SAFE DELIVERY – A SWEDISH HEALTH SYSTEM INTERVENTION

Key words: delivery, asphyxia, intervention, patient safety, cost-effectiveness

Development/research project

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Background: In Sweden perinatal morbidity and mortality is very low and the standard of delivery care considered high. Despite this fact, medical malpractice occurs, resulting in severe asphyxia or death with great suffering for the family and considerable costs for the society. Of the total yearly budget for The Swedish Patient Insurance 20% goes to children who are severely asphyxiated at birth due to suboptimal care. Case records filed at the Swedish County council insurance company from patients asking for financial compensation because of suspected medical malpractice in connection with childbirth during 1990-2005 were scrutinised. Critical areas were identified and we concluded that there is a potential for improvements for a safer delivery at our maternity units.

Purpose: To further improve a safe delivery of the child and thus reduce avoidable perinatal damage

Method: A self-assessment on safety routines around delivery, based on previously identified risk areas ie organisation, communication, competence, technique, drug handling, documentation and follow up was conducted at the maternity unit. A selected group of senior obstetricians, neonatologists and midwives served as auditors. After the self-assessment the intervention process encompasses the following steps:

1. Site inspection by auditors 1-2 months after the completion of a self-assessment report
2. Written report from auditors after site-inspection
3. Written report on agreement of measures of improvements between auditors and management of maternity unit, one month after site inspection
4. Written report from maternity unit on measures of improvements taken, six months after agreement
5. Evaluation by auditors of report on measures taken in order to decide on financial incentive provided for the project
6. Written report from maternity unit on measures of improvements taken, one year after agreement
7. Offering of a web-based interactive educational program in fetal surveillance.

Results: All 46 maternity units in Sweden participate in the intervention. Over 90 auditors have made their audits and been given a report. A web-based CTG program for fetal surveillance has been launched in September 2009. Basal data and experiences from the process have been gathered and a scientific evaluation is ongoing.

Discussion/conclusion: It seems clear that the professional organisations posesses a great potential when collaborating on a national level. On a local level self assessment with peer-review is an efficient tool to improve awareness on patient safety and in creating new ideas. If the intervention, based on an interprofessional engagement, leads to an improved neonatal outcome, it will have a certain impact on public health, but it can also serve as a model for patient safety in other areas.