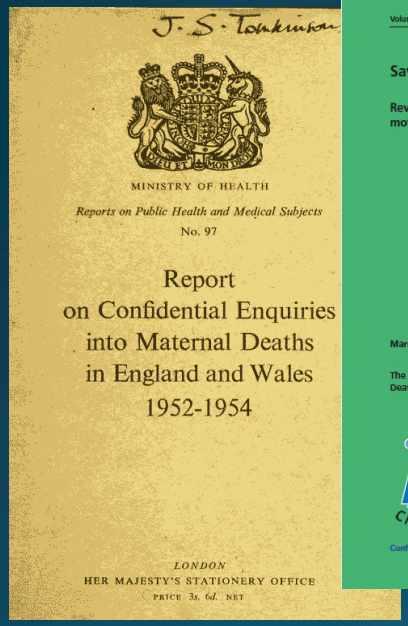
Enabling environments for successful maternal death and near-miss reviews

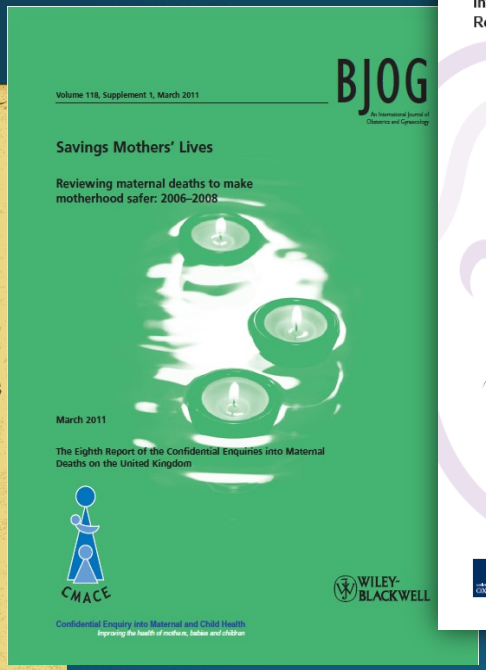
Prof Gwyneth Lewis OBE
Institute for Women's Health
University College London
Mexico 2015

1952-54



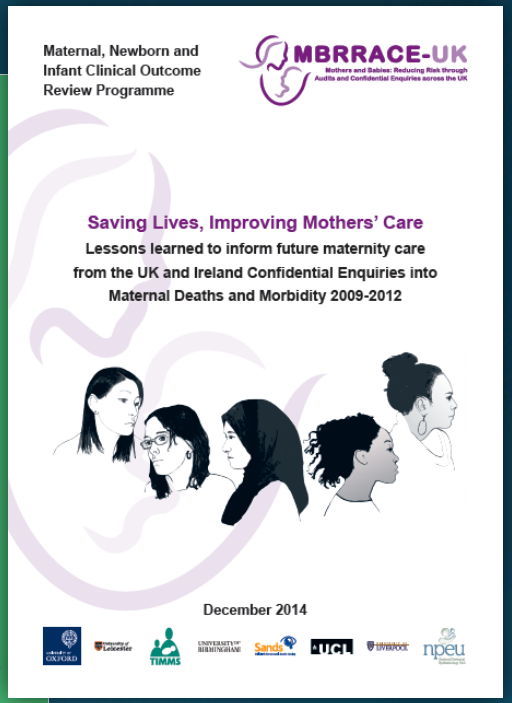
90 per 100,000 maternities

2006-08



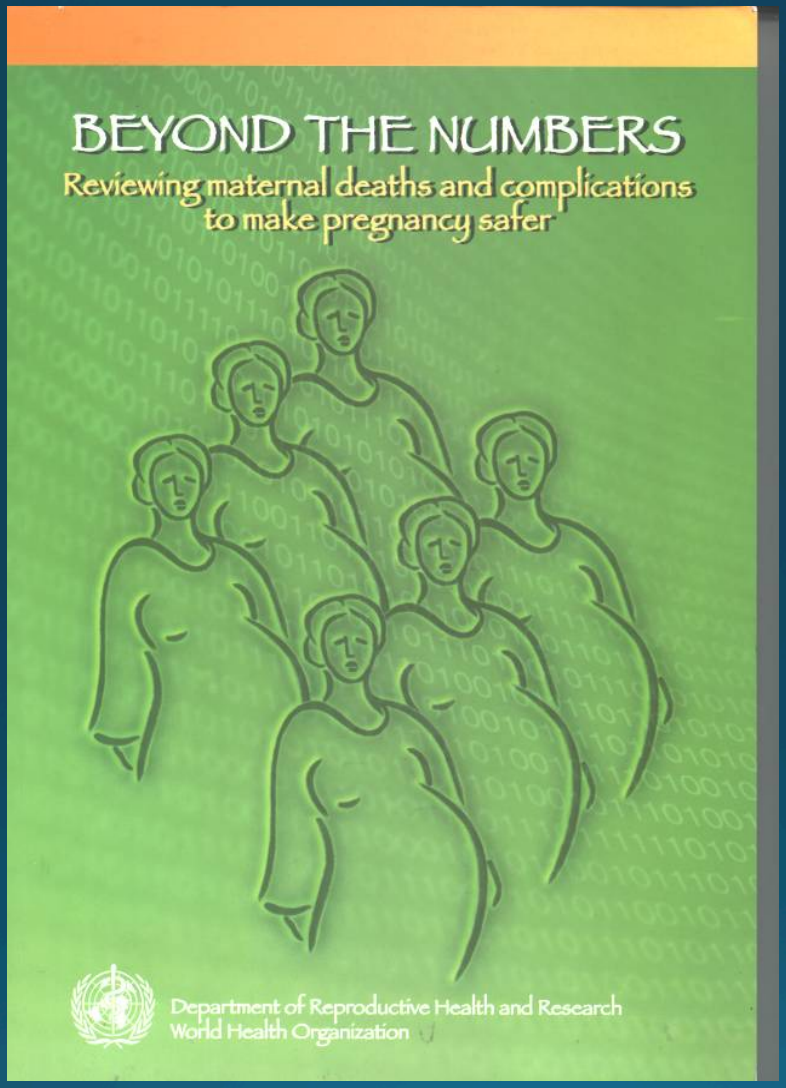
11 per 100,000 Maternities *

2009-12



10 per 100,000 Maternities *
Direct deaths 4

* UK definition Indirect deaths include suicides, hormone dependant malignancies etc


BEYOND THE NUMBERS
Reviewing maternal deaths and complications to make pregnancy safer
Department of Reproductive Health and Research
World Health Organization

The maternal mortality action cycle

The maternal mortality action cycle


16-29
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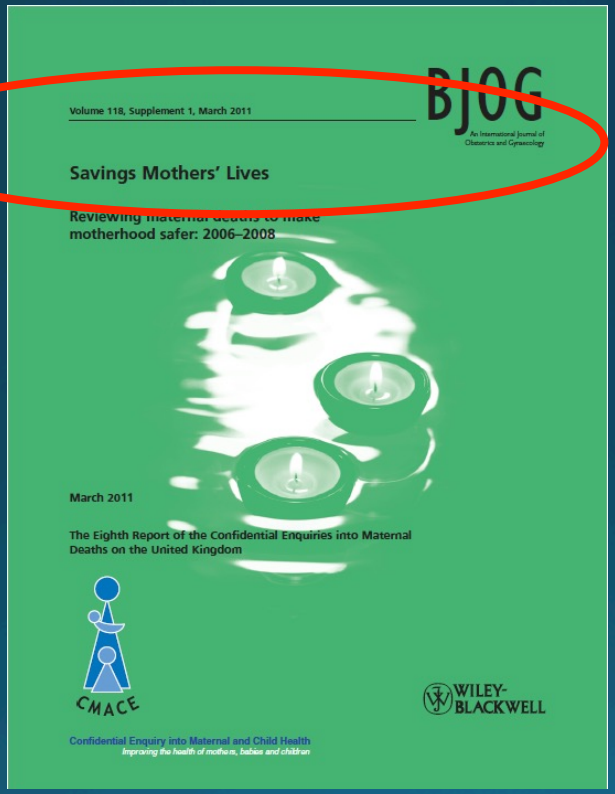
Saving Mothers Lives



Three enabling conditions

- Personal /cultural
- Institutional
- Policy /health system national levels

Three disabling conditions

- Personal /cultural : lack of understanding, no engagement, disenchantment
- Institutional : lack of action, fear of name, shame and blame
- Policy /health system national levels endless promises but lack of action, lack of interest, frequent staff changes, punitive and blaming, changes of policy

A tale of two English cities London & Rochdale 1928

MMR 80

MMR 900

Rochdale Maternal Death Review

MMR reduced from >900 per 100,000 pregnancies (1928)to 280 per 100,000 pregnancies (1934)

“It is important to note that the results were obtained by a change in spirit and method and without any substantial increase in public expenditure.”

Preparations and Appliances

INUNDATION WINDOW FOR CO-

Dr. F. A. HORT (Londo-

Any apparat-

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PUBLIC HEALTH.

Maternal Mortality and Public Opinion.

By ANDREW TOPPING, M.A., M.D., D.P.H., a Senior Medical Officer, London County Council.

In this paper, Dr. Topping brings under discussion a number of the chief factors operative in relation to maternal mortality, and assesses their influence and the possibility of making use of public opinion in combating them. The question of the extent to which public opinion can be employed in this connection is one of importance, and readers of Dr. Topping's paper, like those who had the privilege of hearing it when it was submitted at a meeting of the Maternity and Child Welfare Group, will find in his description of his experiences, and in the views expressed, many hints worthy of consideration for adoption.

THE death of a person long before the allotted span has been reached must always be a regrettable occurrence; where this death

of a swab. It is well known that the death-e
rate varies directly with the length of time
controls the

MATERNAL MORTALITY IN ROCHDALE

AN ACHIEVEMENT IN A BLACK AREA

BY

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AND

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l of the maternal mortality rate to respond enuous measures which have been directed within recent years has created widespread nt and disillusionment. For this reason it desirable that a study should be made of h a deliberate effort to recast the maternity followed by a dramatic fall in the death

of years the high average maternal tain towns in Lancashire and the West e have been a matter of public concern, they formed the subject of a special the Ministry of Health.[1] In Yorkshire wns with an average rate exceeding 5 per 1,000, and which were embraced within this official survey were Barnsley, Bradford, Dewsbury, Halifax, Huddersfield,

“A maternity conscience”


SERE

Maternity conscience

Health professionals have a duty:

- To keep up to date and practice evidence, based medicine.
- Stop harmful activities and question old traditions “ we have always done it this way”
- Regularly review and audit their work and ask what they can learn from cases, especially those which went badly
- Participate in all reviews and enquiries without fear
- Never be afraid to question
- Never put themselves above others or self-promote dangerous or ineffective practice

“fear is toxic to both safety and improvement”.

A promise to learn-a commitment to act. Improving the Safety of Patients in England. London: Department of Health; August 2013.

Ground rules

- We, the staff of the maternity, agree to respect the rules of good conduct during meetings reviewing cases in our facility:
  - Arrive on time to the audit meeting
  - Respect everyone's ideas and ways of expressing these
  - Respect the confidentiality of the discussions in the group
  - Participate actively to discussions
  - Accept discussion and disagreement without verbal violence
  - Agree not to hide useful information or falsify information which could allow the understanding of the audited case
  - Try (as much as possible as it is not easy) to accept that your own actions are questioned

Source: Burkina Faso CMA secteur 30


Mozambique


Moldova


Cameroon

Running a meeting

1. Short follow-up of actions decided on the last meeting – further action needed?
2. Meeting starts with a case summary
3. Case is reviewed, e.g. using the gate-to-gate approach: what went well, what went wrong?
4. Contributions are invited re: reasons why something went wrong
5. Team proposes actions to avoid future shortcomings
6. Minutes are written, specifying: who does What and When?

Clinical Guidelines

NICE guidelines

- Antenatal care
- Caesarean Section
- Intrapartum care
- Postnatal care
- Mental health
- Diabetes in pregnancy
- Socially complex pregnancies

Royal College of Obstetricians and Gynaecologists

Standards for Maternity Care

Report of a Working Party

Royal College *of* OBSTETRICIANS *and* GYNAECOLOGISTS

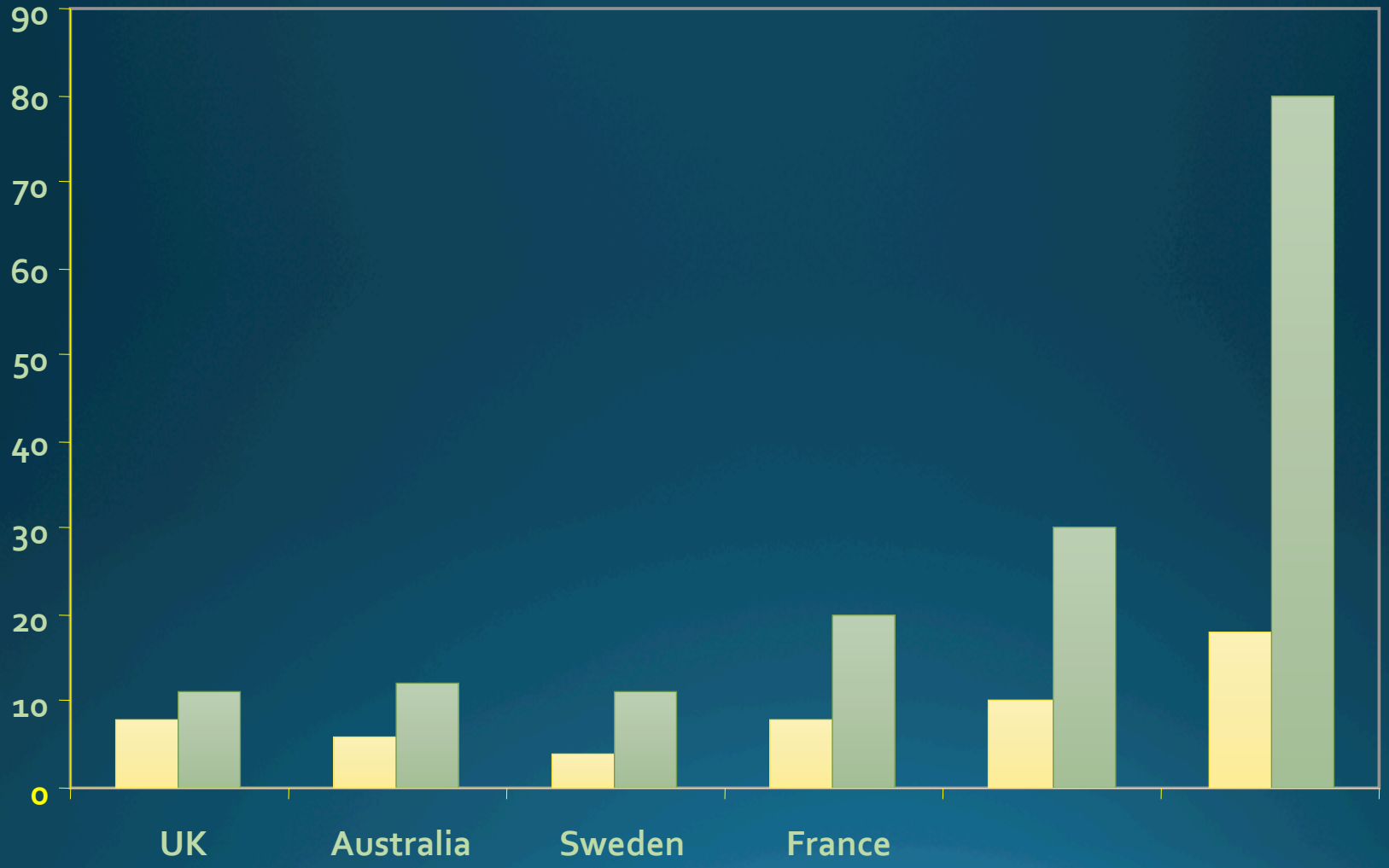
Royal College *of* MIDWIVES

Royal College *of* ANAESTHETISTS

Royal College *of* PAEDIATRICS *and* CHILD HEALTH

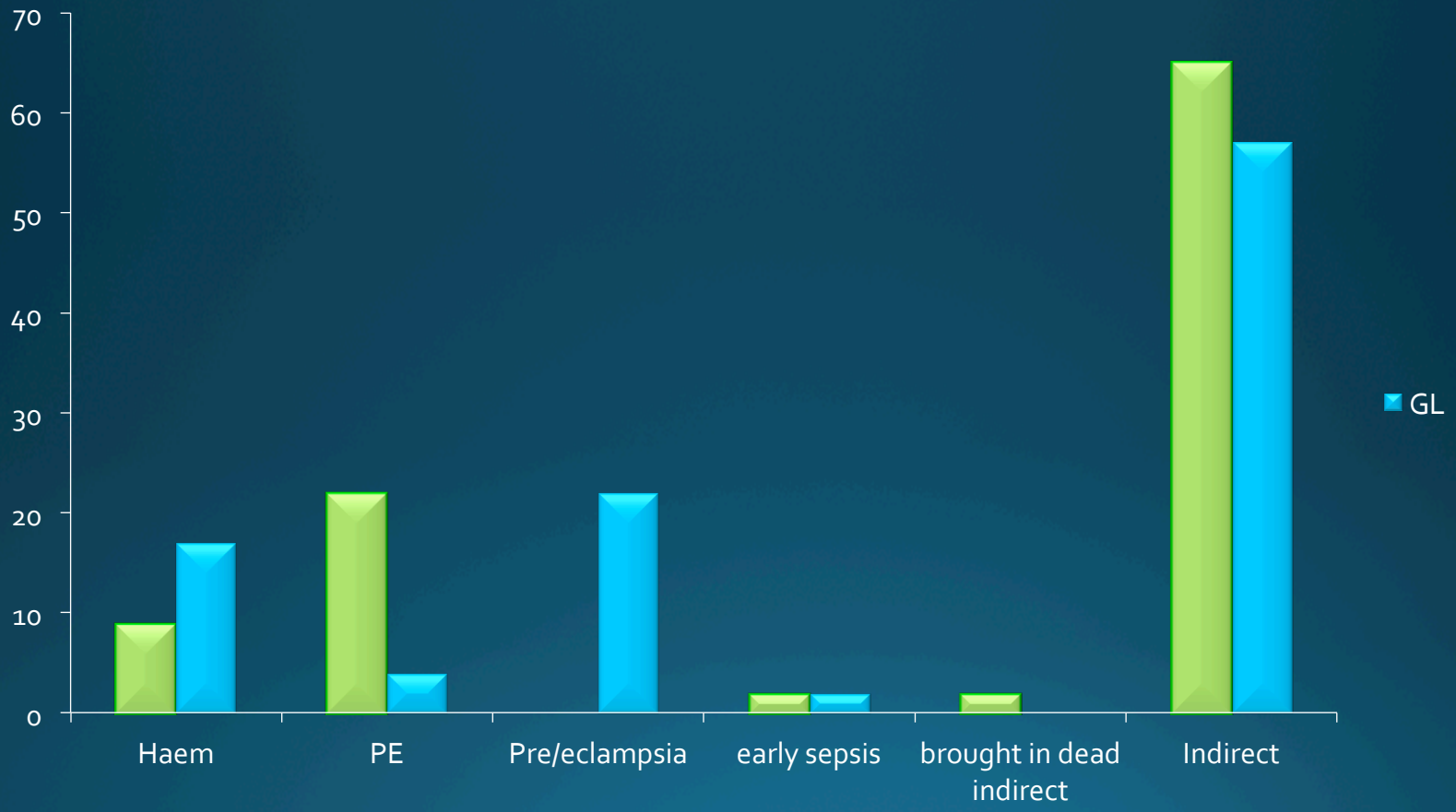
June 2008

Reported and accounted Maternal Mortality Ratios: surveillance and reviews

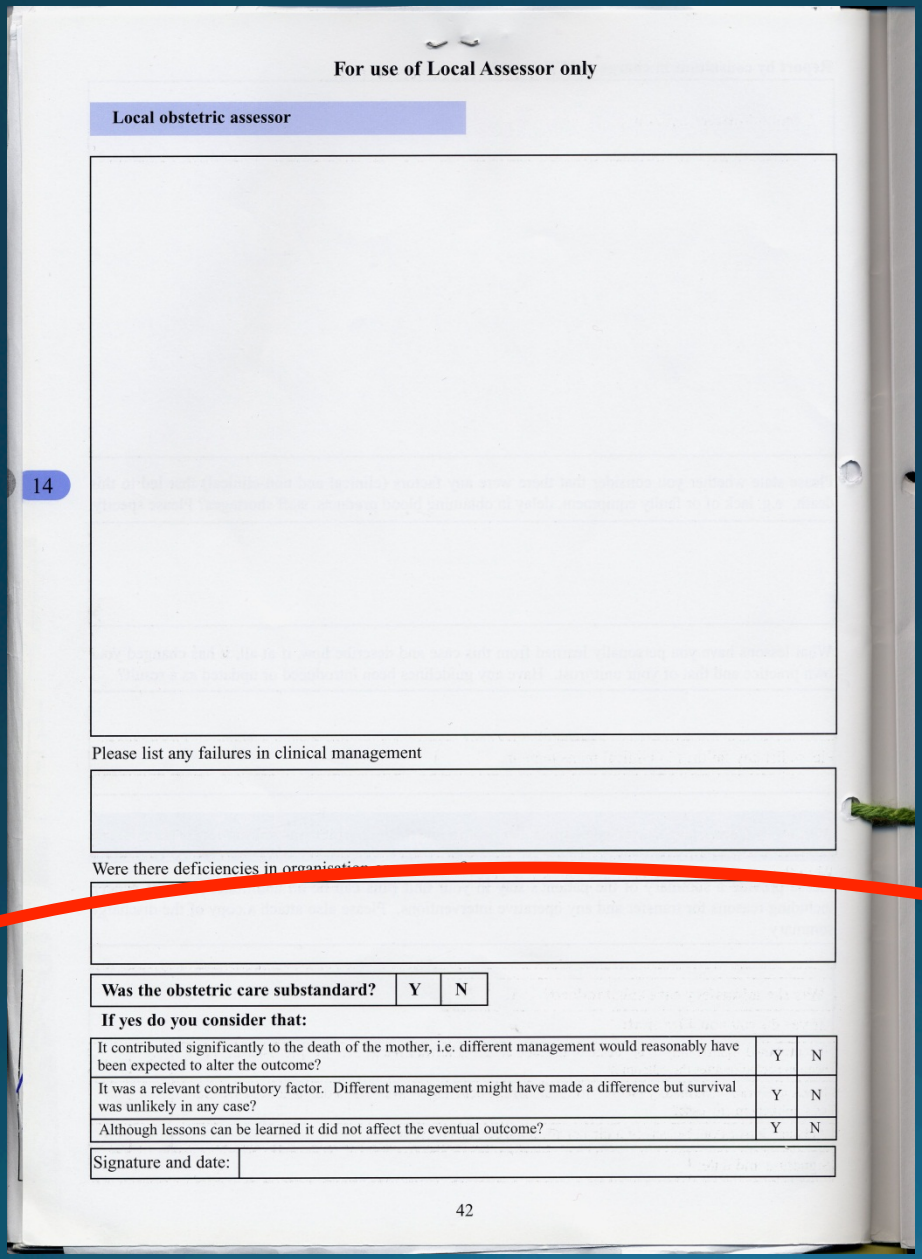


Lewis G in press

Maternal death classification 2009-10



Lewis G in press



For use of Local Assessor only

Local obstetric assessor

14

Please list any failures in clinical management

Were there deficiencies in organisation

Was the obstetric care substandard?	**Y**	**N**

If yes do you consider that:

It contributed significantly to the death of the mother, i.e. different management would reasonably have been expected to alter the outcome?	Y	N
It was a relevant contributory factor. Different management might have made a difference but survival was unlikely in any case?	Y	N
Although lessons can be learned it did not affect the eventual outcome?	Y	N

Signature and date:	

42

Anonymous forms

A promise to learn

"Because human error is normal and, by definition, unintended, well-intentioned people who make errors or who are supported in systems that have failed around them need to be supported, not punished, so they will report their mistakes and the system defects they observe so that all can learn from them".

A promise to learn-a commitment to act. Improving the Safety of Patients in England. London: Department of Health; August 2013.

Government ensured the legal process is separate

Legal

Court

Expert opinion

Case records

Enquiry

Why Mothers Die

Expert opinion

Enquiry Reports

A culture of success

- *Individual* responsibility and ownership
  - Professionalism
  - Fear of blame and punishment
  - Disillusionment through lack of action

- Proactive *institutional* ethos which promotes learning as a part of crucial part improving service and quality of care

- Supportive policy environment at *national/local* level

Key features of successful reviews

- Supported and owned by health professionals who understand the need for this
- No payment
- Sustainable
- Independent from legal process
- ”no names no blame”
- Understand human error
- Supported by local administrators/Ministries of Health
- Include all provides /public/private etc
- Wide dissemination and action on the results


A maternity conscience
Define cases
Identify and collect data
Assess data
Make recommen dations
Implement and refine
Supportive institutional behaviour
Supportive policy environment