

## READINESS

### *Every unit*

- Develop a unit-based protocol that includes resources for supporting patients, their families (including non-family support), and staff after a severe maternal event
- Establish a facility-based multidisciplinary response team that integrates clinical staff and mental health professionals
- Provide unit education on protocols and conduct unit-based drills (with post-drill debriefs) on patient, family, and staff support after a severe maternal event
- Develop a unit culture where patients, families, and staff are informed about potential risk factors and are encouraged to speak up when they feel concern for patient well-being and safety

## RECOGNITION

### *Every patient, family, and staff member*

- Perform timely assessment of emotional and mental health status of patients, their families, and staff during and after a severe maternal event
- Build capacity among staff to recognize signs of acute stress disorder in patients, their families, and staff after a severe maternal event

## RESPONSE

### *Every severe maternal event*

- Provide timely and effective interventions to patients, their families, and staff during and after a severe maternal event
- Communicate a woman's condition with the patient and her family, when appropriate, after a severe maternal event
- Offer support and resources to patients, their families, and staff after a severe maternal event

# Patient, Family, and Staff Support after a Severe Maternal Event

Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women's Health Care disseminates patient safety bundles to help facilitate the standardization process. This bundle reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Although the components of a particular bundle may be adapted to local resources, standardization within an institution is strongly encouraged.

The Council on Patient Safety in Women's Health Care is a broad consortium of organizations across the spectrum of women's health for the promotion of safe health care for every woman.



# PATIENT SAFETY BUNDLE

## REPORTING/SYSTEMS LEARNING

### *Every unit*

- Establish a culture of huddles for high-risk patients and post-event debriefs to identify successes and opportunities for improvement
- Conduct a multidisciplinary review of severe maternal morbidity events for systems issues, to include patient perspectives where feasible
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

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October 2015

For more information visit the Council's website at [www.safehealthcareforeverywoman.org](http://www.safehealthcareforeverywoman.org)