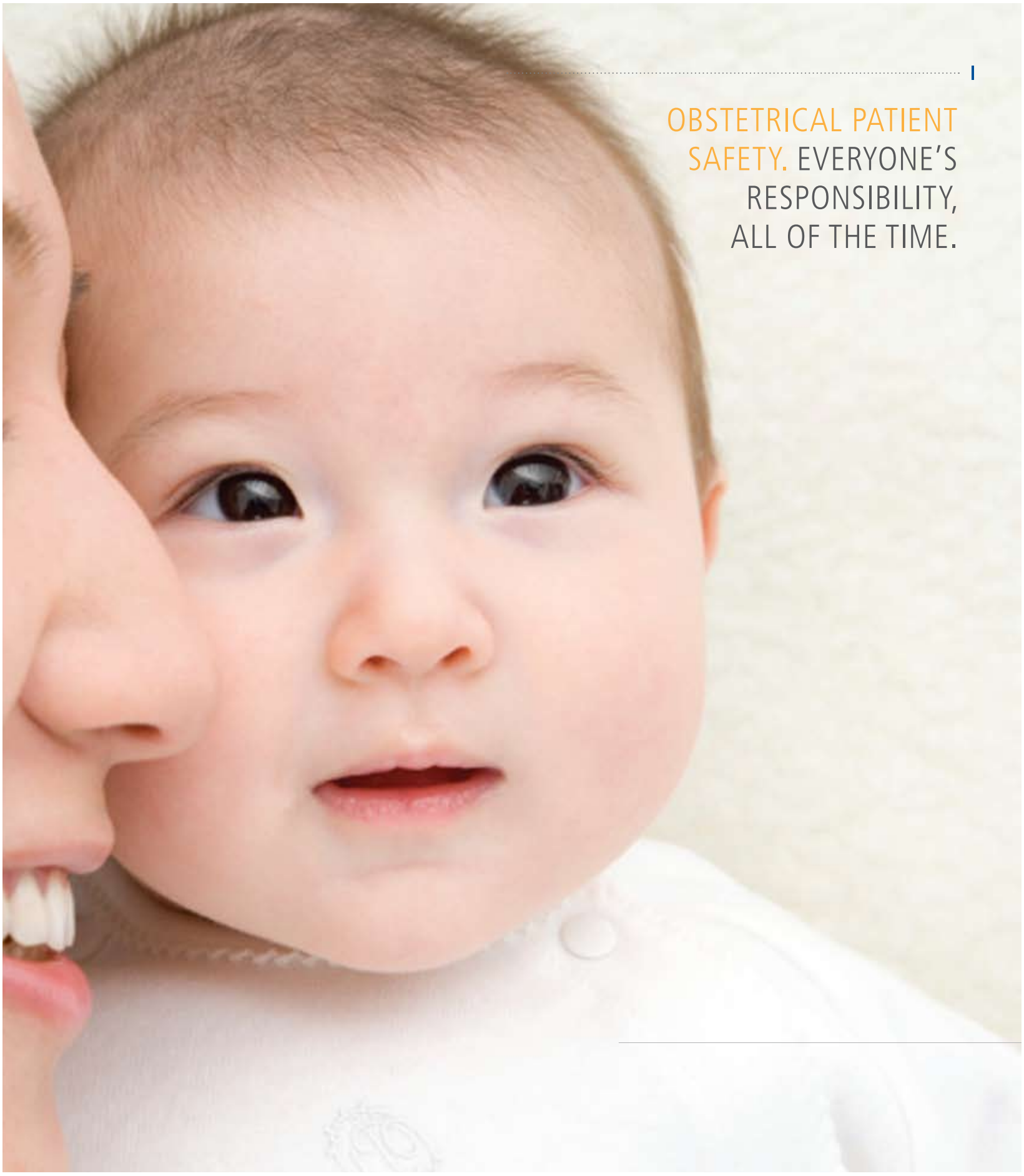
THE **MORE**[OB] PROGRAM

Salus Global Corporation



MOREOB
Taking care of life

Clinical error in obstetrical care is a serious problem and has a tremendous impact on families, healthcare providers, society and governments. These errors can lead to poor outcomes for patients and their babies, which can be devastating to family members.

An environment of system problems, poor communication and threat of litigation puts healthcare providers under a tremendous amount of stress leading to high turnover rates and their withdrawal from practice and care in obstetrics.

MORE OB

MOREOB (Managing Obstetrical Risk Efficiently) is a comprehensive patient safety improvement, and professional development program for caregivers and administrators in hospital obstetrical units.

The **MORE**OB program builds and sustains a culture of safety by developing the knowledge, skills, attitudes, behaviors and practices that make patient safety the number one priority.

MOREOB is a program formed as a result of the common interest in patient safety of the Society of Obstetricians and Gynaecologists of Canada and the Healthcare Insurance Reciprocal of Canada. **Salus Global Corporation** was formed to provide the opportunity for these two organizations to bring together their commitment and dedication to work together towards a safer healthcare system. **Salus Global Corporation** delivers the **MORE**OB program and enables greater patient safety performance by healthcare professionals and the teams they work with through the delivery of high-quality patient safety programs.

VISION

Patient safety is the guiding principal.

GOALS

- Maintain and apply an evidence-based body of current knowledge
- Perform fundamental skills confidently and automatically
- Manage emergencies in an automatic and well-coordinated fashion
- Communicate and work effectively as a collaborative, interprofessional community of practice in partnership with the patient and the family to promote safe care
- Use interprofessional reflective learning to evaluate processes and outcomes of clinical practice and organizational systems
- Be vigilant, and anticipate potential safety risks
- Modify care practices and organizational systems to reduce safety risks and prevent harm

The **MORE**[OB] program focuses on the following key elements to foster an environment of safety:

CULTURE

MORE[OB] focuses on, not only educating individuals, but also on invoking a cultural change. The goal is to ensure new skills in patient safety become a part of everyday practice. The program allows the unit to identify gaps, which impede the building and sustaining of a patient safety culture, and monitor success over time.

COMMUNICATION

Ineffective communication is the most frequently cited category of root causes of sentinel events, therefore, improving communication is an important element found throughout **MORE**[OB] activities. **MORE**[OB] also guides and supports teams in their implementation of specific communication tools.

COLLABORATION

MORE[OB] facilitates building a shared body of knowledge among disciplines that is evidence based and current through core clinical content chapters. Participants are given an opportunity to consolidate their knowledge in an environment that emphasizes team-building and a community of practice approach.

TEAMWORK

Since patient safety cannot be addressed on an individual level alone, teamwork is essential in developing a safer work environment. Rehearsal and preparation for emergency situations and fundamental skills will help caregivers understand both their own role and the roles of others so that team response is automatic and well-coordinated.

REFLECTIVE LEARNING

It is important, not only to practice necessary skills, but also to review any areas for growth. **MORE**[OB] will encourage event review to determine areas for improvement and to determine solutions to prevent future occurrences.

SYSTEM IMPROVEMENTS

MORE[OB] focuses on the system as a whole. Reviews of systems are performed. The purpose of the reviews are to problem solve, determine root causes, identify system failures and make recommendations to prevent recurrence.

MODULE 1

Learning Together

Learning Together is essential to ensure that everyone has the same background knowledge and information to prepare to work more effectively as a team. During this phase, caregivers begin to learn core content individually, as well as attend valuable workshops as a team. This Module develops a foundation of trust and respect.

The following are some of the activities from Module 1:

CORE CONTENT CHAPTERS

- **14 Clinical Topics + 2 Non-Clinical**

SKILLS DRILLS

- **Forceps**
- **Vacuum**
- **Shoulder Dystocia**

WORKSHOP/ OBJECTIVE STRUCTURED CONSOLIDATION OF EDUCATION (OSCE)

- **Management of Labor**
- **Fetal Well-Being**
- **Assisted Vaginal Birth**
- **Breech and Shoulder Dystocia**

THE **MORE**^{OB} PROGRAM IS SPREAD OUT OVER A 3 YEAR PERIOD.

MODULE 2

Working Together

Working Together builds on **Learning Together**. In addition to building on a common knowledge base from the first module, caregivers also work together to practice emergency drills. This will ensure that team response is well coordinated. Adding to the foundation of trust and respect developed in Module 1, communication and teamwork tools are provided at this stage to help foster a more efficient communication environment.

The following are some of the activities from Module 2:

CORE CONTENT CHAPTERS

+ 4 TOPICS

SKILLS DRILLS

WORKSHOP/OSCE-MANY TOPICS TO CHOSE FROM

EMERGENCY DRILLS

Fetal Bradycardia

Vaginal Breech Delivery

Cord Prolapse

Postpartum Hemorrhage

Shoulder Dystocia

Twins

COMMUNICATION AND TEAMWORK

14 tools

AUDIT

Module 3

Changing Culture

This phase is about solidifying the elements of the previous two phases. It takes time to evolve culture and constant evaluation, reflection and learning are necessary for growth. No Harm Event multidisciplinary reviews are performed using Root Cause Analysis. The team begins to develop recommendations in **Module 2** (from Emergency Drills, Audits, and their workshops and OSCE's), they now make these recommendations robust using Failure Mode and Effects Analysis. At the end of this module a review of the program's impact takes place and recommendations are made for further improvements.

The following are some of the activities from Module 3:

CORE CONTENT CHAPTERS

+ 7 TOPICS

TOPICS

SKILLS DRILLS

WORKSHOP/OSCE

EMERGENCY DRILLS

COMMUNICATION AND TEAMWORK

AUDITS

EVENT REVIEW

RCA (ROOT CAUSE ANALYSIS)

FAILURE MODE AND EFFECT ANALYSIS (FMEA)

Achievements

MORE^{OB} was found to improve outcomes in the following areas (statistically significant):

- Reduced NICU admissions[1]
- Reduced length of time of infants on ventilation[1]
- Reduced severe infant morbidity (respiratory distress; bacterial sepsis; omphalitis; cerebral, intraventricular or subarachnoid hemorrhage due to birth injury; intracranial non-traumatic hemorrhage)[1]
- Reduced maternal tears/ lacerations and length of stay[1]
- Higher risk deliveries diverted to higher level of care hospitals[1]
- Increase in core clinical knowledge for all participants in all hospital care levels[2]
- Improved and sustained patient safety culture[2]
- Decrease in liability incurred costs and average cost per claim[2]

In addition hospitals have reported the following:

- Reduced admissions for latent stage of labor
- Reduced elective inductions
- Reduced time from admission to induction
- Reduced PPH
- Reduced neonatal sepsis
- Improved management of shoulder dystocia
- Reduced brachial plexus injury
- Improved patient satisfaction and/or fewer complaints
- Improved job satisfaction
- Reduction in harm and no harm events
- Improvement in the standardization and consistency of care practices

1. Frick, C. et al. (2009, June). Outcomes Following Province-Wide Implementation of the Managing Obstetrical Risk Efficiently (MORE^{OB}) Program in Alberta. Poster Presentation SOGC ACM Halifax, NS

2. Data on file

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