Learning SBAR structure following incidents in Maternity Services

PURPOSE OF A LEARNING SBAR IN MATERNITY SERVICES

NORTH WEST MATERNAL MEDICINE NETWORK

Lancashire & South Cumbria
Cheshire & Merseyside
Greater Manchester

Clarity
Ensure that key information from the incident is shared concisely and that staff understand the lessons learned.

Action-Oriented
Focus on specific actions that need to be taken to improve patient safety.

Supportive Learning
Reinforce a culture of learning and improvement, rather than blame, and promote the application of best practices to prevent future incidents.

By using this SBAR format, maternity teams can communicate essential information effectively, promote shared understanding, and drive meaningful safety improvements

Here is how a Learning SBAR (Situation, Background, Assessment, Recommendation) might be structured for maternity services following an incident:

Situation

Briefly describe the incident that occurred in the maternity service.

Example: "A postpartum haemorrhage (PPH) occurred during a delivery, resulting in severe maternal blood loss. There was a delay in initiating the massive obstetric haemorrhage protocol leading to a deterioration in the patient's condition."

State the immediate impact or outcome:"The patient required emergency surgery and intensive care support. Fortunately, the patient is now stable, but the delay highlighted critical areas for review and improvement."

Background

Provide context for the incident.

Outline the relevant clinical situation: "The patient was admitted for induction of labour at 39 weeks due to gestational hypertension. Labour progressed without complications until delivery, when a PPH was identified."

Include any contributing factors identified:

Communication challenges between team members.

Delay in recognising the severity of the haemorrhage.

Issues accessing or activating the necessary emergency protocols in a timely manner.

Assessment

Analyse the factors that contributed to the incident and the learning points identified.

"The investigation revealed a lack of clarity in roles during emergencies, contributing to delays in protocol activation. Additionally, staff were unfamiliar with the new location of emergency blood supplies, and communication barriers hindered efficient decision-making."

Summarise what worked well and what needs improvement: "While the team successfully stabilised the patient, the response time and protocol adherence need to be addressed to ensure quicker intervention in the future."

Recommendation

Outline clear, actionable steps to address the issues.

Training and Drills: Regular multidisciplinary emergency simulations for obstetric emergencies, focusing on postpartum haemorrhage response and teamwork.

Protocol Review and Accessibility: Review and update the massive obstetric haemorrhage protocol to ensure clarity. Ensure all staff know the locations of emergency supplies and how to access them quickly.

Communication Improvements: Implement a structured communication tool, like SBAR, for critical situations. Consider having a "crisis leader" role during emergencies to coordinate and streamline communication.

Monitoring and Feedback: Regularly review adherence to protocols and provide feedback to staff. Create a system for continuous learning and reflection on emergency responses.