Perinatal mortality and morbidity audit in a Dutch teaching hospital

4 years of multidisciplinary improvement of care

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CONCLUSION

The perinatal mortality and morbidity audit improves obstetric care at our hospital by:

1. Increasing awareness among caregivers on specific problems pertaining to obstetric care.
2. Leading to concrete improvements in our system of care based on the findings in the audit.
3. A greater sense of interdisciplinary collaboration and understanding amongst caregivers.

BACKGROUND

- The perinatal audit was initiated in 2010, predominantly because birth outcomes in the Netherlands lagged behind in comparison to most other Western-European countries.
- This mandatory national program was a strategy to systematically identify substandard care factors (SSF).
- An SSF is any factor in which care was not delivered in accordance with professional requirements for good clinical practice, national guidelines or local protocols.
- After identification of SSF's in a dedicated perinatal audit meeting, improvements in obstetric care are made based a Plan-Do-Check-Act-cycle.

RESULTS

Most important challenges:

Lack of time to conduct an in-depth investigation of underlying causes of SSF's

Smaller sense of urgency to make changes in care amongst those who are not present at the audit meetings

Changes in health care personnel over time

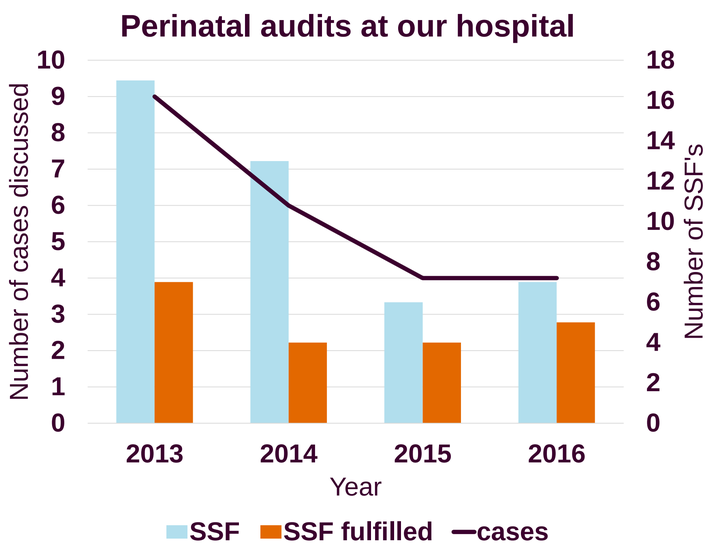
Most important success factors:

Perseverance of a dedicated audit team

Reaching out via e-mail to those not present at the audit meeting, informing them about the outcomes

Figure 3. *Challenges and success factors in the organization of the perinatal audit.*

RESULTS



Categories of SSF's

Lack of interdisciplinary collaboration, such as differences in protocols on prolonged ruptures of the membranes

Barriers in the health care organization, such as difficulties in reaching an emergency phone number

Lack of knowledge, such as on the correct description of fetal heart monitoring

Care improvements

Improvement of existing protocols and development of new ones

Team trainings, such as on obstetric emergencies

'Heads-up' to all caregivers, for example on the need for adequate documentation in patient notes

Figure 1. *Overview of the number of cases discussed, substandard care factors (SSF's) found, and the number of SSF' for which an improvement had been implemented by the time of the next audit meeting. A total of 9 audit meetings took place. Another 22 concrete suggestions to further optimise care were made during the meetings, 50% of which were implemented. A description is shown of important categories of SSF's and care improvements. Data were derived from logbooks.*

METHODS

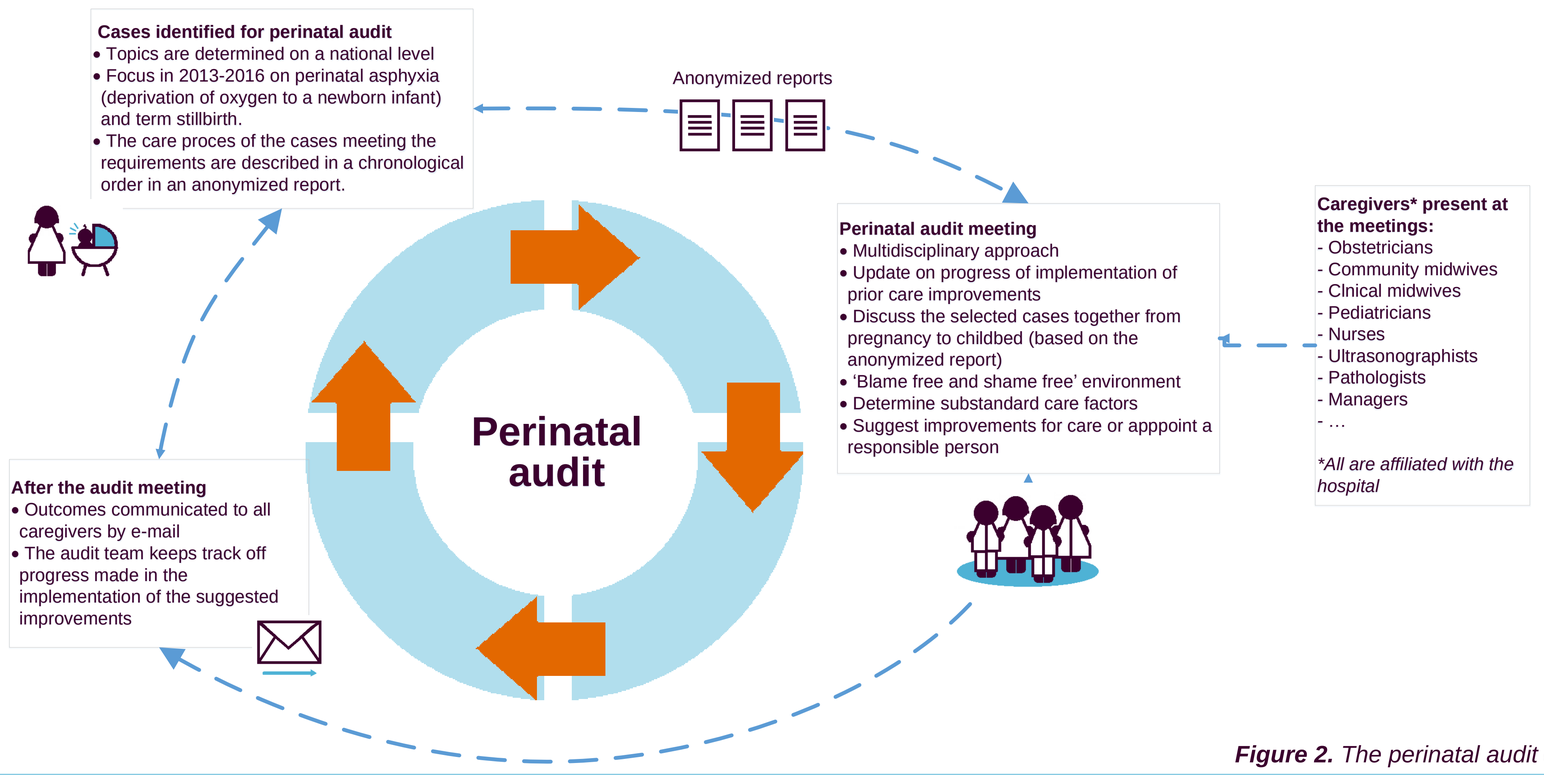


Figure 2. *The perinatal audit cycle*

DISCUSSION

- Any patient case (not necessarily severe illness or mortality) selected for an audit can help to identify factors in which patient care can be improved.
- The audit leads to a greater sense of interdisciplinary collaboration and understanding, due to the ability to reflect as a group on these often severe cases.
- The current perinatal audit topics (2017-2019) are perinatal asphyxia, preterm mortality, uterine rupture and babies with hyperbilirubinemia (jaundice)
- Choices are yet to be made regarding the possible role that patients could play in the perinatal audit.

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