The chart shows the percentage distribution of questions on the Obstetric and Neonatal Quality and Safety exam across the major content categories covered on the examination.
**EXAM OUTLINE**
Areas of knowledge to be tested on the Obstetric and Neonatal Quality and Safety examination are listed in the following outline. This list is not intended as an all-inclusive review. It is provided only to help candidates evaluate their own practice.

Percentages identified for the topic areas represent the number of test questions assigned to each content area. These percentages do not necessarily reflect the content of future examinations.

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<th>Section</th>
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<tr>
<td>10.00</td>
<td>Quality and Safety Assessment and Gap Analysis (21%)</td>
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<td>Methods to assess organization, institutional and environmental culture and patient experience</td>
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<td>Quality and Safety metrics to identify state of performance, gaps and opportunities</td>
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<td>11.00</td>
<td>Integrate Quality and Safety in Practice (21%)</td>
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<td>Quality and Safety aims, tools, checklists and communication strategies</td>
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<td>Training exercises, learning principles, mock codes and simulation</td>
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<td>12.00</td>
<td>Develop and Implement Quality and Safety into Practice (25%)</td>
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<td>Integration into workflow, error prevention strategies and auditing</td>
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<td>13.00</td>
<td>Evaluation and Measures of Effectiveness (23%)</td>
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<td>Tools of evaluation (Fishbone, flow chart, run chart, control charts)</td>
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<td>Evaluate the balance between quality, outcomes and cost</td>
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<td>Strategies for sustainment and positive change</td>
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<td>14.00</td>
<td>Professional and Ethical Issues (10%)</td>
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<td>Adverse events, disclosure, transparency, patient trust and mitigation</td>
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EXAMINATION CONTENT

ASSOCIATED COMPETENCIES

- Systematically assess the organization, institutional and environmental culture, patient experience and outcomes, leadership and teamwork by using a variety of methods (e.g., surveys, direct observation and/or environmental scans, adverse events, system errors, and near misses) to identify gaps in quality and safety.

- Maintain current knowledge of national quality and safety standards and clinical guidelines from regulatory, accreditation, and specialty organizations, to promote ongoing change in practice to meet quality and safety indicators.

- Evaluate quality and safety metrics by analyzing baseline and ongoing data to determine current state of performance, identify gaps, and identify opportunities for improvement.

- Incorporate quality and safety aims, tools, checklists and communication strategies into evidence-based projects to improve obstetric and neonatal care.

- Foster team function by integrating leadership and teamwork skills that empower members of the clinical team and improve communication to achieve a climate of safety.

- Educate and train obstetric and/or neonatal teams on quality and safety practices by conducting and debriefing team training exercises and implementing education using effective learning principles to improve task knowledge and optimize team functioning (e.g. mock codes, simulations).

- Advocate for ongoing resource needs by serving as a liaison for quality and safety matters between clinicians and administrators (e.g., participating in meetings, serving on committees and through risk assessment activities) to improve care and outcomes.

- Inform patients, colleagues, employers and the public about quality and safety initiatives/outcomes by disseminating outcome data, participating in benchmarking and publishing reports to maintain transparency.

- Select and monitor key quality metrics that assess a balanced set of quality and safety domains indicative of organizational culture and benchmarking.

- Apply recognized methods to design quality and safety initiatives in collaboration with necessary stakeholders to identify the target population, measures (e.g., structure, process, outcomes) and data collection approaches to address identified opportunities.

- Integrate quality and safety practices into daily clinical workflow by using error prevention strategies, appropriate technology, and principles of high reliability to guide practice and improve outcomes.

- Evaluate the implementation of quality improvement initiatives using relevant tools (e.g., fishbone, flow chart, run charts and control charts) to measure effectiveness of processes and outcomes.

- Articulate the value of specific obstetric and neonatal quality initiatives by evaluating the balance between quality, outcome and cost, including the perspectives of all stakeholders (e.g., healthcare team, patients, and families).

- Identify strategies of moving quality improvement initiatives into sustainment in order to maintain positive change in an overall obstetric and neonatal quality and safety program.
I. Methods to assess organization, institutional and environmental culture and patient experience

- Healthcare quality improvement goals
  - Domains of quality
    - Timeliness
    - Effectiveness
    - Patient centered
    - Efficiency
    - Safety
    - Equitability

- Dimensions of quality (Donabedian)
  - Structure
  - Process
  - Outcome

- System goals
  - Population health
  - Patient experience
  - Healthcare

- Adverse events and event reporting
  - Monitoring and procedure surveillance
  - Incident/safety reports
  - Near misses
  - Root cause analysis
  - Mortality and morbidity

- Methods of event reporting
  - Video
  - Direct observation
  - Auditing
  - Patient reported events

- Institutional processes and priorities
  - Regulatory
  - Certifications
  - Accreditation
  - Peer-review

- Assessment strategies
  - Defining population
  - Assembling teams
  - Reviewing literature
  - Identifying measures
  - Assessing patient/family perspective

- Assess and improve organizational culture
  - Culture
  - Just culture

II. National Quality and Safety Standards and Clinical Guidelines

- Awareness of legal/statutory and national quality and safety standards and clinical practice guidelines in obstetrical and neonatal care
  - Perinatal core measures
  - GBS guidelines
  - Guidelines to prevent hospital associated infections
  - Guidelines for perinatal care current edition
  - AWOHNN guidelines Maternal health

III. Quality and Safety metrics to identify state of performance, gaps and opportunities

- General quality and safety principles and terminology
  - Quality assurance versus quality improvement
  - Quality versus safety

- Metrics
  - Outcome
  - Process
  - Structure
  - Access
  - Risk adjustment
  - Benchmarking
  - Gap analysis
  - Participation and shared decision making
  - Systems thinking

- Methodologies of data display

- How to implement and evaluate data collection strategies
  - Process tools
  - Huddle tools
  - Trigger tools
  - Chart review
INTEGRATE QUALITY AND SAFETY IN PRACTICE

I. Quality and Safety aims, tools, checklists and communication strategies
• Human psychology and cognition
  - Situational awareness
  - Violations of process/protocols
  - Risk taking
  - Fear of repercussions
  - Cognitive biases
  - Attention and distractions
  - Stress
  - Burn out and fatigue
• Safety climate
  - Briefings
  - Family involvement councils
  - Committees
• Collaborations and effective communication strategies
  - Standardized communication
  - Handoffs
  - SBAR
  - I-PASS
  - Debriefing
  - Care transitions

II. Team function, leadership, empowerment
• Leadership skills
  - Self-awareness/management
  - Mentoring
  - Sustainability
  - Succession and transition planning
  - Communication and conflict management
  - Change management
• Principles and concepts of teams
  - Team development
  - Structures and function
  - Diversity and inclusivity
  - Collaboration
  - Mutual respect
  - Information diffusion
  - Team meetings
  - Code of conduct

III. Training exercises, learning principles, mock codes and simulation
• Effective learning/teaching principles
  - Adult learning principles
  - Generational learning styles
  - Remote or distance learning methodologies
  - Interprofessional
• Use and principles of simulation
  - Unit drills
  - Simulated care processes

IV. Advocating for ongoing resources, risk management
• Methods for determining human resource needs
  - Hours per patient day
  - Work hours per unit of service
  - Work hours per birth
  - Clinician to patient ratio
  - Standards for staffing
• Human factors that impact the work environment
  - EMR
  - Medical devices
  - Alarm fatigue
  - Distractions
  - Interruptions
  - Overcrowding
  - Noise
  - Ergonomics of procedures
  - Patient census acuity
  - Staffing
  - Fatigue
  - Work arounds
  - Design of systems and processes
• Relevant aspects of structural design standards
  - Layout and design
  - Resource placement
  - Lighting
  - Signage and way finding
INTEGRATE QUALITY AND SAFETY IN PRACTICE (CONTINUED)

V. Inform and disseminate outcome data, benchmarking and transparency

• Various methods for educating and disseminating
  QNS data to various stakeholders
  - Annual reports
  - Presentations
  - Publications
  - Public reporting
  - Websites
  - Social/other medias

• Share data on key quality indicators with
  colleagues/organizations to improve
  - Education campaigns
  - Peer
    - Benchmarking/accountability
I. Selecting and monitoring key quality metrics

- Prioritize opportunities for improvement
  Relative importance to different stakeholders
  - Patient, family, provider, facility, healthcare, system, payor

- Develop goal statements
  Specific
  Measurable
  Achievable
  Relevant
  Timebound

- Types of metrics
  Outcome
  Process
  Structure
  Access
  Patient experience
  Patient satisfaction

- Balancing measures and metrics
  Unintended consequences of metrics
  Balancing measure to mitigate unintended consequences
  Outcome, process and structure measures

- Familiarity with common methods for quality and safety improvement initiatives
  Models for improvement
  - PDSA/PDCA
  Improve
  Six sigma
  Lean

II. Identify population, measures and data collection

- Project team formation and dynamics
  Identification of stakeholders
  Identification of champions
  Influencer model
  Patient/family perspective

- Appraise and prioritize literature relevant to project
  Randomized trials
  Meta-analysis
  Expert opinion
  Observational studies
  Consensus documents

• Improvement process
  Selection of interventions
  Planning implementation

• Tracking of improvements
  Data definitions
  Data collection
  Data quality assurance
  Graphs and tables
  Analysis
  Interpretation

III. Integration into workflow, error prevention strategies and auditing

- Errors and Risk reduction strategies and use of cognitive aids
  Bundles
  Checklists
  Flow sheets
  Timeouts
  Guidelines
  Structured communication
  Patient identification
  Barcodes
  E-prescribing
  Computerized physician order entry
  Medication administration processes
  Human milk handling processes
  Blood product administration processes
  Food and nutrition safety

- Errors and Risk reduction strategies and use of cognitive aids
  Feedback
  Surveillance
I. Tools of evaluation (Fishbone, flow chart, run chart, control charts)

- Evaluation of outcomes and performance improvement
  - Run charts
  - Control charts
  - Dashboards
  - Interpret data

- Role of technology in quality improvements
  - Data standardization and retrieval
  - Standardization of EMR

II. Evaluate the balance between quality, outcomes and cost

- Understanding the interplay between costs, quality and value from the perspective of various stakeholders
  - Monetary
  - Non-monetary
  - Patient and family experience
  - Value equals quality divided by cost

- Identification of waste
  - Duplication
  - Tools to identify waste
  - Wait times

III. Strategies for sustainment and positive change

- Recognition of threats to implementation and sustainability
  - Fatigue
    - Project fatigue
  - Backsliding
  - Knowledge exclusivity
  - Large scale implementation without testing
  - Research models
  - Knowledge degradation
  - Lack of upper level support/commitment
  - Lack of team integrity
  - Lack of personnel
  - Competing priorities
  - Disruptive behavior
  - Hierarchical professional behaviors

- Steps in project sustainability
  - Communication
  - Reporting
  - Ongoing ownership
  - Celebration of success
  - Modification of data collection and review
I. Adverse events, disclosures, transparency, patient trust and risk mitigation

- Elements of effective disclosure
  - Mandatory versus voluntary disclosure
  - Disclosure of errors and near misses
  - Explanation as to why error occurred
  - How effects will be minimized
  - Steps to prevent recurrences
  - Apology
  - Acknowledgement of responsibility

- Distinguishing different types of error including system error, blameless human error (inadvertent), and accountable human error (at risk, reckless, intentional harm)
  - Differentiating human error from system error
  - Differentiate between human error, at risk behavior, and reckless behavior

- Understanding and mitigating psychological harm experience by the patient and second victims
  - Second victims
  - Debriefing
  - Communication strategies
  - Counseling, employee assistance
  - Support groups
  - Emotional support

II. Professional and ethical issues

- Ethical principles as they apply to patients, families, providers and organizations
  - Patient/family access
  - Fairness, truthfulness, justice, beneficence, nonmaleficence, autonomy

- Awareness of differences between quality improvement projects and research
  - Human subject protections
  - IRB or local approval mechanism
  - Compare research to quality improvement
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