



Standardisation of interfacility transfer of critically ill maternity patients; Stakeholder analysis, Gemba walk and preliminary survey

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Introduction

Our maternity service currently caters for 7566 deliveries annually. Most patients are treated entirely on site. However, a small number of patients require transfer to a nearby general hospital to receive a higher level of care. In 2021, six patients required transfer to the intensive care unit (ICU) [1]. Loss of important information during transfers can lead to preventable medical errors. The use of a handover communication tool is advised by several guidelines internationally [2]. Currently, no such tool exists between our two sites. We aimed to obtain staff feedback on this process, before creating one.

Methods

A process map was formulated (Figure 1.) and a Gemba walk was carried out. A stakeholder analysis (Figure 2.) was performed. A qualitative questionnaire was distributed to the key stakeholder group. This quality improvement project received approval from our organisation's ethics committee. No source of funding was received for this project.

Results

The Gemba walk recorded feedback from staff involved in the transfer process. This included midwives, nurses, and doctors. Sixteen key stakeholders from both units responded to the qualitative questionnaire. This included directors of midwifery/nursing, consultants and junior doctors in obstetrics, anaesthesia, ICU, and neonatology. Eighty percent had previously been involved in a transfer. Forty-seven percent deemed the experience moderately stressful. All respondents agreed that the inclusion of team contact details from both hospitals would be beneficial.

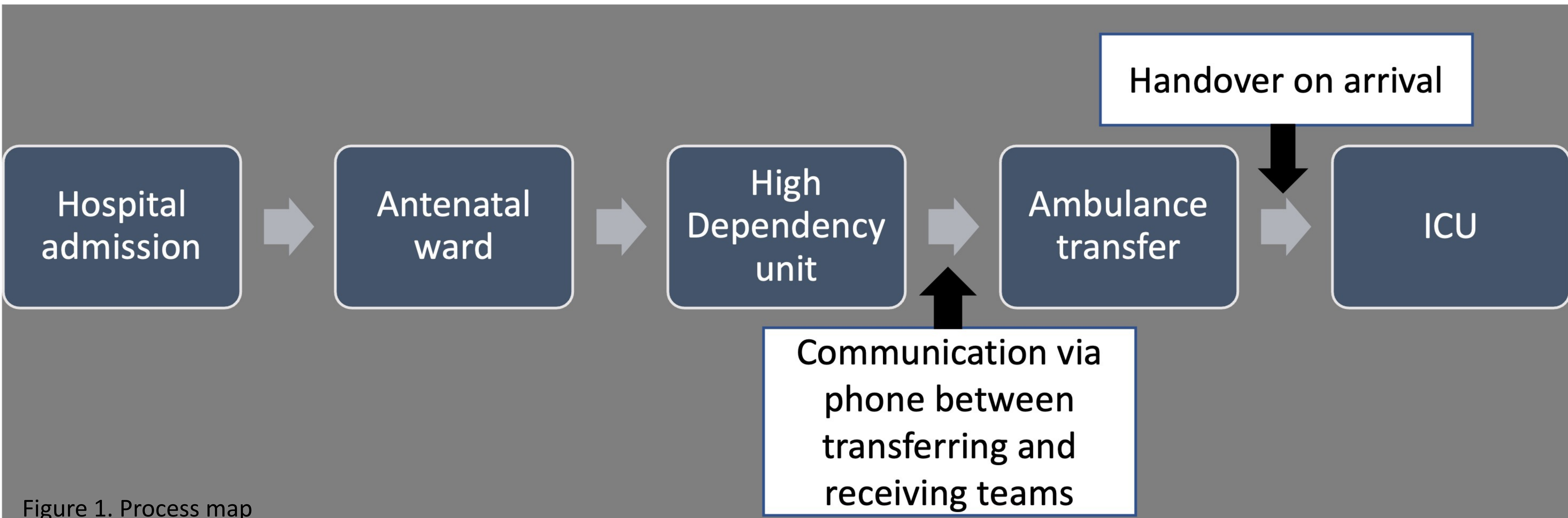


Figure 1. Process map

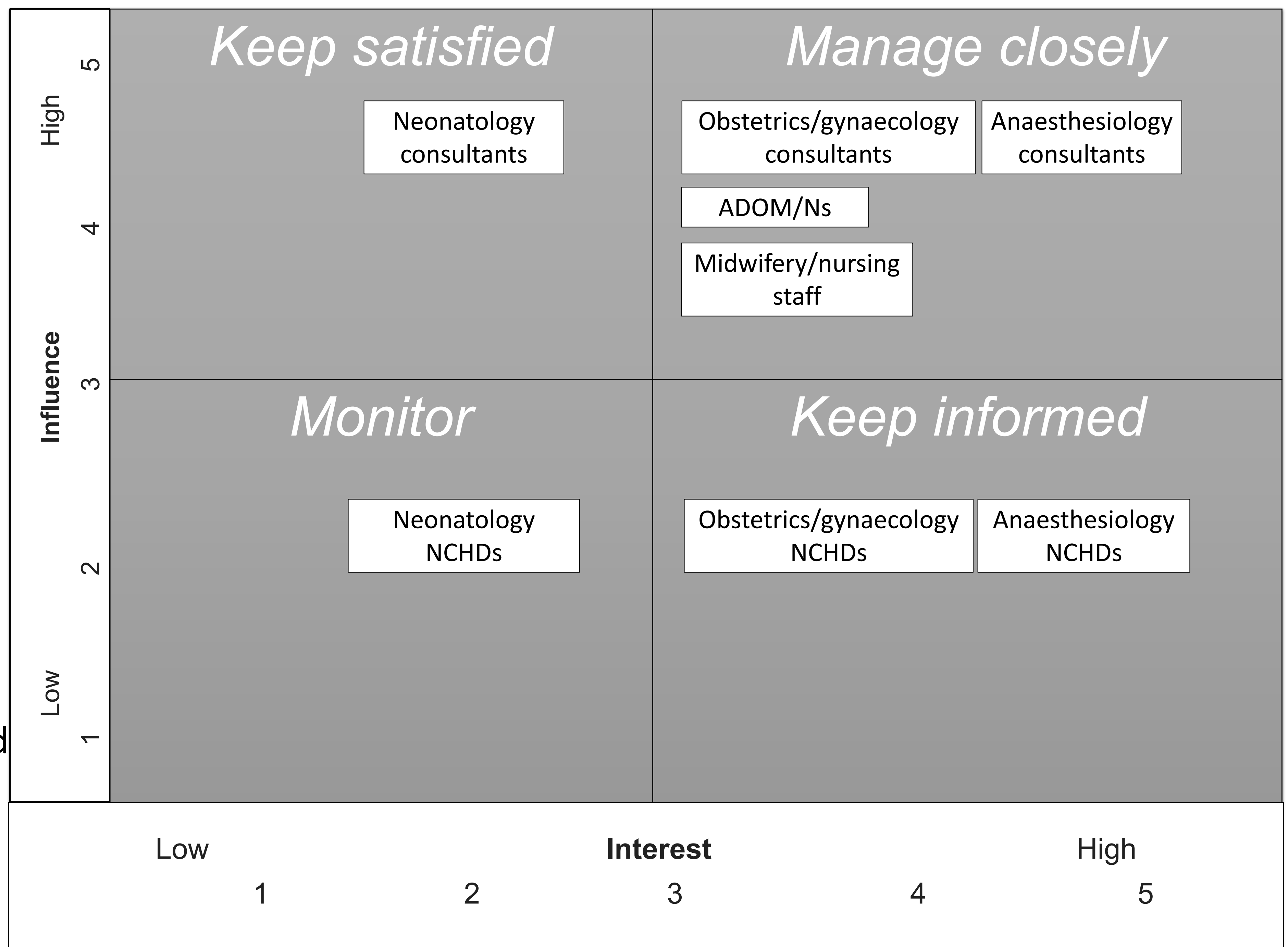


Figure 2. Stakeholder analysis. *Influence rating: 1 being lowest, 5 being highest level of influence; Interest rating: 1 being lowest, 5 being highest level of interest.*

Discussion

The predominant feedback received was that a clear transfer pathway should be in place. In particular, communication between transferring team and receiving team could be improved. This feedback will aid in the creation of a handover communication tool for critically ill obstetric patients. This quality improvement initiative is the first step in improving the transfer pathway and will improve patient safety.

References

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