



OB Hospital Teams Call

November 24, 2014

12:30 – 1:30 PM

Agenda

- ILPQC Updates
 - Communications
 - Birth Certificate Accuracy Initiative
- Team Talks
 - PDSA Cycle
 - Hospital Presentations
- Next Steps

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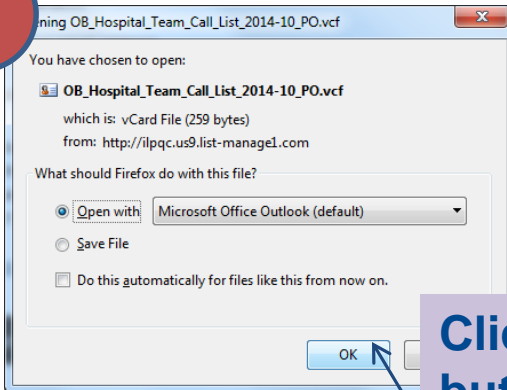
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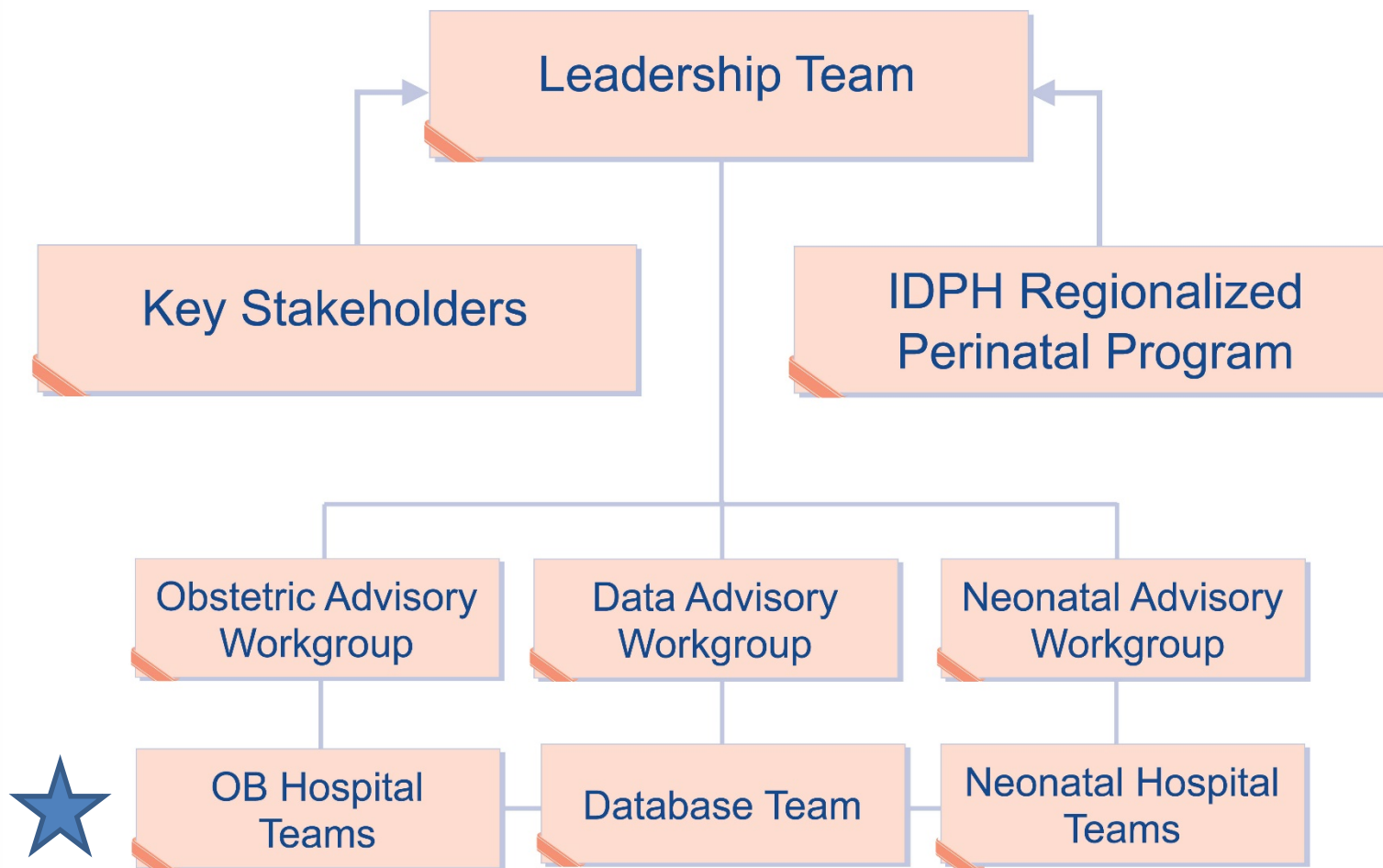
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ILPQC Structure



Second Annual Conference



- Thank you for attending and a special thanks to those who presented posters or volunteered to help!
- Please send any feedback or suggestions for next year to info@ilpqc.org

2014-2015 OB Initiatives

- Launching Birth Certificate accuracy in collaboration with IDPH
 - Cindy Mitchell – lead
- Preparing for hypertension initiative identified at conference
 - Implementation of new hypertension guidelines with focus on maternal morbidity reduction
 - Email info@ilpqc.org if you would like to join the OB Advisory subgroup responsible for planning this initiative

Birth Certificate Accuracy

- Partnership with IDPH/IHA/ILPQC
- Birth Certificate Initiative Workgroup
 - Consultation from Ohio Perinatal Quality Collaborative
 - Developed key variables, accuracy data form, revised birth certificate guidebook
 - Feedback from State Quality Council and OB Advisory Workgroup
- **Aim: Obtain 95% accuracy on key birth certificate variables**

Approach

- Identify Hospital Teams: **physician lead, nurse lead, birth certificate clerk required**; quality lead and other team members encouraged
- Confirm access to ILPQC REDCap data system via info@ilpqc.org by 12/5/14
- Submit Birth Certificate Team roster and ILPQC data system access request using the forms available at www.ilpqc.org by 12/5/14
- Launch initiative on December 15 Teams Call with live demo and REDCap training

Approach

- Collect baseline accuracy data
 - Team reviews 10 charts per month for 3 months (retrospective, planning on August, September, October)
 - Review completed birth certificate against actual medical record and record if 17 selected variables are accurate (chart matches birth certificate - yes/no)
 - Sampling: Divide total births < 38w6d (unless not available) by 10 then choose every x chart for review. Level III need at least 2/10 charts <34 wks.
 - Accuracy data reported in ILPQC REDCap data system
 - Regroup on a call for feedback on process and content

Approach

- Birth certificate accuracy education for hospital teams
 - Monthly ILPQC Hospital Team Calls
 - Tracking accuracy data
 - 3 teams / month report on PDSA cycles, challenges & successes
 - Identify focus areas for ongoing education
 - Webinar(s) national / state speakers
 - Targeting face-to-face team training in spring
- Focus on QI at hospital level
 - Support PDSA cycles to improve system for completing birth certificates
 - Support education on improving collection of each key variable

Ongoing Data Collection

- Hospital teams review 10 charts per month for accuracy on 17 key variables
 - Enter accuracy data into ILPQC REDCap data system
- Monthly accuracy data available to hospitals via secure ILPQC data system portal
 - Track improvement in hospital's birth certificate accuracy rate for each key variable and overall
 - Comparison across time and across all hospitals
 - Teams implement PDSA cycles based on data

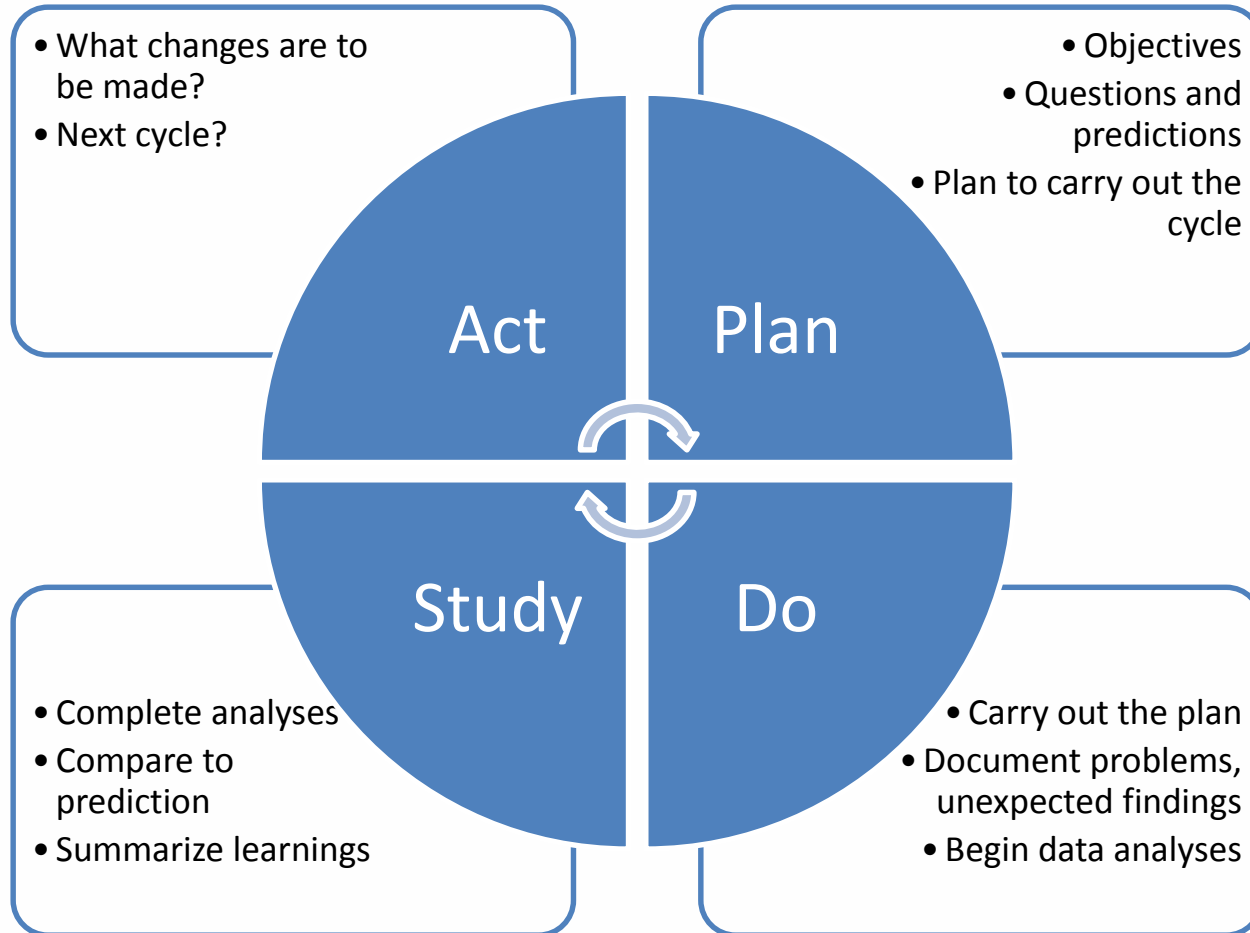
Variables to Audit

- HTN
- Diabetes
- Previous Preterm Birth
- Augmentation of labor
- Induction of labor
- ANCS (Antenatal Corticosteroids)
- Fetal intolerance to labor
- Antibiotics received during labor
- Gestational age
- Assisted Ventilation
- NICU Admission
- Infant Feeding
- Mother's Social Security number
- Date of first prenatal care visit
- WIC participation
- Source of Payment
- Date of last menstrual period

Team Talks

- Teams present 5-10 min on current QI work
 - What was the test of change (i.e., your QI process)?
 - What did you predict your change would improve?
 - What did you learn?
- Generate discussion and learning through sharing
- Begin with conference poster presentations, other QI, then will move to birth certificate initiative QI work
- Sign up form for volunteers on website
 - Would like all teams to present within next year

PDSA Cycle



Team Talks

1. Rita Brennan, Claudia Mahoney, Lisa Sullivan

Central DuPage Hospital

Winfield IL

2. Sally Krempel and Joan Rucker

MacNeal Hospital

Team Talk 1

Rita Brennan, Claudia Mahoney, Lisa Sullivan
Central DuPage Hospital



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Preventing Early Elective Deliveries: The 39 week Rule

Central DuPage Hospital
Winfield, IL
ILPQC November 24, 2014



Background

Problem:

- 2010 Leapfrog data demonstrated EED rate > 30%
- CDH was not in compliance with the 5% goal for the state

Goal:

Reduce and sustain EED to < 5% by 1st Qtr FY 12

Program development:

- Commissioned workgroups to identify issues, barriers and challenges.
- Evaluation of data collection completed.
- Definitions for EED agreed upon by committee.

Methodology:

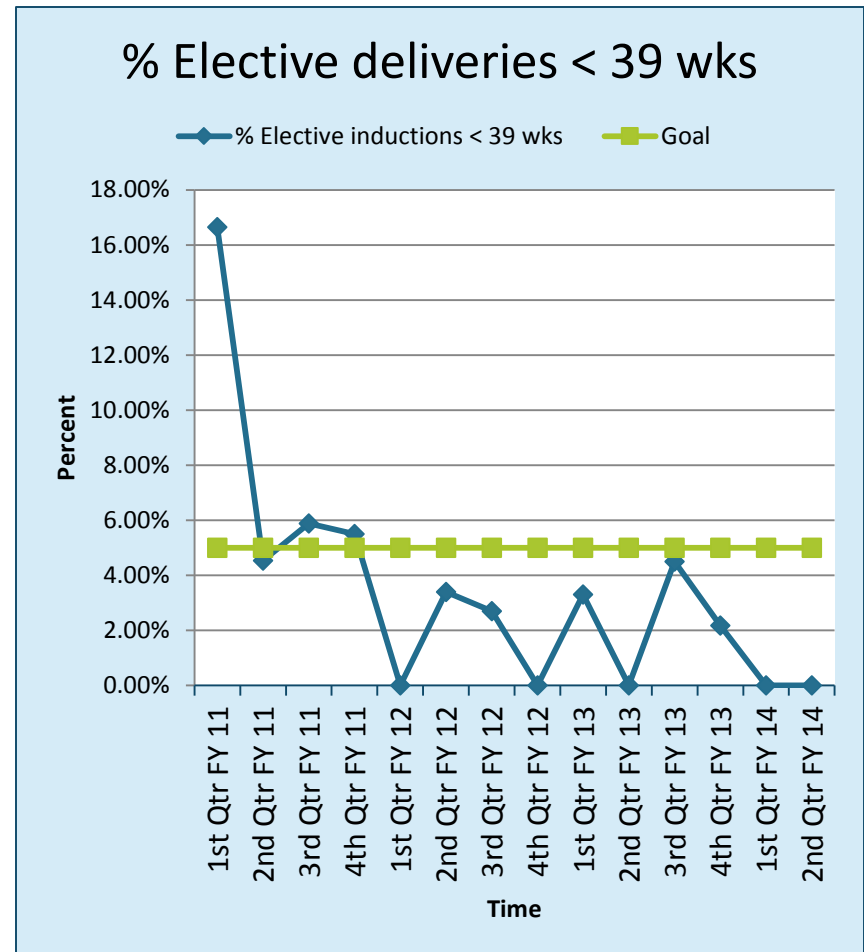
PDCA performance improvement methodology implemented

PLAN: Identified goal. Obtained current baseline data. Identified possible strategies for improvement.

DO:

- **Education:**
 - Physician and nursing education.
 - Institute for Healthcare Improvement Learning Series.
- **Process/practice change:**
 - Changes in how induction and cesarean section are scheduled.
 - Definition of medically indicated deliveries agreed upon- Implemented Leapfrog criteria.
- **Compliance measure:**
 - Review all cases of < 39 week deliveries.
 - Chair of OB PI reviews cases that fall out; discusses with physician
- **Patient education:**
 - Patient educational material

- **Check**
 - Review all deliveries less than 39 weeks.
 - Benchmark with state data
 - Benchmark with Leapfrog data
 - Share data with stakeholders
- **ACT**
 - Continued need to reinforce guidelines
 - Involve L&D Nursing Councils in improvement process



■ **Changes over time:**

- Policy developed to include “Hard Stop” when early delivery may not be medically necessary. Maternal-Fetal Medicine approval needed.
- OB Performance Improvement Committee expanded. Now the Perinatal Improvement Team.
- The Joint Commission Perinatal Core Measures reporting required in 2014

■ **Challenges:**

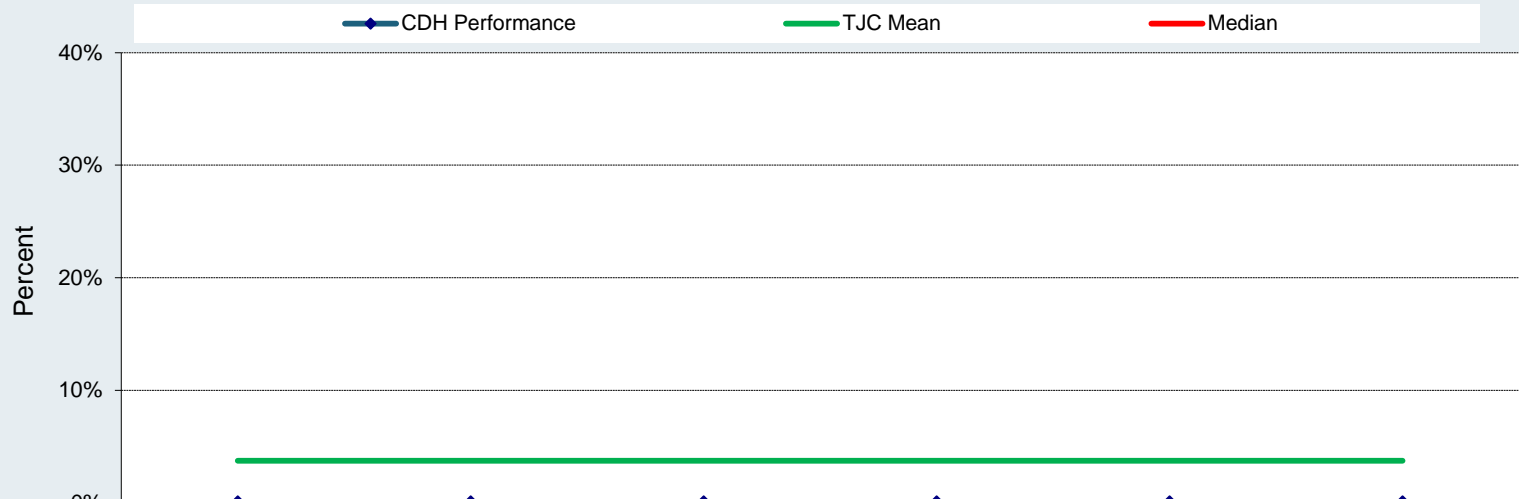
- Resistance
- Different definitions of EED
- Scheduling of C/S

■ **Lessons Learned**

- Multidisciplinary teamwork is necessary to make change.
- Change takes time.
- Constant surveillance is needed to sustain change.

Where we are now

PC01 - Elective Delivery



	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
CDH Performance	0	0	0	0	0	0
Num	0	0	0	0	0	0
Den	5	11	7	7	10	4
TJC Mean	0.0373	0.0373	0.0373	0.0373	0.0373	0.0373
Median	0	0	0	0	0	0

Sample Population

Team Talk 2

Sally Krempel and Joan Rucker

MacNeal Hospital

Changing Hospital Culture: Collaborative Response to Emergency Cesarean Sections

Katherine Q. Hodur,
Sally M. Krempel,
Joan E. Rucker
& Barbara C. Schuch



MacNeal Hospital

Background

- IDPH Visit Preparation January 2012
- Decision to Incision time for Emergency Cesarean Sections-“30-Minute Rule”
- American College of Obstetrics & Gynecology (ACOG) Standard of Care
- Retrospective Data Collection
- Gap Analysis
 1. All Birth Center Staff not using Standardized Nomenclature
 2. Perceived Lack of Communication & Teamwork



OBG Management (Dec. 2011), Vol. 23 No. 12

“Standardization has long been recognized as an essential element of patient safety, and a growing body of contemporary evidence confirms that standardization can reduce adverse outcomes and malpractice claims. In FHR monitoring, standardization can help ensure that common obstacles to rapid delivery are not overlooked and that decisions are made in a timely fashion.”



Part I-NICHD NOMENCLATURE: Speaking a Common Language

When Interpreting Fetal Monitor Tracings

- Discuss briefly the history of standardized fetal monitoring terminology
- Review the basic definitions & categorical levels of NICHD Nomenclature (Standardized Communication for Fetal Heart Rate Pattern Interpretation)
- Apply NICHD Nomenclature to fetal monitor tracings.



Standardized Nomenclature

NICHD Standard Nomenclature supported by:

1. American College of Obstetrics & Gynecologists (ACOG)
 2. Association of Women's Health, Obstetrics & Neonatal Nurses (AWHONN)
 3. American College of Midwives
- Reviewed definitions of NICHD Nomenclature
 - Fetal monitoring strip review & pattern interpretation
 - Handouts
 1. 2010 NCC Monograph as reference
 2. Pocket Card of NICHD Nomenclature*



In addition...

- NICHD Categories added to the QS computer charting for the nursing staff
- C/S decision time added for ease in data collection
- Professional responsibility discussed regarding:
 1. Continuing education and certification (C-EFM through ANCC)
 2. Accurate diagnosis, medical record reflecting the same message



Collaboration

“All Perinatal staff should participate in education about the chosen language together, even though it has not been traditional for nurses and doctors to attend the same EFM class. Certification in EFM could encourage ongoing education for nurses and physicians as a team.”

Kathleen Simpson Rice, PhD, RN, FAAN



Part II-CRITICAL CONCEPTS FOR TEAMWORK TRAINING IN OBSTETRICS

Meet the Needs Identified in the Gap Analysis

- Implement a teaching plan for staff to improve *standardized* communication and teamwork skills
- Interdisciplinary education involving *standardized* communication skills and emergency cesarean section drill simulation for team stakeholders



Standardized Communication

- Briefing
- SBAR
- Closed loop communication
- Situational awareness
- Situation monitoring
- Debriefing



Collaborative Response to Emergency Cesarean Section Guidelines

- To ensure the activation of appropriate and required personnel during an emergency cesarean section
- In alignment with hospital's Regional Perinatal Network
- Guidelines and summary of roles are described
- Approved by OB physicians and Pediatric Hospitalist Group



Part III-Neonatal Outcomes

Physiologic Basis of Fetal Heart Rate Monitoring

- The objective of intrapartum FHR monitoring is to assess fetal oxygenation
- Fetal oxygenation involves the transfer of oxygen from the environment to the fetus and the subsequent fetal response
- Fetal neurologic injury due to disrupted oxygen transfer does not occur unless it progresses at least to the stage of significant metabolic acidemia (umbilical artery pH <7.0 and base deficit $>12\text{mmol/L}$)
- Normal: pH 7.26 ± 0.07 Base Deficit* 4 ± 3



Fetal acidemia and electronic fetal heart rate patterns: Is there evidence of an association?

- The Journal of Maternal-Fetal and Neonatal Medicine (2006):
 - In the absence of catastrophic events, in a fetus with an initially normal FHR pattern, the development of significant acidemia in the presence of variant FHR patterns evolves over a significant period of time, of the order of at least one hour



Part IV-Potential Postpartum Outcomes

- Post traumatic stress disorder
- Postpartum depression
- Disruption of maternal-infant bonding
- Unsuccessful breastfeeding experiences
- Negative effects on personal relationships



Potential Postpartum Outcomes

- Program Objectives:
 - Identify potential negative postpartum outcomes related to emergency cesarean sections.
 - Discuss supportive postpartum interventions to promote positive patient outcomes.



Kurt Lewin's Three-Step Change Model

Identification of potential negative postpartum outcomes facilitates the need to change current practices and promote movement into evidence-based postpartum interventions that promote positive patient outcomes.



Changing Hospital Culture

A *positive* change within culture will not only *promote* a new approach of professional practice, it will also *promote* an optimal new beginning for mother, infant and family.



Outcomes and Evaluations

Promoting effective collaboration between healthcare professionals, patients and their families will ultimately enhance

quality of care,

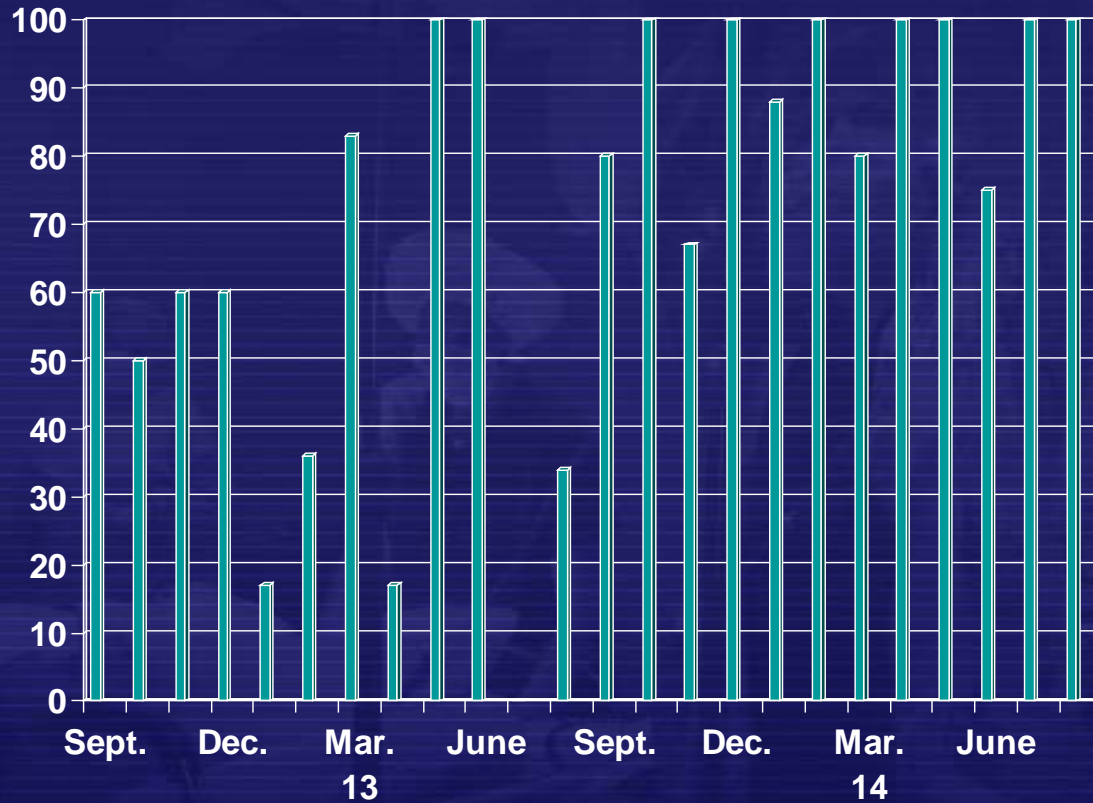
patient safety and

improve patients' perspective

of emergency birthing experiences.



March 2013 forward...Depicts Post Education Improvement (Test of Change)...



Abstract

Background/ Significance of the Problem

Based upon the American College of Obstetrics and Gynecology's (ACOG) and the American Academy of Pediatrics (AAP) recommended standard (30 minutes from decision to incision for emergency cesarean sections) the "30-minute rule," a preliminary data review of "decision to incision" time audits identified discrepancies in standardized communication and collaboration between medical and nursing staff.

This four part educational program aimed to change the culture and create an effective and collaborative response to emergency cesarean sections:

- I-NICHD Nomenclature: Speaking a Common Language When Interpreting Fetal Heart Rate Tracings
- II-Concepts for Teamwork Training in Obstetrics Background and Significance
- III-Neonatal Outcomes
- IV-Potential Postpartum Outcomes

Change Theorist

By integrating Kurt Lewin's "Change Management Model", this educational program's aim was to change the culture and create an effective and collaborative response to emergency cesarean sections.



Materials & Methods

Participants

Strategy for Improvement & Implementation

The methodology of this interprofessional program incorporated a broad range of instruction (didactic lecture, fetal strip review & simulation) focused on standardized communication, interprofessional teamwork training, potential maternal/ infant outcomes and simulation of emergency cesarean section scenarios.



Program Objectives

- Review the basic definitions & categorical levels of NICHD Nomenclature: (Standardized Communication for Fetal Heart Rate Pattern Interpretation)
- Apply NICHD Nomenclature to fetal monitor tracings
- Relate the four primary teamwork skills to critical concepts in obstetrics: (Leadership, communication, situational monitoring and mutual support)
- Identify high risk critical situations with appropriate responses
- Relate the impact of fetal outcomes to the fetal monitor tracings
- Identify compounding maternal antepartum and intrapartum factors with neonatal outcomes
- Discuss complications of the newborn associated with "failure to rescue" events
- Identify potential negative postpartum outcomes related to emergency cesarean sections
- Discuss supportive postpartum interventions to promote positive patient outcomes

Barriers/Results

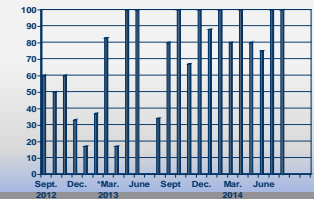
Barriers to sustained culture change continue to be identified through the debriefing of each individual case and addressed through the provider and nurse "peer review process."

Barriers Encountered

- Compliance with Standardized Nomenclature for Fetal Monitoring (NICHD language)
 - Teamwork
 - Following ER C/S Guidelines
 - RN, Physician & Anesthesia Delays
- Improving patient safety and quality of care was the primary focus of the project.

2012-2014 Decision to Incision Data *(Table 1)

Cases which met the "30-min. Rule" standard ACOG Benchmark (% Compliance) March 2013-March 2014 data, reflects post education results



Conclusion

Through implementation of this four part educational program, in conjunction with the development of departmental guidelines, ongoing data collection, and quality improvement review, this program was able to facilitate and sustain effective interprofessional collaboration and has made a significant impact on compliance with the ACOG "30-minute rule" standard, see:

2012-2014 Decision to Incision Data (Table 1)*

Implications for Practice

- Apply the project's objectives to clinical practice.
- Sustainment of culture change beyond the initial implementation of the project.

Acknowledgements

Barbara C. Schuch, MSN, RNC-OB, C-EFM, Sally M. Krempel, MSN, RNC-OB, Dr. L. Carl Jurgens, Joan E. Rucker, MSN, Katherine Q. Hodur, MSN, RNC-MNN, CBC & Dr. Ramesh Seeras (left to right).



References

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Next Steps

- Submit your hospital team roster for the Birth Certificate Initiative on www.ilpqc.org
- Submit form to request REDCap access for team members on www.ilpqc.org by 12/5/14
- Email info@ilpqc.org if your team is interested in participating in the hypertension initiative or if you would like to join the planning subgroup
- Live data demonstration for Birth Certificate Accuracy launch on next Hospital Teams Call: December 15th from 12:30-1:30 PM

Thank You

For continuing to move obstetric and neonatal
QI forward in Illinois to help make Illinois an
even better place to be born!

