



PVB Monthly Webinar: Utilizing Cesarean Delivery decision huddles and checklists

April 26th, 2021

12:30-1:30 PM

Introductions

- Please enter for yourself and all those in the room with you viewing the webinar into the chat box your:
 - Name
 - Role
 - Institution
- If you are only on the phone line, please be sure to let us know so we can note your attendance



Overview



- Face-to-Face 2021
- Labor Culture Survey Updates
- PVB Data Review
- Tampa General: *Implementing an Interdisciplinary Pre-Cesarean Huddle Form*
- Team Talk: *Javon Bea*
- PVB Next Steps
- PVB Office Hours
 - *Join us after the call to ask...*
 - *Specific data questions*
 - *Storyboard/Face-to-Face help*



2021 FACE-TO-FACE VIRTUAL MEETING

Illinois Perinatal Quality Collaborative's

2021 Virtual Face to Face Meeting

On-Line and Free!

Calling all nurses, providers and staff!

May 26

The OB Face-to-Face meeting topics include: Promoting Vaginal Birth, Birth Equity, and MNO-OB Sustainability. This day will be worth 3.75 contact hours.

May 27

The Neonatal Face-to-Face meeting topics include: Babies Antibiotic Stewardship Improvement Collaborative (BASIC), Equitable Care, and MNO-Neonatal Sustainability. This day will be worth 3.75 contact hours.

Breakout sessions, Hospital Storyboards, QI Awards and more!



Featured Speakers



Dr. Amanda Bennett
OB & Neo Day



Dr. Joseph Cantey
Neo Day



Dr. Audra Meadows
OB Day



Dr. Russell Kirby
Neo Day



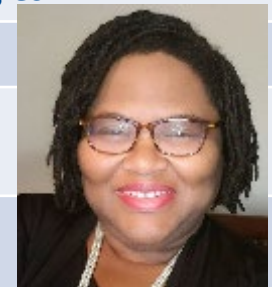
LaToshia Rouse
OB Day



CME's offered through
Northwestern Medicine[®]
Feinberg School of Medicine

2021 OB F2F Agenda

Time	Session/Speaker
8:30 – 9:00 am	Welcome & Overview; Working Together in 2021- Ann Borders
9:00 – 9:45 am	Birth Equity Plenary Session- Audra Meadows
9:45 – 9:55 am	Break
9:55 – 10:40 am	PVB QI Team Panel: Sharing Strategies for Success- ILPQC PVB Teams
10:40 – 11:10am	Unpacking the Birth Equity Initiative and Toolkit- Ann Borders
11:10 – 11:30 pm	QI Team Awards
11:30 – 1:00 pm	Virtual Storyboard Review & Lunch
1:00 – 1:35 pm	Breakout Session 1: Small Group Key Topic Discussions on Implementation Strategies
1:35 – 1:45 pm	Break
1:45 – 2:20 pm	Breakout Session 2: Small Group Key Topic Discussions on Implementation Strategies
2:20 – 2:30 pm	Break
2:30 – 3:15 pm	Engaging Patients in QI Work- LaToshia Rouse
3:15-3:30 pm	Wrap up and Next Steps for 2021- Ann Borders



OB F2F Storyboard Session



- All teams will be asked to create a story board for the May 2021 “Face to Face” to share their QI teams progress on ILPQC initiatives

- Storyboard should focus on...

- PVB Successful Launch

- Baseline data display
- 30/60/90d plan
- Progress on key imitative aims

- MNO-OB Sustainability

- Sustainability plan
- MNO-OB Data
- Strategies for improving Narcan Counseling and Prenatal Screening

<Hospital Logo>		<Hospital Name>		ILPQC 2021 OB Storyboard
2. Hospital & QI Team Overview Fill in QI Team & Roles Here		4. MNO-OB Sustainability Sustainability Plan		5. PVB Launch Baseline Date
3. Birth Equity (BE)		MNO-OB Data		30/60/90 day plans
(Tell us about your BE QI Team and share 1 key goal your team has for the initiative.)		Strategies for improving Narcan counseling & mental screening.		Share your progress and key steps for launching your labor culture survey.

**Join us after this call
for any questions!**

You are ILPQC!



- Get **READY**... ILPQC wants to celebrate you during our virtual Face-to-Face Meeting!
- Coordinate with your colleagues to create a slide or send in a picture to celebrate your QI team

- Ideas to include on slide:

- Team/Hospital Picture
- Picture of QI bulletin board
- Location/Region
- Birth Volume/NICU Beds
- Perinatal Level and Network
- Current & Future Initiatives
- Contact information for your team for collaboration



- Submit by emailing your slide or picture to info@ilpqc.org and be entered into a raffle for a pizza lunch

2021 OUTSTANDING LAUNCH AWARDS

ILPQC 2021 FACE-TO-FACE MEETING

PVB

AWARD CRITERIA

- ✓ Team Roster sent to ILPQC
+
- ✓ All 2019 Q4 Baseline Data
Submitted
+
- ✓ All Data Submitted *
- +
- ✓ PVB Readiness Survey
Submitted

**ALL DATA SUBMITTED (HOSPITAL + PATIENT LEVEL)
JANUARY THROUGH MARCH 2021 **BY APRIL 30TH***



LABOR CULTURE SURVEY FAQS

LCS Resources Available

1. Administration Buy-in Email

- Sample language for teams to share with administration to assist with buy-in and help with LCS distribution

2. Labor Culture Launch Email

- Explanation of LCS and instructions that can be used for all clinical staff

3. LCS Follow-up Email #1

- Sample email that can be personalized to assist with LCS completion

4. LCS Follow-up Email #2:

- Sample email that can be personalized to share your breakdown and nurse and physician participation

5. LCS Flyer

- Post around your unit in break rooms, bathrooms, nurses stations, physician workrooms etc.

Calling ALL Labor & Delivery Clinicians and Staff:
Complete your Labor Culture Survey today!

What: A quick survey that provides unique opportunity for our team to gain a deeper understanding of our current labor & delivery clinical culture. All entries will remain anonymous.

Who: All nurses, doctors, midwives and other clinical staff should participate and complete the survey.

When: Complete the survey between Date and Date

How: Follow the directions below to complete your survey now in 10-15 minutes. Remember all survey entries will remain anonymous.



Complete your survey now:

- Step 1: Scan the QR code
- Step 2: Choose your hospital from the drop-down menu
- Step 3: Answer the questions and submit



Questions? Please contact:

ILPQC Central: info@ilpqc.org
Francesca Carlock: F.Carlock@northshore.org
Dr. Emily White-Vangompel: E.WhiteVangompel@northshore.org



Resources will be sent via email and are available on the ILPQC website!

View LCS Participation Reports



2,345 surveys completed across Illinois

1

REDCap®

Logged in as e-suse | Log out

- My Projects
- REDCap Messenger
- Project Home and Design
 - Project Home · Project Setup
 - Designer · Dictionary · Codebook
 - Project status: **Production**
- Data Collection
 - Survey Distribution Tools
 - Record Status Dashboard
 - Add / Edit Records
 - Show data collection instruments
- Applications
 - Alerts & Notifications
 - Calendar
 - Data Exports, Reports, and Stats
 - Data Import Tool
 - Data Comparison Tool
 - Logging
 - Field Comments
 - File Repository
 - User Roles · DAGs
- Project Bookmarks
 - Report

2

ILPQC LABOR CULTURE SURVEY - REPORTING TOOL

LOGIN

Welcome, e-suse

Hospital ID:
 [Go](#)

3

Role	LD Nurses	OBs	CNM	Family Medicine Physician	Anesthesiologists	Nurse Educator
% of surveys completed for each role						
# of surveys with the following choice for each role						
# of total staff in that role						12

Questions your hospital staff are asking you...



Is this really an anonymous survey? The survey asks for my hospital, my role, my race/ethnicity, and the number of years I've worked at this institution. Won't my hospital be able to figure out who I am?

Helpful response:

- **No, your hospital will not see any of the individual survey data.**
- When your hospital liaison logs into REDCap, what they will see is a summary report of individuals classified ONLY by their clinical role (physician, nurse, midwife) and nothing else.
- They will not be able to see the race/ethnicity, gender, or practice information on any report arising from this survey.
- The answers to the culture questions will be aggregated by role, and not by any smaller group divisions. If any group has less than 2 individuals, this group's responses will not be reported.

Questions your hospital staff are asking you...



Will the ILPQC team report out individual respondent data? ?

No, data will be aggregated at the collaborative level and will not be connected to individual hospitals

Can I take the survey without answering these questions?

No, unfortunately we need this information to make sure that our survey is capturing a representative group of clinicians in Illinois.

Questions your hospital staff are asking you...



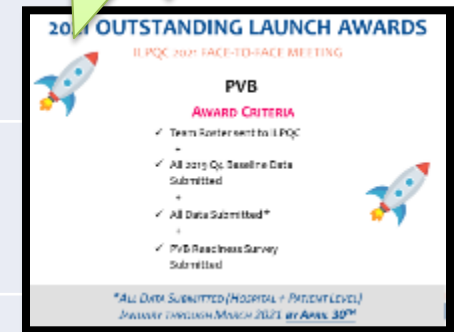
Why is there no neutral option for the attitudes and beliefs questions? Is this an error?

No, this “forced choice” is very much intentional, though it may feel uncomfortable at times. After our extensive pilot testing in other states, we have found that the neutral option was not functioning well to measure what the instrument intended.

This is a measurement issue (not a clinical one) and individuals taking the survey should just do their best to answer how they feel. There is no right or wrong answer. Finally, if you feel very uncomfortable, you have the ability to skip the question.

PVB DATA REVIEW

ILPQC Hospital Team Data Submission (95 Teams Total)



Month	Teams Reporting Patient Data	Teams Reporting Hospital Data
Baseline (Q4 2019)	84	73
January 2021	75	70
February 2021	74	61
March 2021	68	51

Use your hospital data form as a QI team meeting roadmap to guide your efforts. Please contact us if you need help getting started with reviewing and entering your data.

If hospital data is not submitted for a given month you will not have access team's NTSV C-Section rate over time.

PVB AIMs & Measures

Overall Initiative Aim

70% of participating hospitals at or below 24.7% C/S delivery rate (Healthy People 2020) among NTSV births

Overall state C/S rate among NTSV births at or below 24.7%

Structure Measures

Implement provider and nurse education and other strategies to achieve buy-in.

Implement standardized protocol/processes for induction, labor support management and response to labor and fetal heart rate abnormalities.

Implement and integrate PVB order sets, protocols and documentation into the EMR.

Implement cesarean decision checklist using ACOG/SMFM labor guidelines.

Implement decision huddles and/or decision debriefs with appropriate care team to standardize use of ACOG/SMFM guidelines and checklist.

Implement workflow process using ACOG/SMFM cesarean decision checklist through shared decision making with patient (decision huddle with provider, nurse and patient to review treatment options, risk/benefits, and ACOG/SMFM guidelines).

Implement standardized patient education with positive messaging promoting vaginal birth strategies and techniques for women and families.

Integrate process to review and share data that includes provider-level data with clinical team.

Process Measures

Percentage of providers and nurses receiving standardized education regarding:

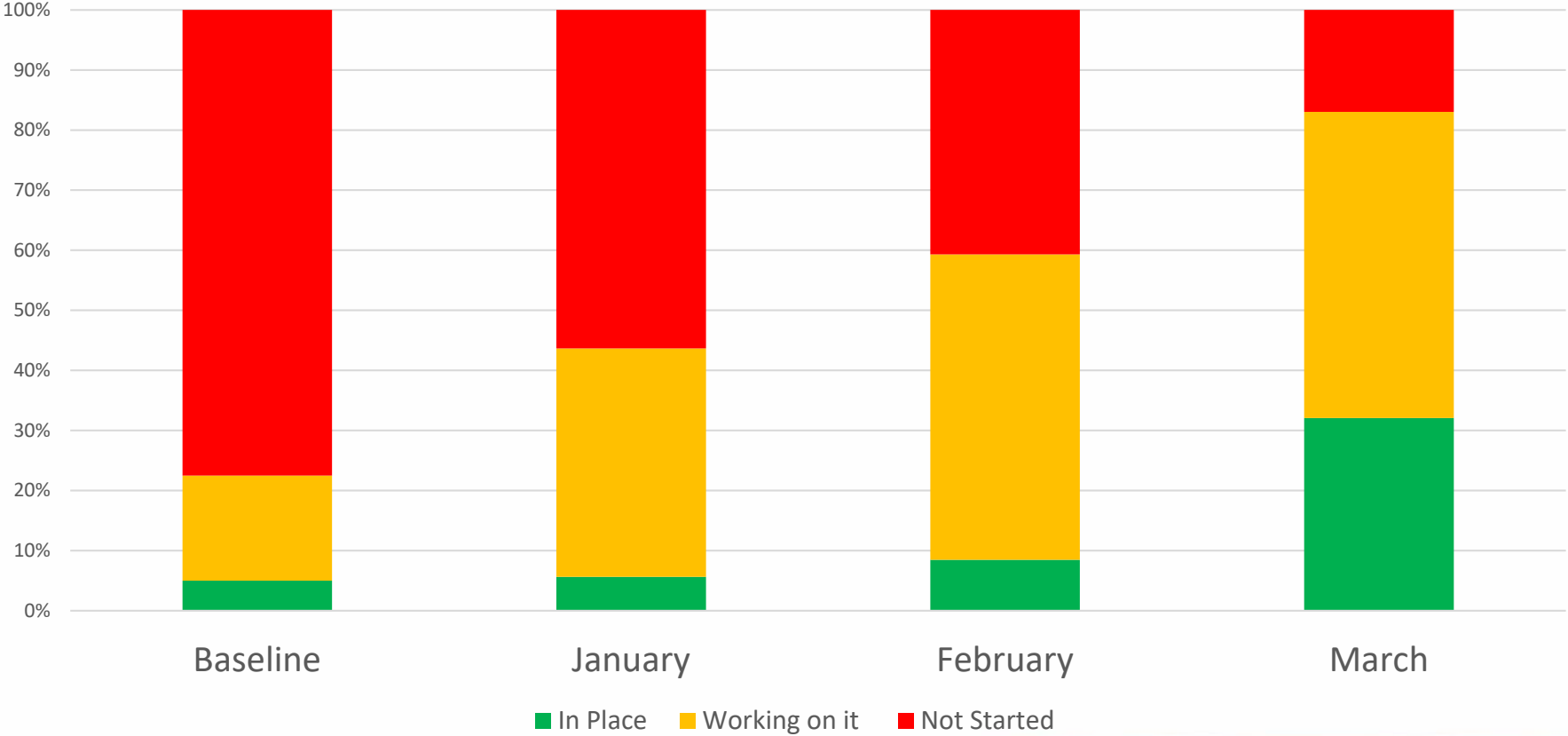
- ACOG/SMFM labor guidelines
- labor management strategies/response for labor challenges
- protocol for facilitating decision huddles and/or decision debriefs

80% of cesarean deliveries among NTSV births meeting ACOG/SMFM criteria for cesarean (based on random sample of deliveries):

- NTSV spontaneous labor arrest/labor dystocia/FTP/CPD;
- NTSV induced labor management;
- FHR abnormalities

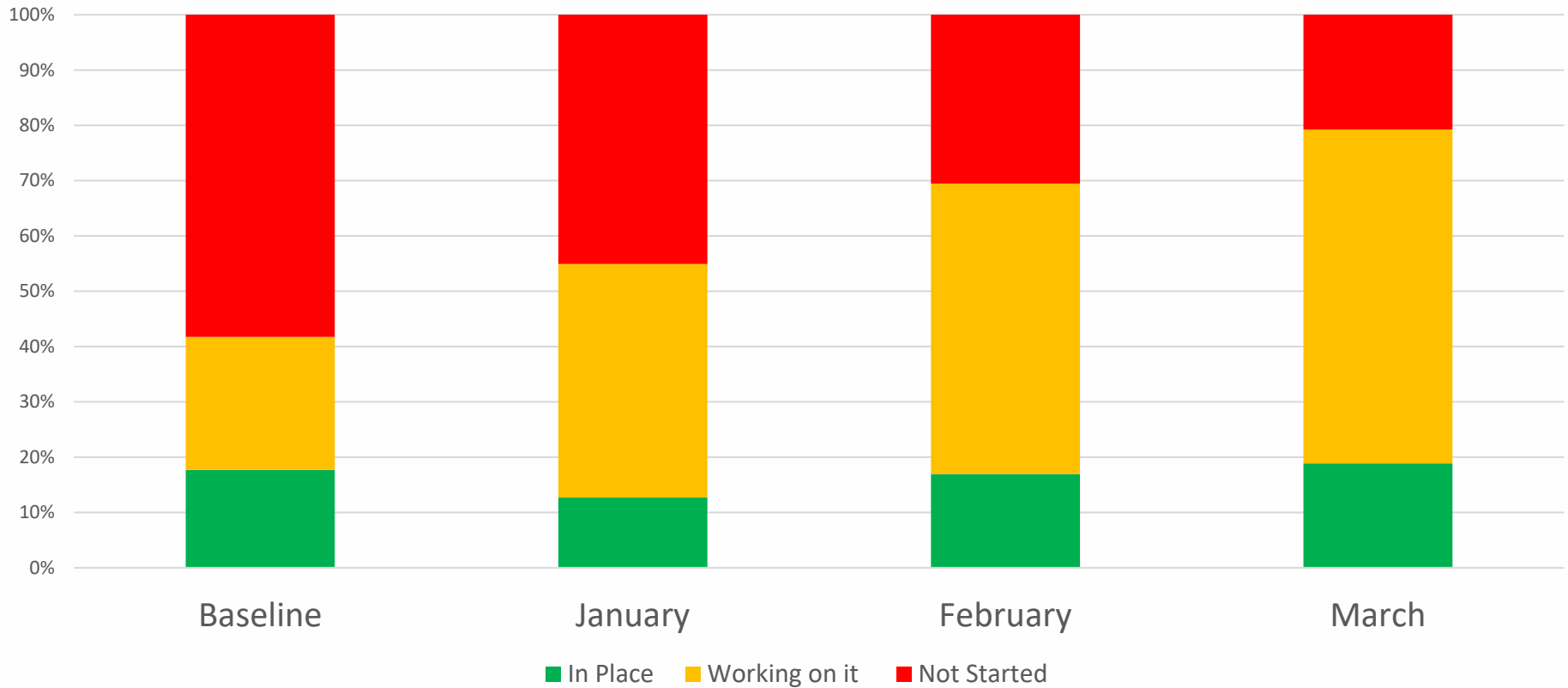
Structure Measures

Integrated process to review and share data that includes provider-level data with labor and delivery clinical teams



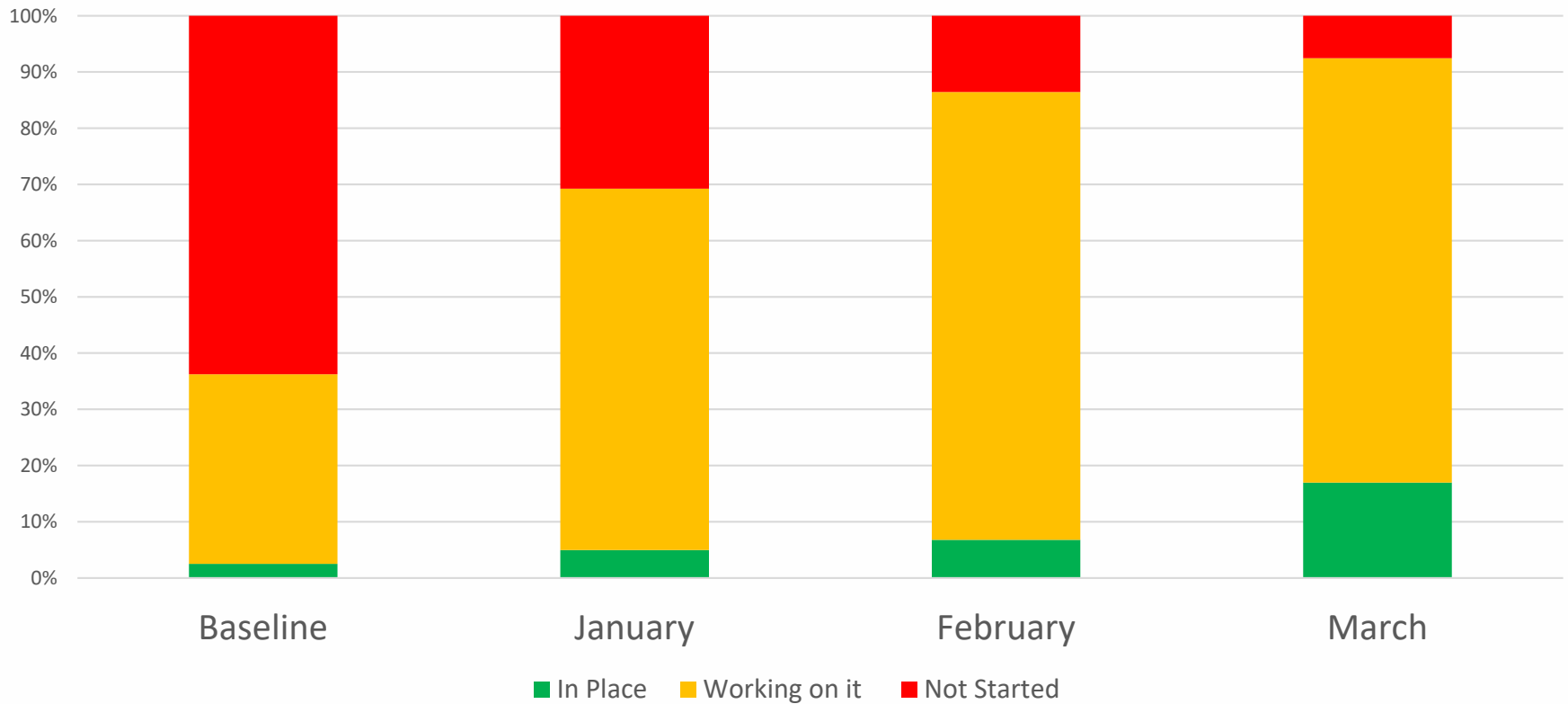
Structure Measures

Implemented standardized protocol/processes for induction, labor support management and response to labor and FHR abnormalities



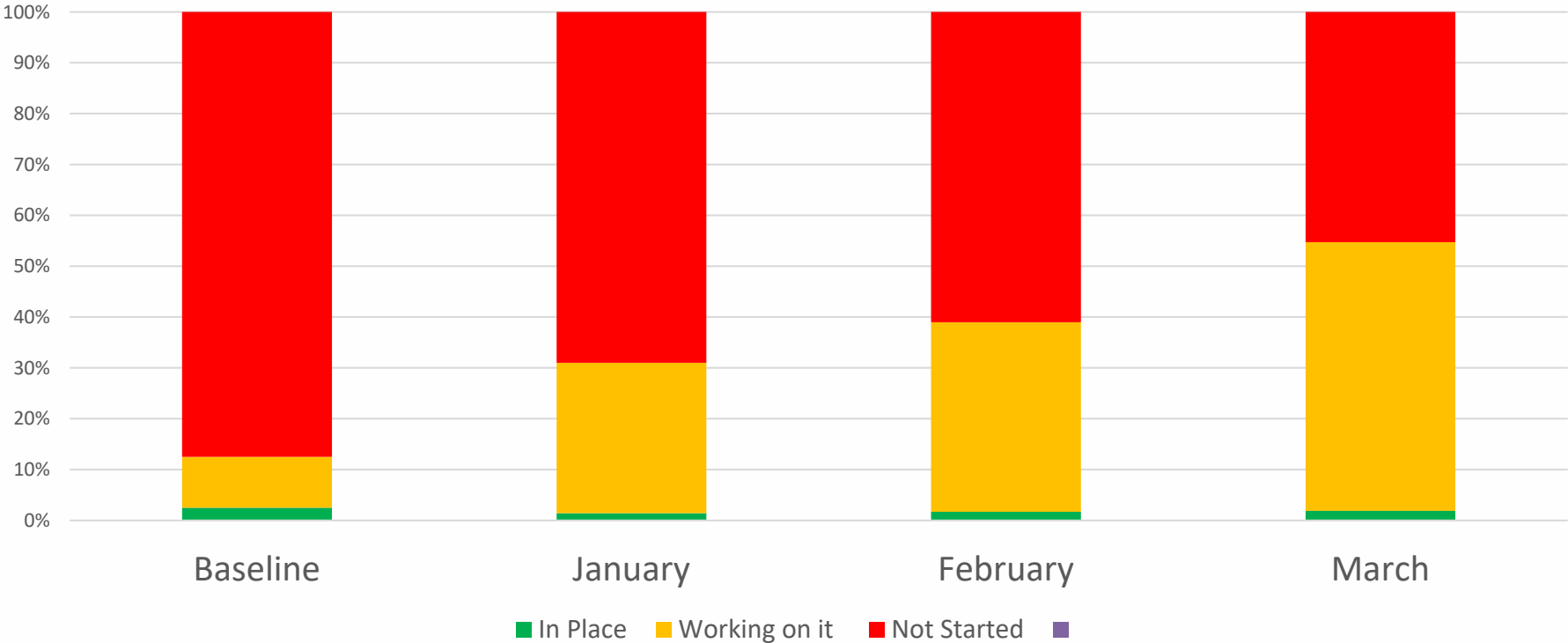
Structure Measures

Implemented provider and nurse education and other strategies to achieve buy-in



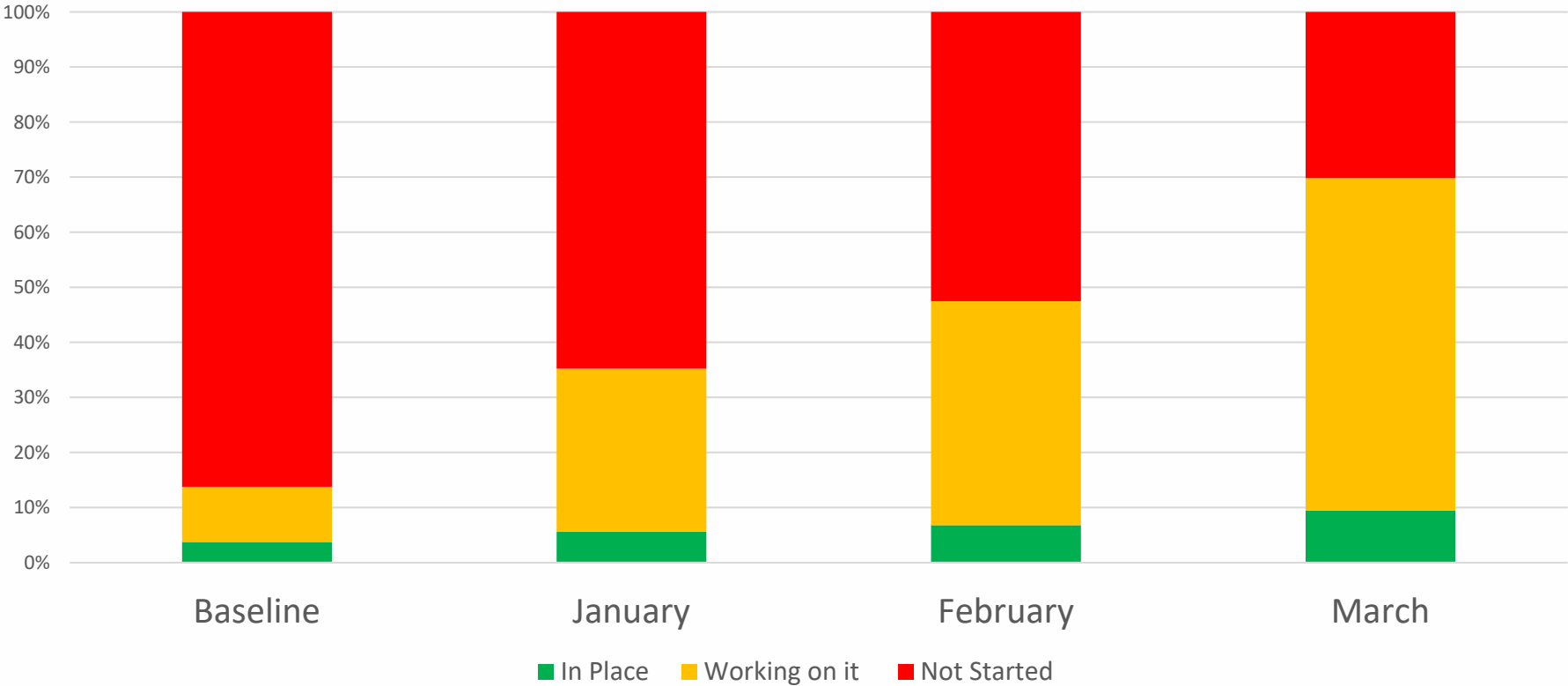
Structure Measures

Implemented and integrated PVB order sets, protocols, and documentation into the EMR



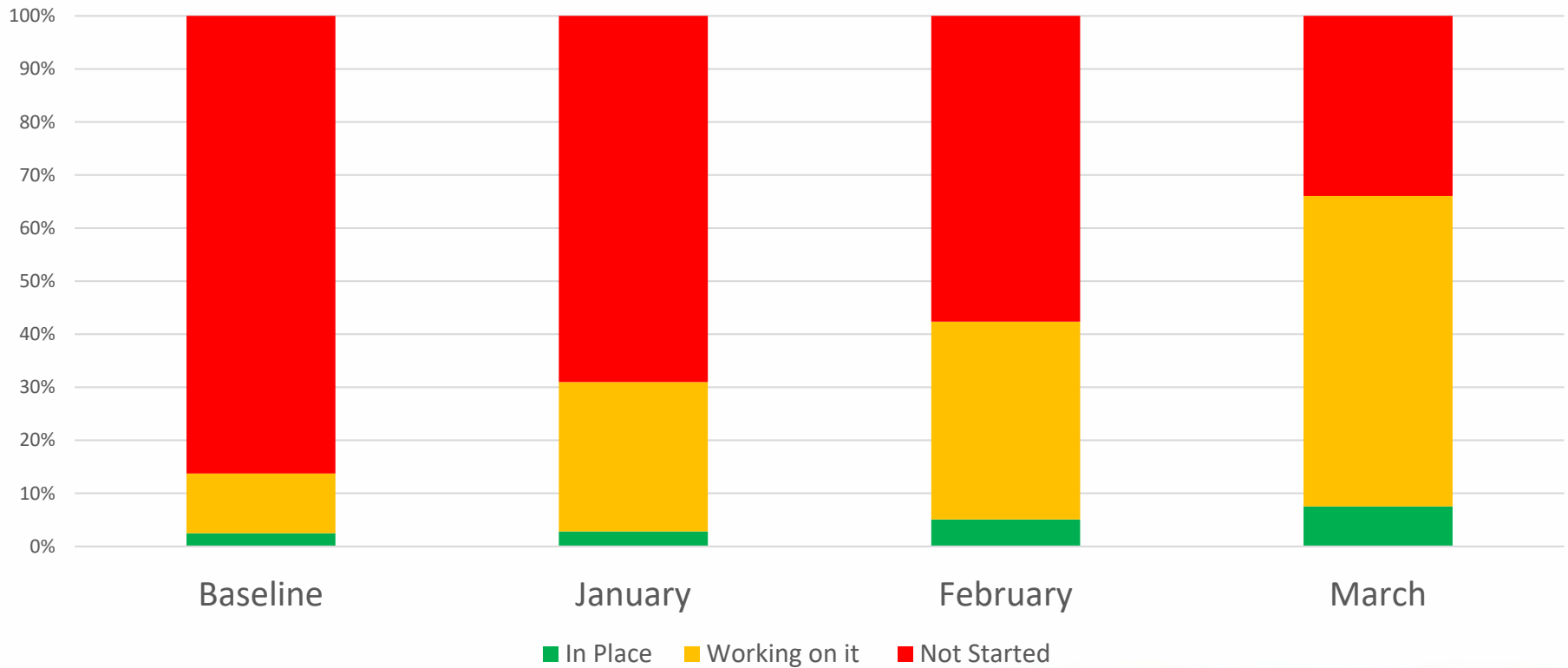
Structure Measures

Implemented cesarean decision checklist using ACOG/SMFM labor guidelines



Structure Measures

Implemented decision huddles and/or decision debriefs with appropriate care team to standardize use of ACOG/SMFM guidelines and checklist



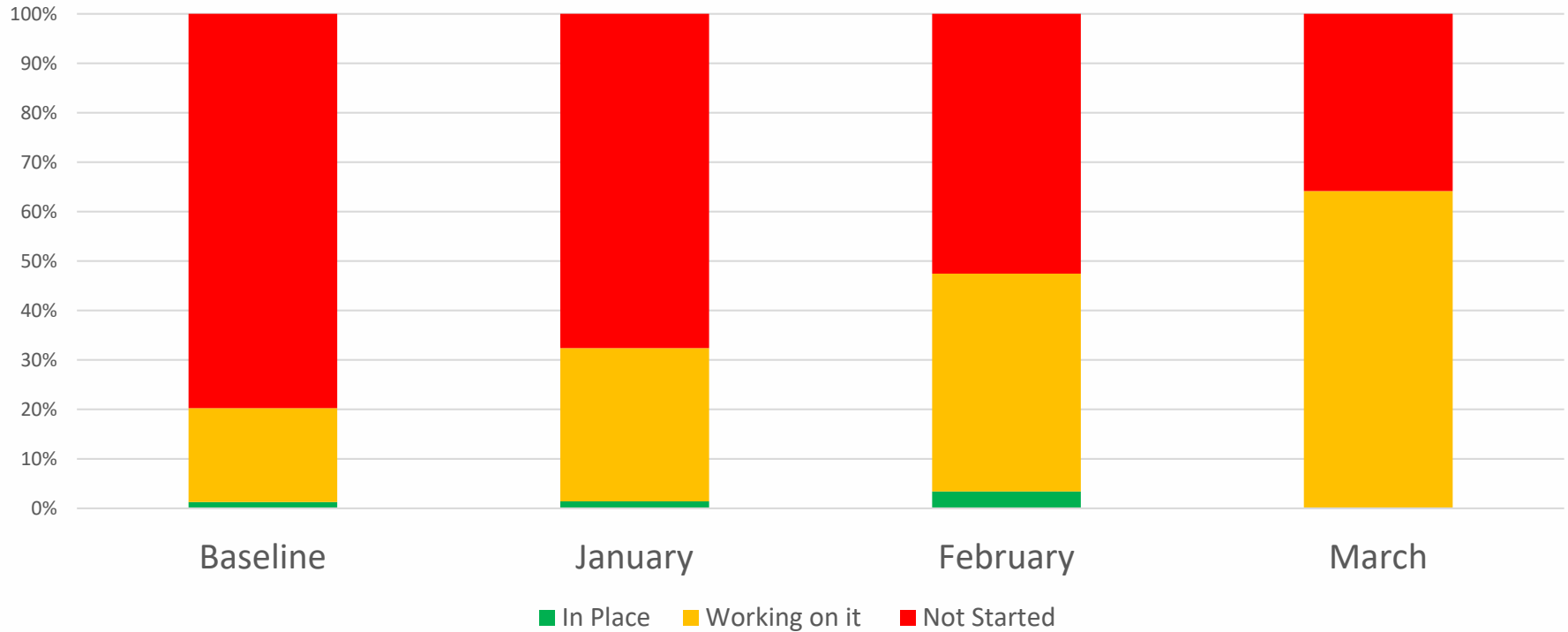
Structure Measures

Implemented workflow process to incorporate shared decision making with the patient



Structure Measures

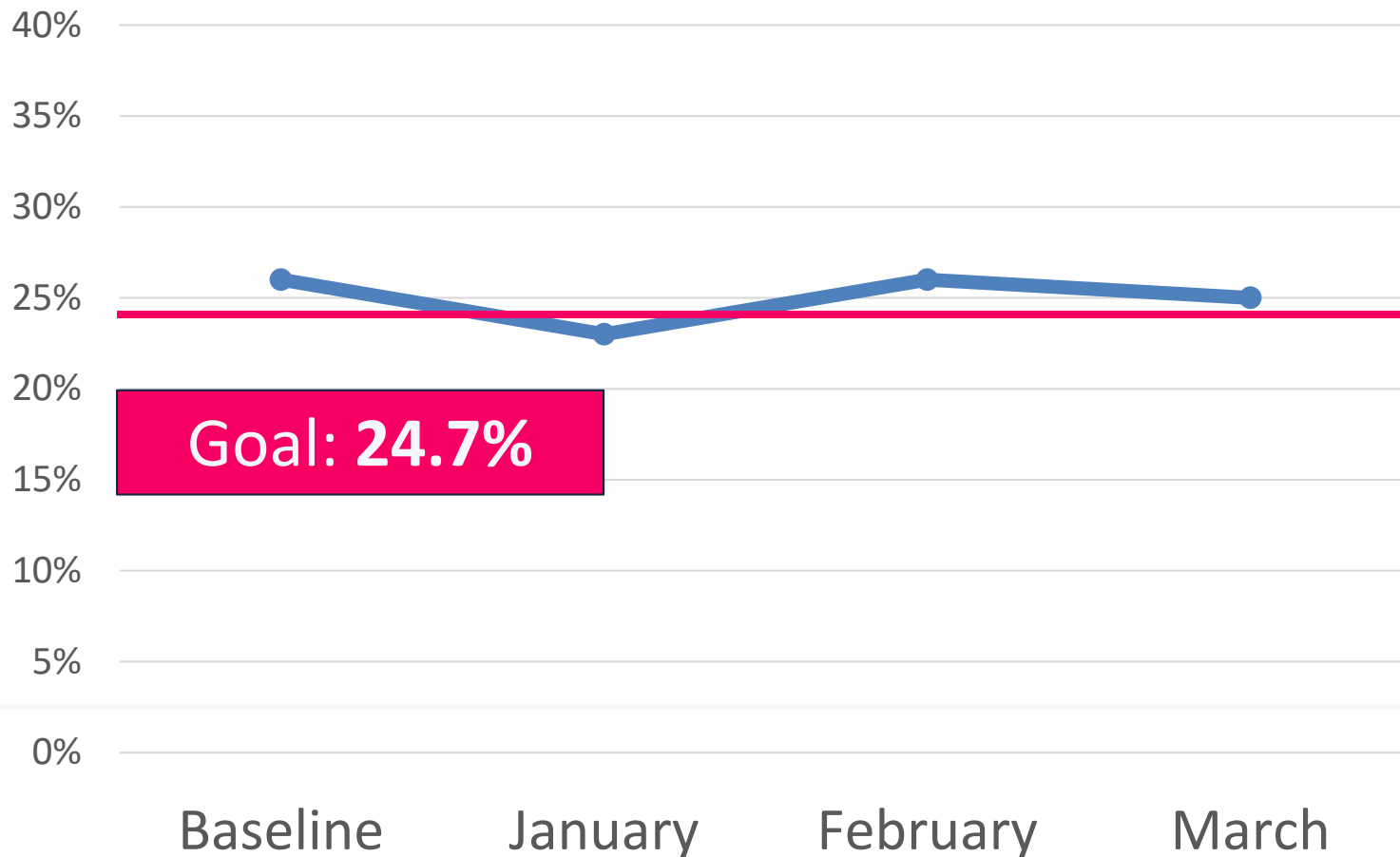
Implemented standardized patient education with positive messaging promoting vaginal birth strategies and techniques for women and families



ILPQC NTSV C-Section Rates



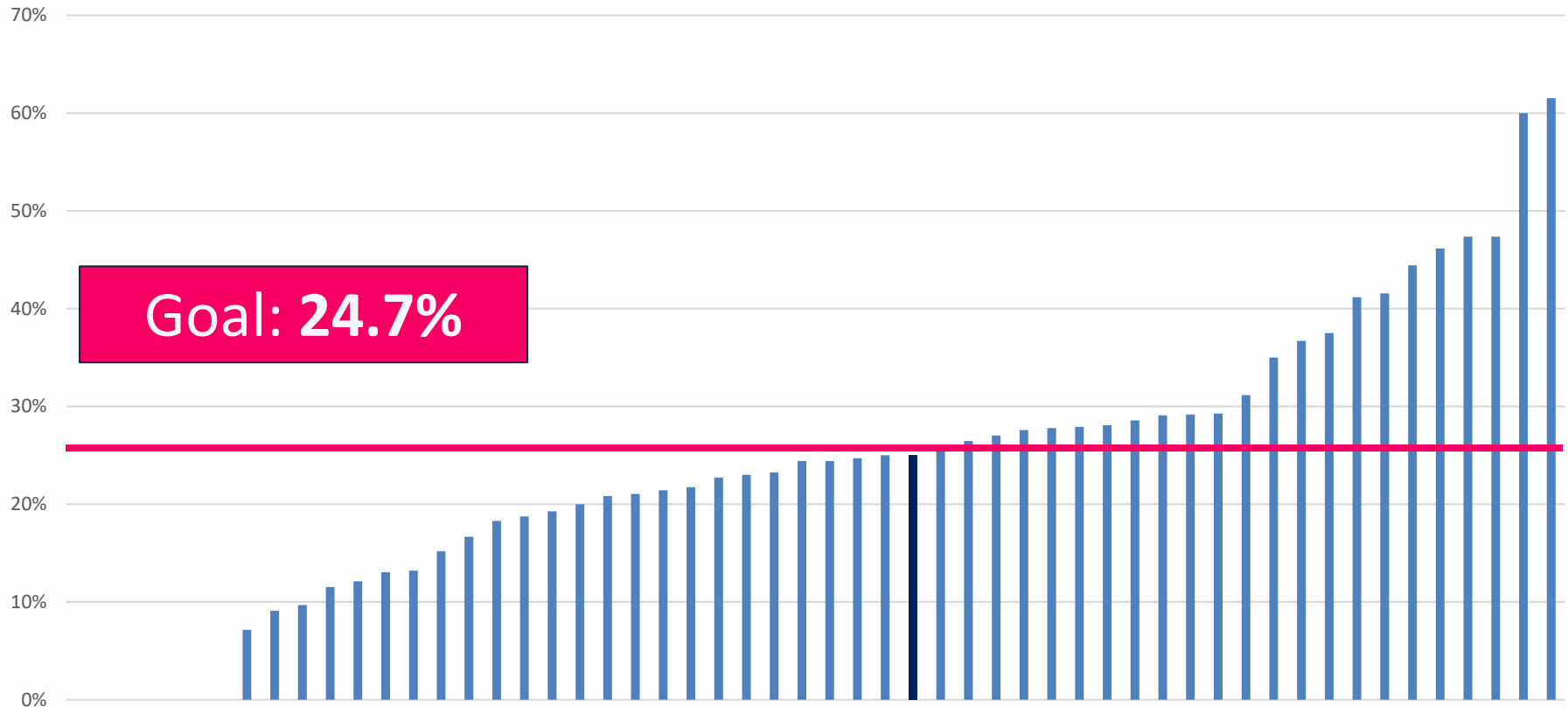
ILPQC NTSV C-Section Rates



March NTSV C-Section Rates

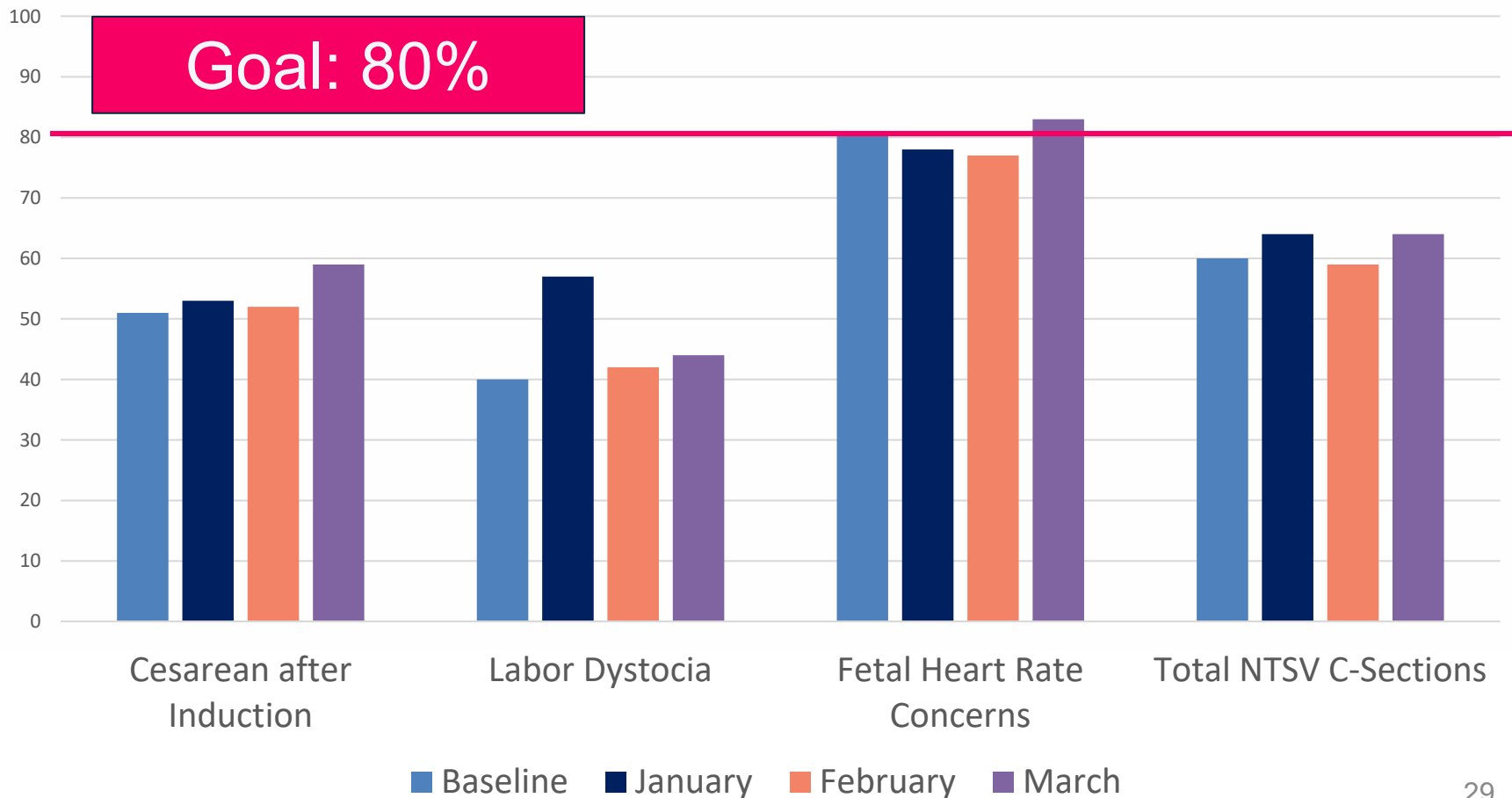


ILPQC NTSV C-Section Rates March 2021



NTSV C-Sections Meeting ACOG/SMFM Criteria

% of NTSV C-Sections Meeting ACOG/SMFM Criteria for ILPQC
Hospitals Baseline Data



INCORPORATING ACOG/SMFM GUIDELINES INTO C/S DECISIONS

Promoting Vaginal Birth Key Driver Diagram

Strategies

1. Create a QI team of providers, staff & administrators to lead the effort & cultivate buy-in
2. Conduct the Labor Culture Survey to understand current attitudes and beliefs of labor and delivery staff and unit norms.
3. Educate physicians/midwives and nurses on ACOG/SMFM labor management guidelines and labor support techniques
4. Develop patient education with positive messaging to women and families about intended vaginal birth strategies/techniques that prevent cesareans through prenatal classes and patient education
5. Utilize care team huddles/debriefs to identify and review delivery decisions for consistency with process flows/protocols/checklist
6. Integrate order sets, protocols, and documentation for the safe reduction of primary cesareans into EMR
7. Share provider-level measures with department with the goal of working to transparency/open data
8. Implement policies, protocols and support tools for women who present in latent (early) labor to safely encourage early labor at home
- 9a. Implement policies and protocols for encouraging movement in labor and intermittent monitoring for low-risk women
- 9b. Implement policies and protocols for induction of labor
- 9c. Implement policies and protocols for pain management and labor support
10. Implement standard criteria for diagnosis and treatment of labor dystocia, arrest disorders and failed induction
11. Develop checklist for ensuring ACOG/SMFM criteria for c/s is met
- 12a. Implement training/procedures for identification and appropriate interventions for malpositions (e.g. OP/OT)
- 12b. Implement standardized assessment, and response to fetal heart rate concerns

Drivers

culture change that promotes, and supports vaginal birth

2. Develop standardized processes for induction and labor support

3. Develop standardized protocols for identification and response to labor challenges / abnormalities

AIM

To support vaginal birth and reduce primary cesareans to reach the Healthy People goal for low risk cesarean section target rate of 24.7% by December 2022

13. Implementation of a workflow process for shared decision making (decision huddle with provider, nurse and patient to review treatment options, risk/benefits, and ACOG/SMFM guidelines)

1. Facilitate clinical culture change that promotes, and supports vaginal birth

- Facilitate clinical culture change that promotes, and supports vaginal birth
- Create a QI team of providers, staff & administrators to lead the effort & cultivate buy-in
- Conduct the Labor Culture Survey to understand current attitudes and beliefs of labor and delivery staff and unit norms.
- **Educate physicians/midwives and nurses on ACOG/SMFM labor management guidelines and labor support techniques**

1. Facilitate clinical culture change that promotes, and supports vaginal birth

- Develop patient education with positive messaging to women and families about intended vaginal birth strategies/techniques that prevent cesareans through prenatal classes and patient education
- Utilize care team huddles/debriefs to identify and review delivery decisions for consistency with process flows/protocols/checklist
- Integrate order sets, protocols, and documentation for the safe reduction of primary cesareans into EMR
- Share provider-level measures with department with the goal of working to transparency/open data

2. Develop standardized processes for induction and labor support

- Implement policies and protocols for encouraging movement in labor and intermittent monitoring for low-risk women
- Implement policies and protocols for induction of labor
- Implement policies and protocols for pain management and labor support

3. Develop standardized protocols for identification and response to labor challenges / abnormalities



- Implement standard criteria for diagnosis and treatment of labor dystocia, arrest disorders and failed induction
- Implement standardized assessment, and response to fetal heart rate concerns
- Develop checklist for ensuring ACOG/SMFM criteria for c/s is met
- Implementation of a workflow process for shared decision making (decision huddle with provider, nurse and patient to review treatment options, risk/benefits, and ACOG/SMFM guidelines)

ILPQC ACOG/SMFM Checklist

NEW!

- Helps all staff determine if ACOG/SMFM c/s delivery criteria is being met!
- Useful communication tool for bedside RN & delivering provider
- Available in your newsletter and the online ILPQC PVB Toolkit

ACOG/SMFM Guidelines

Checklist for Labor Dystocia & Arrest

Use this checklist with the appropriate care team members to assist in diagnosing failed induction, labor dystocia or arrest and determining if ACOG/SMFM Criteria have been met, prior to decision to proceed to cesarean section.

Place patient sticker here

Delivery Provider: _____; Initials: _____

Labor & Delivery RN: _____; Initials: _____

Date & Time: _____

Failed induction: _____

Both boxes should be checked if cervix unfavorable (Bishop Score < 8 for nullips and <6 for multips):

- Cervical Ripening used (when starting with unfavorable Bishop scores as noted above).
- Oxytocin administered for at least 12-18 hrs after membrane rupture, without achieving cervical change and regular contractions. *Note: at least 24 hrs of oxytocin administration after membrane rupture is preferable if maternal & fetal statuses permit

Latent phase arrest (cervix <6cm): _____

Both boxes should be checked:

- Oxytocin administered for at least 12-18 hrs after membrane rupture, without achieving cervical change and regular contractions.
- A longer duration of the latent phase is preferable (24 hrs or longer if maternal & fetal statuses permit).

Active phase arrest (cervix ≥6cm): _____

Both boxes should be checked:

- Membranes ruptured (if possible).
- No cervical change after at least 4 hrs of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hrs of oxytocin administration with inadequate uterine activity.

Second stage arrest (cervix 10cm/pushing): _____

Two boxes should be checked:

- Fetal position known and rotation attempted if OP
- For nulliparous:** 3hr or more of active pushing (4hr with epidural)
- For multiparous:** 2 hr or more of active pushing (3hr with epidural)

- Although not fulfilling the above criteria for labor dystocia, my clinical judgment deems this cesarean delivery indicated

ACOG/SMFM Guidelines



Illinois Perinatal
Quality Collaborative

www.ilpqc.org

Ex:
1

Checklist for Labor Dystocia & Arrest

Use this checklist with the appropriate care team members to assist in diagnosing failed induction, labor dystocia or arrest and determining if ACOG/SMFM Criteria have been met, prior to decision to proceed to cesarean section.

Jane Smith
DOB: 1/1/91

Delivery Provider: Dr. Borders ; Initials: AB
Labor & Delivery RN: A Perrault ; Initials: AP
Date & Time : 4/26/21 @ 2125

Failed induction: X

Both boxes should be checked if cervix unfavorable (Bishop Score < 8 for nullips and <6 for multips) :

- Cervical Ripening used (when starting with unfavorable Bishop scores as noted above).
- Oxytocin administered for at least 12-18 hrs after membrane rupture, without achieving cervical change and regular contractions. *Note: at least 24 hrs of oxytocin administration after membrane rupture is preferable if maternal & fetal statuses permit

Ex:
2

Although not fulfilling the above criteria for labor dystocia, my clinical judgment deems this cesarean delivery indicated

Additional ILPQC Toolkit Items



Other tools available & to consider

- **FPQC** Sample Checklists
 - Hackensack Meridian Health Pre-Cesarean Checklist and Team Huddle Form
 - Tampa General Pre-cesarean Huddle form
- **CMQCC**: Pre-Cesarean Checklist for Labor Dystocia or Failed Induction

Hackensack Meridian Health
Pre-Cesarean Checklist for Labor Dystocia, Failed Induction and Fetal Heart Rate Abnormalities

Active Phase Arrest: ≥ 6 cm Dilatation (must fulfill one of the two criteria)

Indication for Primary Cesarean Delivery:

- Failed Induction (must have both criteria: 1 cervix unfavorable, Bishop Score < 8 for nullip and < 6 for multip)
- Cervical Ripening used (when starting with unfavorable Bishop scores as noted above). Ripening agent used: _____
- Unfavorable _____ Person (ripening not used) If cervix unfavorable
- AND
- Unable to generate regular contractions (every 3 minutes) and cervical change after oxytocin administered for at least 12-18 hours after membrane rupture. Note: at least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit
- Failed Induction: Duration in hours: _____
- Latent Phase Arrest: < 6 cm dilatation (must fulfill one of the two criteria)
- Moderate or strong contractions palpated for > 12 hours without cervical change
- OR
- IUPC > 200 MVU for > 12 hours without cervical change

*As long as cervical progress is being made, a slow but progressive latent phase (e.g. greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women) is not an indication for cesarean delivery as long as fetal and maternal statuses remain reassuring. Please exercise caution when diagnosing latent phase arrest and allow for sufficient time to enter the active phase.

Tampa General Hospital
Pre-Cesarean Huddle Form

The intent of this form/toolkit is to define criteria for arrest of dilatation, failed induction and interventions for NRP/HT as defined by the FPQC. It is also meant to explore alternate options to prevent cesarean sections in an interdisciplinary setting on the OR unit.

Huddle should occur when a c/s is being considered due to arrest, failed IOL or NRP/HTs. Huddles can occur for other reasons as deemed necessary by the pending team.

Date and time of huddle: _____ Current room: _____
 Obedience and Gestational age: _____
 ROM time: _____ Last Cervical Exam: _____

Obstetrician: _____
 Midwife/physician: _____
 Safety Nurse &/or Charge Nurse: _____
 Anesthesia provider (MD/ANP/CRNA): _____
 Primary RN present: _____
 Anesthesia at bedside: _____

Reason for huddle: Arrest of dilatation Failed induction Interventions done thus far for huddle All of these

CMQCC
California Maternal Quality Collaborative
Appendix J

Pre-cesarean Checklist for Labor Dystocia or Failed Induction

Patient Name: _____ MR#: _____
 Gestational Age: _____ Date of C-section: _____
 Time: _____
 Obstetrician: _____ Initial: _____
 OR
 Bedside Nurse: _____ Initial: _____

Indication for Primary Cesarean Delivery:

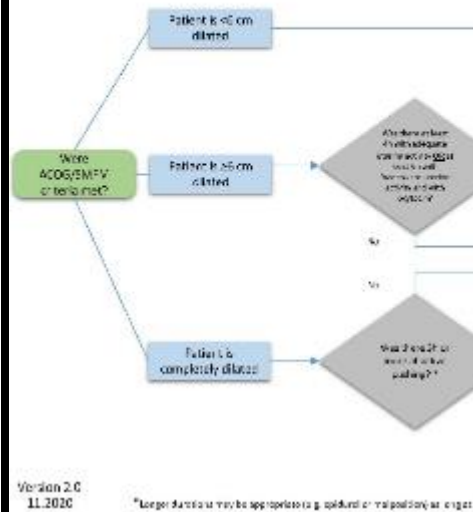
- Active Phase Arrest: ≥ 6 cm Dilatation (must fulfill one of the two criteria)
- Multipara with epidural pushing for at least 4 hours
- OR
- Multipara without epidural pushing for at least 3 hours
- OR
- Multipara with epidural pushing for at least 3 hours
- OR
- Multipara without epidural pushing for at least 2 hours
- Although not fulfilling contemporary criteria for labor dystocia as described above, my clinical judgment deems this cesarean delivery indicated
- Failed induction: Duration in hours: _____
- Latent Phase Arrest: Duration in hours: _____
- Active Phase Arrest: Duration in hours: _____
- Second Stage Arrest: Duration in hours: _____

Comments: _____

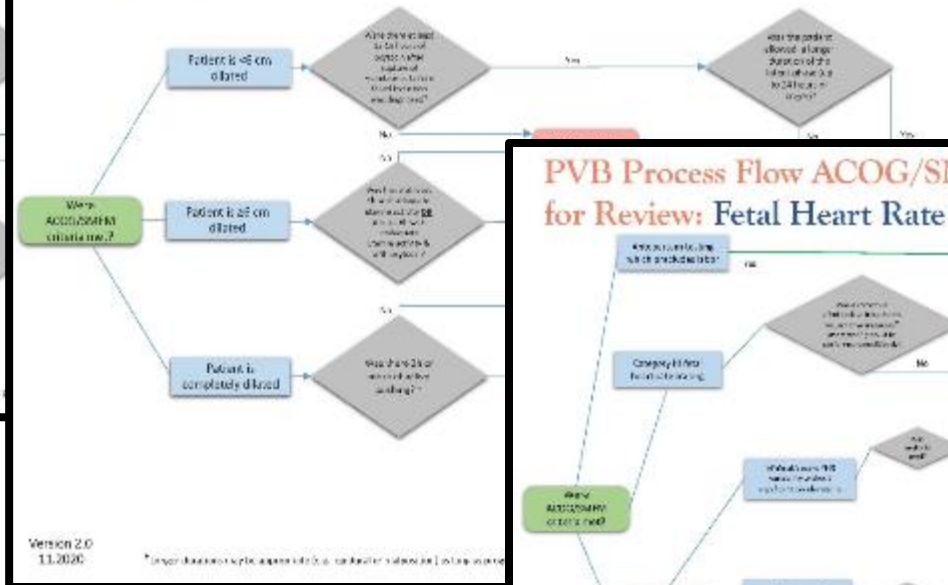
Adapted with permission from Miller Children's and Women's Hospital.

ILPQC Toolkit Items: Process Flow Diagrams for ACOG/SMFM Criteria

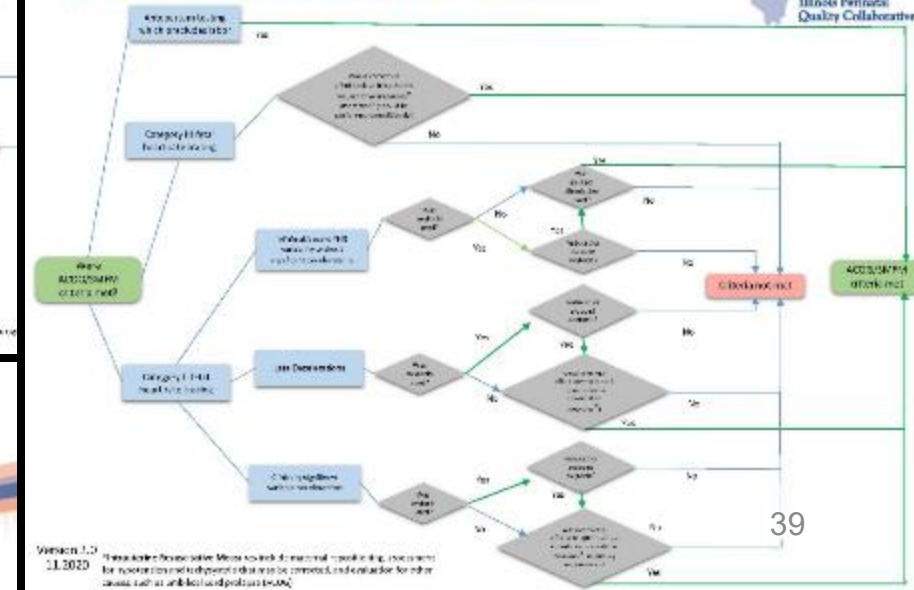
PVB Process Flow ACOG/SMFM Criteria for Review: Labor Dystocia/ Failure to Progress



PVB Process Flow ACOG/SMFM Criteria for Review: Induction



PVB Process Flow ACOG/SMFM Criteria for Review: Fetal Heart Rate Concerns



TAMPA GENERAL HOSPITAL:
DANIELLE BRENNAN, BSN, RNC AND
LINDSAY GREENFIELD, MSN, APRN



Implementing an Interdisciplinary Pre-Cesarean Huddle Form

Safe Reduction of Primary
Cesarean Delivery

Danielle Brennan, BSN, RNC and Lindsay Greenfield, MSN, APRN



Tampa General Hospital

Teaching hospital for
University of South
Florida Morsani
College of Medicine-
Tertiary, quaternary
care center for West
Central Florida

Statistics:

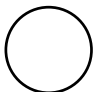
- Labor and Delivery- 21 LDRs, 13 triage beds, 4 OR's, 5 PACU
- 6200+ deliveries per year

Practices:

- USF faculty practice: 22 generalists, 12 MFM, 12 CNMs
- TGH Genesis Women's Center: resident and fellow clinic, Low risk and high volume high risk
- Women's Health Care: Independent CNM practice with private office and service FQHCs across Tampa
- Suncoast FQHCs
- One independent private practitioner

Designations:

- Magnet Designated Facility
- Baby Friendly
- Center of Excellence for VBAC and Accreta



FPQC Partnership

Have participated in most FPQC initiatives:

Maternal hemorrhage

Maternal Hypertension

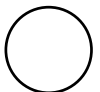
Antenatal Steroids

PROVIDE 1.0 and 2.0

Immediate post-partum LARC

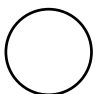
Neonatal Abstinence

Maternal Opioid Recovery Effort



PROVIDE 1.0

- Focus area: Fetal Heart rate concerns
- Starting rate: 28.3%
- Goal: 20% reduction = 22.64%
- Rate at close of initiative (18 months): 22.12% -Goal MET



Challenges & Successes

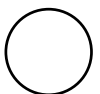
PROVIDE 1.0

Challenges:

- Creating the culture
- Buy-in from nurses and providers
- Changes to EMR documentation/flowsheets

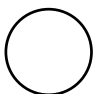
Successes:

- Mandatory online Interpretation of FHR course for providers and nurses
- Intermittent auscultation initiative
- Participation in labor workshop hosted by FPQC CNM's
- Posting of weekly and monthly NTSV rates by admitting provider group
- Unblinded FY data by provider group
- Regular announcements at safety huddle
- **Pre-Cesarean Huddle form**



Implementing a Pre-C/S huddle

- Less about the ‘form’; more focus on the conversation
- Get 1 person of influence on board with the idea- this is your champion!
- Make small adjustments based on feedback
- Nurse leaders- hold your own huddles!

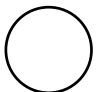


Make it hard to be against!

Integrity, Compassion, & Safety

The intent of this form/huddle is to define criteria for arrest of dilatation, failed induction and interventions for NRFHT's as defined by the FPQC. It is also meant to explore safe options to prevent cesarean sections in an interdisciplinary setting on the OB unit.

Huddle should occur when a c/s is being considered due to labor dystocia, failed IOL or NRFHT's. Huddles can occur for other reasons as deemed necessary by the providing team.



Challenges

1

Resistance (buy-in/push back)

2

Sustaining Improvements

3

Competing priorities

- Difficult shifts
- Staffing

4

Fatigue

5

COVID



How Can We Improve Our Huddle? Get feedback!

1

Gather Feedback from Providers and Nursing

- Provider Feedback Survey
- Nursing feedback Survey

2

Continue to Do Huddles

3

Continue Modifications

- Feedback-based
- Highlight Our New Focus



Feedback Survey

Confidential

Pre-cesarean Huddle Survey
Page 1

Pre-cesarean Huddle Provider Survey

Record ID: _____

What is your provider role as Labor and Delivery?

- Attending Physician
- Certified Nurse Midwife (CNM)
- Resident Physician
- Anesthesia Provider (CRNA or MD)

Have you personally participated in a Pre-Cesarean Interdisciplinary Huddle?

- Yes
- No
- I Don't Know

How many times have you used the pre-cesarean section huddle form?

- 1-5
- 6-10
- 11-15
- More than 15

You have a patient who is not progressing well in labor. How likely are you to initiate a huddle?

- Very likely
- Somewhat likely
- Neutral
- Somewhat unlikely
- Very Unlikely

You have a patient with a concerning fetal heart rate tracing. How likely are you to initiate a huddle?

- Very likely
- Somewhat likely
- Neutral
- Somewhat unlikely
- Very Unlikely

You have a patient with a prolonged induction. How likely are you to initiate a huddle?

- Very likely
- Somewhat likely
- Neutral
- Somewhat unlikely
- Very Unlikely

The Pre-Cesarean Huddle form has improved communication.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

I have been able to voice my thoughts and concerns during the discussions.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

8/21/2020 2:09pm

PHOENIXRECAPING REDCap

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Page 2

What aspects of this form and discussion have worked well? (Select all that apply.)

- The form is easy to fill out
- It can be filled out in a timely fashion
- Everyone can voice their opinions
- We can review the course of the patient
- It gets everyone on the same page
- We may identify interventions that we have not tried
- Other

(Include other ways in which the huddle has worked well)

	Extremely well	Somewhat well	Slightly / not really	Not at all	Can't answer / don't know
Facilitating clear communication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clarifying the indication for cesarean section	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Discussing attempted interventions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Communicating the plan of care to the patient	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What barriers have been encountered that have inhibited the use of the form?

- There's not enough time
- I forget to use it
- I don't like using it
- I can't ever find the form
- It is challenging to get everyone together to discuss
- Other

(Include other barriers to using the huddle form)

What challenges have you experienced while using the form?

- The form is too long
- I can't voice my opinions openly
- No one listens during the discussion
- Feel attacked
- Other

(Include other challenges you have encountered)

8/21/2020 2:09pm

PHOENIXRECAPING REDCap

Confidential

Page 3

In what way(s) could we improve the huddle process?

- Make it shorter/fewer questions
- Give everyone a chance to speak
- Make the form more readily available
- Change who should be at the huddle
- Other

(Include other possible improvements)

The Pre-Cesarean Huddle form has improved patient care.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

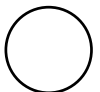
The Pre-Cesarean Huddle form has improved patient safety.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

The Pre-Cesarean Huddle form has reduced the number of unindicated Cesarean sections.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

Please provide any additional feedback you may have regarding the Pre-Cesarean Huddle form.



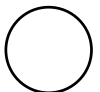
Team Member Education

Staff/provider education

- Launch Party with both PROVIDE 1.0 & 2.0
- Ed-blocks with case reviews (live & now virtual)
- Friday Updates
- Continued e-learnings/Relias Pearls

Barriers and how we overcame these


- Provider education buy in- made FHR education part of recredentialing every 2 years.
- Posted algorithm for management of Category 2 in various locations for easy use and consistency



Multiple versions

1st version

Pre-Cesarean Huddle Form



The intent of this form/huddle is to define criteria for arrest of labor, failed induction and interventions for NRPMT as defined by the IROG. It is also meant to explore options to prevent cesarean sections in an interdisciplinary setting on the OB unit.

Huddle should occur when a c/s is being considered due to arrest, failed IU, or NRPMT. Huddles can occur for other reasons as deemed necessary by the providing team.

Date and time of huddle: _____ Current room: _____
 GYN and Primary Obstetrical team: _____ Late Cervical Exam: _____
 ROM time: _____
 Obstetrical history: _____
 Attending physician(s) report: _____
 Safety Nurse (Nurse Charge Nurse) (required): _____
 Decision provider (MD/Resident) (required): _____
 Primary RN (available): _____
 Anesthesia (available): _____

Reason for huddle: (circle all that apply) - Arrest of Labor/Dystocia - Malposition - Failed IU
 IUGR - Fetal Growth Restriction - SPPRO - Arrest of Induction/Late Dystocia - Malposition - Failed IU
 Other: _____ Variability: _____

PIT passed (circle all that apply) - Early - Variable - Late - Prolonged
 Decidua present (circle all that apply) - Early - Variable - Late - Prolonged
 Accents present - Yes / No Category of tracing - 1 2 3


Interventions done thus far (circle all that apply) - *Response - *TFT looks for hypotension *OO *Tetralatine
 *Decrease Pitocin *Stop Pitocin *Amniotomomy for variable decels *Remove Cervical
 *Remove balloon/Cook *Vaginal exam/PAS to elicit fetal response for minimal variability

See back of page for Labor (Dystocia, Failed IU, and Late Category 2 Alpha 1/3).

- Resource-Florida Perinatal Quality Collaborative
- Labor/Dystocia criteria:
 - 1st Stage - not in labor, does not meet these criteria (cannot call c/s due to Arrest if less than 6 cm, active labor has not been achieved, consider giving more time)
 - 2nd Stage - 1st stage - was there at least 4 hours with adequate uterine activity or at least 6 hours with inadequate uterine activity and with oxytocin? If no, does not meet criteria for arrest-consider giving more time
 - 3rd Stage - 2nd stage - was there at least 3 hours or more in second stage-4 hours with an epidural? If not, consider next criteria for arrest, consider giving more time - Multiparous- was there at least 2 hours or more in the second stage (without an epidural)?
- Failed IU Criteria:
 - 1st Stage dilated, was there at least 12 hours of oxytocin after rupture of membranes?
 - 2nd Stage dilated, was there at least 4h with adequate uterine activity or at least 6h with inadequate uterine activity and with oxytocin?
 - 3rd Stage dilated, was there 3h or more of active pushing (4h with epidural)?

2nd version

Pre-Cesarean Huddle Form



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 ROM time: _____
 Obstetrical history: _____
 Attending physician(s) report: _____
 Safety Nurse (Nurse Charge Nurse) (required): _____
 Decision provider (MD/Resident) (required): _____
 Primary RN (available): _____
 Anesthesia (available): _____

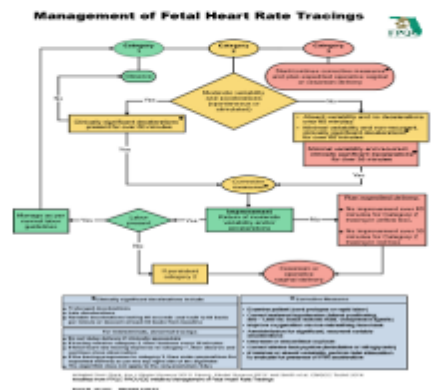
Reason for huddle: (circle all that apply)
 IUGR - Fetal Growth Restriction - SPPRO - Arrest of Induction/Late Dystocia - Malposition - Failed IU
 Other: _____ Variability: _____

PIT passed (circle all that apply) - Early - Variable - Late - Prolonged
 Decidua present (circle all that apply) - Early - Variable - Late - Prolonged
 Accents present - Yes / No Category of tracing - 1 2 3

Interventions done thus far (circle all that apply) - *Response - *TFT looks for hypotension *OO *Tetralatine
 *Decrease Pitocin *Stop Pitocin *Amniotomomy for variable decels *Remove Cervical
 *Remove balloon/Cook *Vaginal exam/PAS to elicit fetal response for minimal variability

See back of page for Labor (Dystocia, Failed IU, and Late Category 2 Alpha 1/3).

- Labor/Dystocia criteria:
 - 1st Stage - not in labor, does not meet these criteria (cannot call c/s due to Arrest if less than 6 cm, active labor has not been achieved, consider giving more time)
 - 2nd Stage - 1st stage - was there at least 4 hours with adequate uterine activity or at least 6 hours with inadequate uterine activity and with oxytocin? If no, does not meet criteria for arrest-consider giving more time
 - 3rd Stage - 2nd stage - was there at least 2 hours or more in second stage-4 hours with an epidural? If not, consider next criteria for arrest, consider giving more time - Multiparous- was there at least 2 hours or more in the second stage (without an epidural)?
- Failed IU Criteria:
 - 1st Stage dilated, was there at least 12 hours of oxytocin after rupture of membranes?
 - 2nd Stage dilated, was there at least 4h with adequate uterine activity or at least 6h with inadequate uterine activity and with oxytocin?
 - 3rd Stage dilated, was there 3h or more of active pushing (4h with epidural)?



Pre-Cesarean Huddle Form: A Communication Tool

Pre-Cesarean Huddle Form



Patient name/MRN or sticker

The intent of this form/huddle is to define criteria for arrest of dilatation, failed induction and interventions for NRFHT's as defined by the FPQC. It is also meant to explore safe options to prevent cesarean sections in an interdisciplinary setting on the OB unit.

Huddle should occur when a c/s is being considered due to labor dystocia, failed IOL or NRFHT's. Huddles can occur for other reasons as deemed necessary by the providing team.

- ❖ **Date and time of huddle-** _____
- ❖ **G's and P's and Gestational age-** _____ Current room _____
- ❖ **ROM time** _____ Last Cervical Exam _____ Length of time since exam changed _____

❖ **Attendees- list names**

Attending physician*required _____
 Safety Nurse &/or Charge Nurse* 1 required _____
 Bedside provider (CNM/Resident) *1 required _____
 Primary RN (if available) _____
 Anesthesia (if available) _____

❖ **Reason for huddle- (circle all that apply)**

C/S being considered- Labor Dystocia(Arrest of dilatation) Failed IOL NRFHT Maternal Condition
 Other _____

❖ **Labor Dystocia-** (<6cm cannot be labor dystocia) only applies to spontaneous labor- not IOL's

- o Is the patient 5 – 9.5 cm? Has the patient had adequate cty for at least 4h or 6h if inadequate cty? If not, she needs more time.
- o Is the gt 10cm? - Prime- should push for minimum 3h, 4h with epidural. Multiparous- push for minimum 2h, 3h with epidural. If not, she needs more time

❖ **Failed IOL-** If the patient was an IOL on admission, she will not be considered labor dystocia- she is a failed IOL.

- o If the gt is <6cm- were there at least 12h of oxytocin after ROM? If no, needs more time.
- o If the gt is 6 – 10 cm- was there at least 4h adequate or 6h inadequate cty with oxytocin? If not, she needs more time.
- o 10 cm- at least 3h of pushing, 4h with epidural. If not, needs more time.

❖ **FHT agreed upon interpretation at the time of huddle-** Baseline _____ Variability _____

Decels present (circle all that apply) - Early Variable Late Prolonged

Accels present- Yes / No _____ Category of tracing- 1 2 3

❖ **Interventions done thus far (circle all that apply)** - *Reposition *IVF bolus for hypotension *O2 *Terbutaline

*Decrease Pitocin *Stop Pitocin *Amnioinfusion for variable decels *Remove Cervidil

❖ **Remove balloon/Cook** *Vaginal exam/VAS to elicit fetal response for minimal variability

❖ **Birth Outcome: Apgars** pH _____ Vag or C/S _____
 See back of page for FHR Algorithm diagram and explanations. Please document huddle in Progress note- obhuddle

❖ **Labor Dystocia criteria-**

Version 1.3 5/21/2020

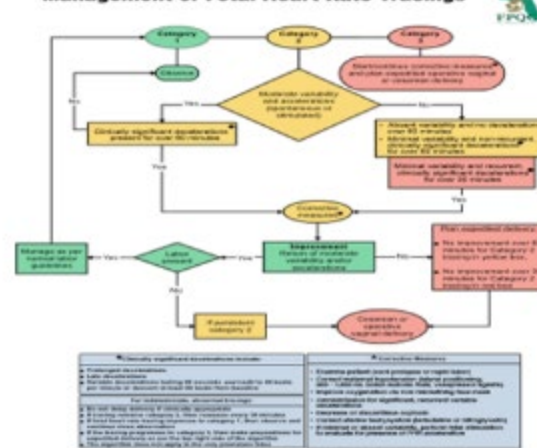
❖ **Labor Dystocia criteria-**

- o **Less than 5cm** – not in labor, does not meet these criteria (cannot call c/s due to Arrest if less than 6 cm, active labor has not been achieved, consider giving more time)
- o **5cm – 9.5 cm dilated**- was there at least 4 hours with adequate uterine activity or at least 6 hours with inadequate uterine activity and with oxytocin? If no, does not meet criteria for arrest- consider giving more time
- o **10cm** - Prime/gravida- was there at least 3 hours or more in second stage- 4 hours with an epidural? If not, does not meet criteria for arrest, consider giving more time. Multiparous- was there at least 2 hours or more in the second stage (without an epidural)?

❖ **Failed IOL Criteria-**

- o **If 6cm dilated** were there at least 12 hours of oxytocin after rupture of membranes?
- o **If 8-10cm dilated**, was there at least 4h with adequate uterine activity or at least 6h with inadequate uterine activity and with oxytocin?
- o **If completely dilated**, was there 3h or more of active pushing (4h with epidural)?

Management of Fetal Heart Rate Tracings



Reference:

Spong, C.Y., Scandola, Y., Winstrom, K.D., Marzer, B.M. and Spong, G.R. Preventing the First Cesarean Delivery: Summary of a Joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists Workshop. *Obstet. Gynecol.* 2014; 123(3): 538-549.

Version 1.3 5/21/2020



Final Version



Pre-Cesarean Huddle Form



Patient name/MRN or sticker

The intent of this form/huddle is to define criteria for arrest of dilatation, failed induction and interventions for NRFHT's as defined by the FPQC. It is also meant to explore safe options to prevent cesarean sections in an interdisciplinary setting on the OB unit.

Huddle should occur when a c/s is being considered due to labor dystocia, failed IOL or NRFHT's. Huddles can occur for other reasons as deemed necessary by the providing team.

- ❖ Date and time of huddle- 4-21 @ 0510
- ❖ G's and P's and Gestational age- 16 31 Current room 4208
- ❖ ROM time Room Last Cervical Exam 5/7/12 Length of time since exam changed 0.245
- ❖ Attendees- list names

Attending physician*required Dr. Bruder
 Safety Nurse &/or Charge Nurse* 1 required Sheal Muriah
 Bedside provider (CNM/Resident) *1 required Sarka
 Primary RN (if available) Sulanner
 Anesthesia (if available) _____

- ❖ Reason for huddle- (circle all that apply)

C/S being considered- Labor Dystocia(Arrest of dilatation) Failed IOL (NRFHT) Maternal Condition
 Other _____

- ❖ Labor Dystocia- (<6cm cannot be labor dystocia) only applies to spontaneous labor- not IOL's
 - Is the patient 6 - 9.5 cm? Has the patient had adequate ctx for at least 4h or 6h if inadequate ctx? If not, she needs more time.
 - Is the pt 10cm? - Prime- should push for minimum 3h, 4h with epidural. Multiparous- push for minimum 2h, 3h with epidural. If not, she needs more time
- ❖ Failed IOL- If the patient was an IOL on admission, she will not be considered labor dystocia- she is a failed IOL.
 - If the pt is <6cm- were there at least 12h of oxytocin after ROM? If no, needs more time.
 - If the pt is 6 - 10 cm- was there at least 4h adequate or 6h inadequate ctx with oxytocin? If not, she needs more time.
 - 10 cm- at least 3h of pushing, 4h with epidural. If not, needs more time.

❖ FHT agreed upon interpretation at the time of huddle- Baseline 160 Variability Minimal
 Decels present (circle all that apply) - Early Variable (Late) Prolonged
 Accels present- Yes No Category of tracing- 1 2 3

- ❖ Interventions done thus far (circle all that apply) * Reposition * IV bolus for hypotension * O2 * Terbutaline

* Decrease Pitocin * Stop Pitocin * Amnioinfusion for variable decels * Remove Cervidil

* Remove balloon/Cook * Vaginal exam/VAS to elicit fetal response for minimal variability

- ❖ Birth Outcome: Apgars 9-9 pH _____ Vag or C/S _____
- See back of page for FHR Algorithm diagram and explanations. Please document huddle in Progress note/obhuddle

Knee chest @ 1328
baby out @ 1436
SVD @ 1436
Room 6!



Completed Example

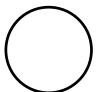
Importance of the First Birth

If a woman has a Cesarean birth in the first labor, over 90% of ALL subsequent births will be Cesarean births

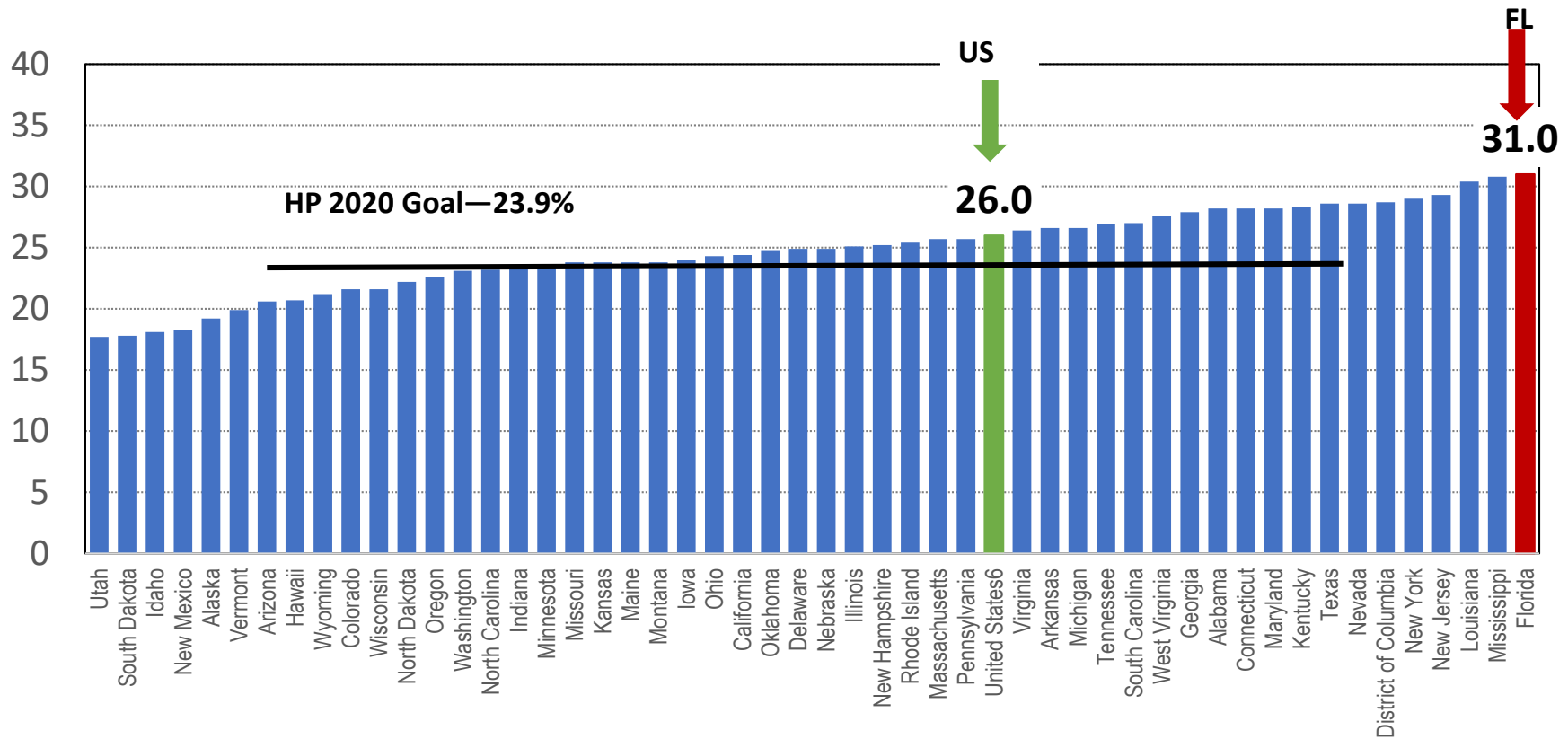


A classic example of path dependency

If a woman has a vaginal birth in the first labor, over 90% of ALL subsequent births will be vaginal births



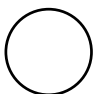
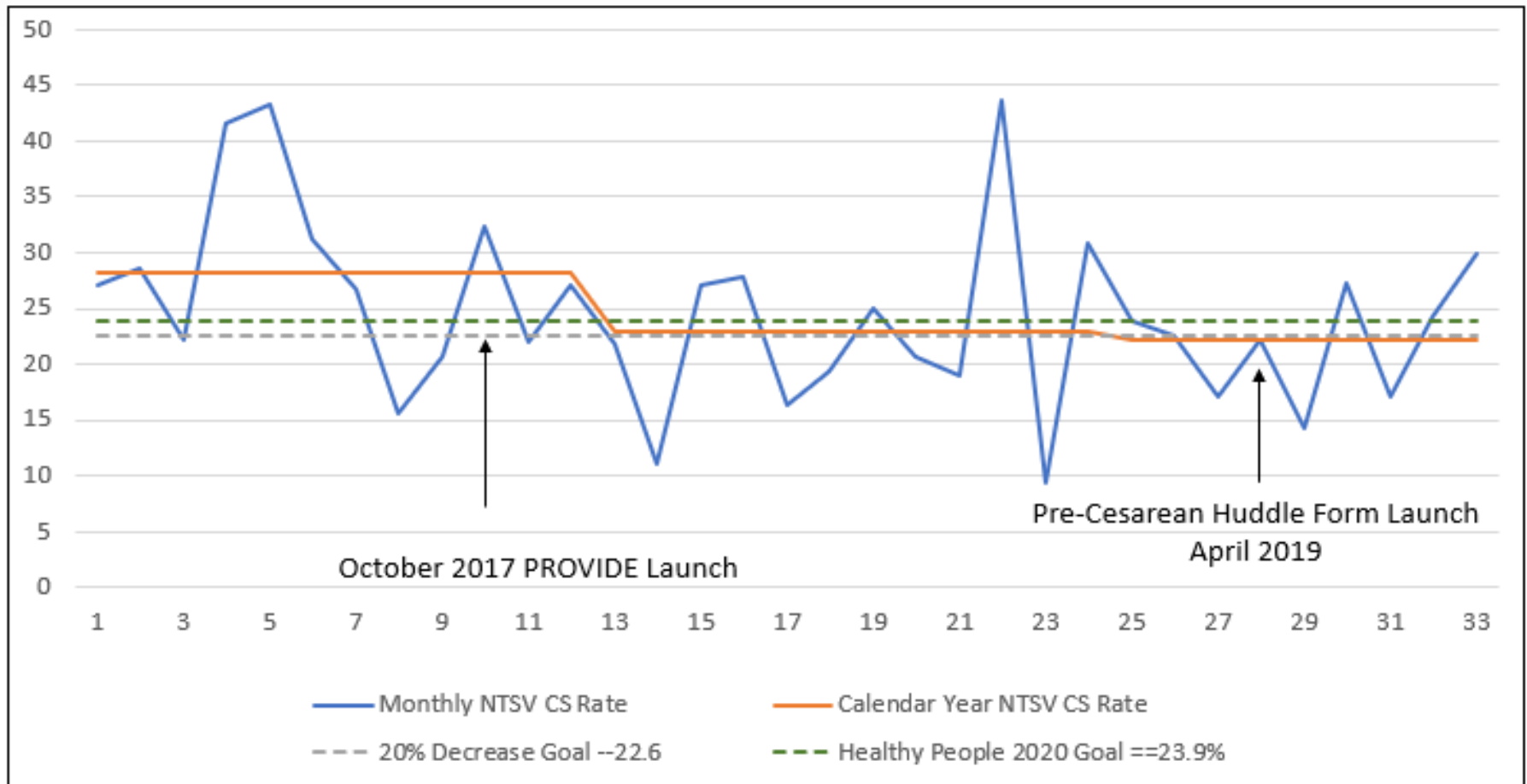
Share Data! NTSV Cesarean Rates U.S. States, 2017



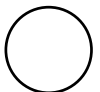
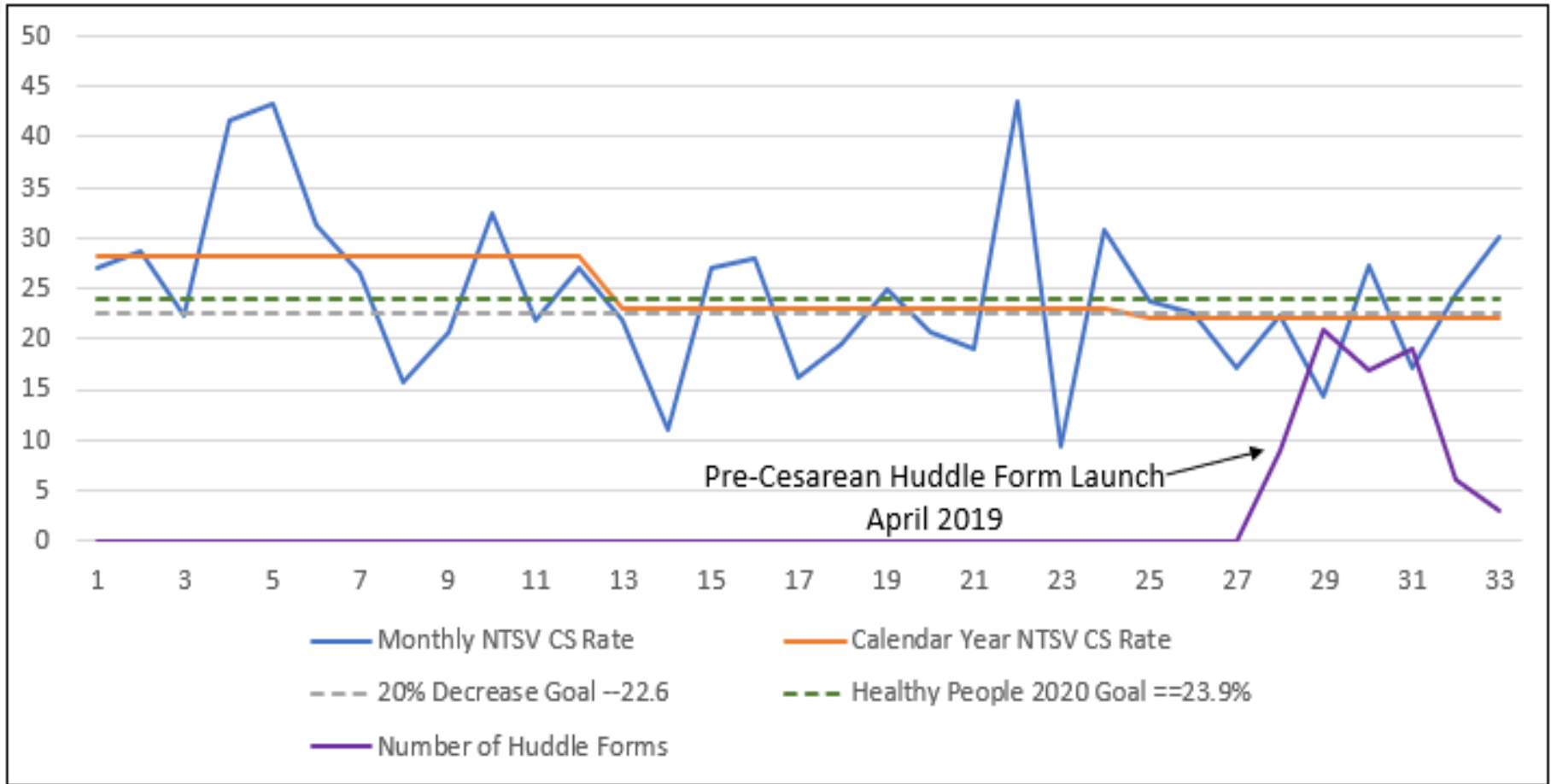
Source: NCHS (2017) Final Birth Data 2017



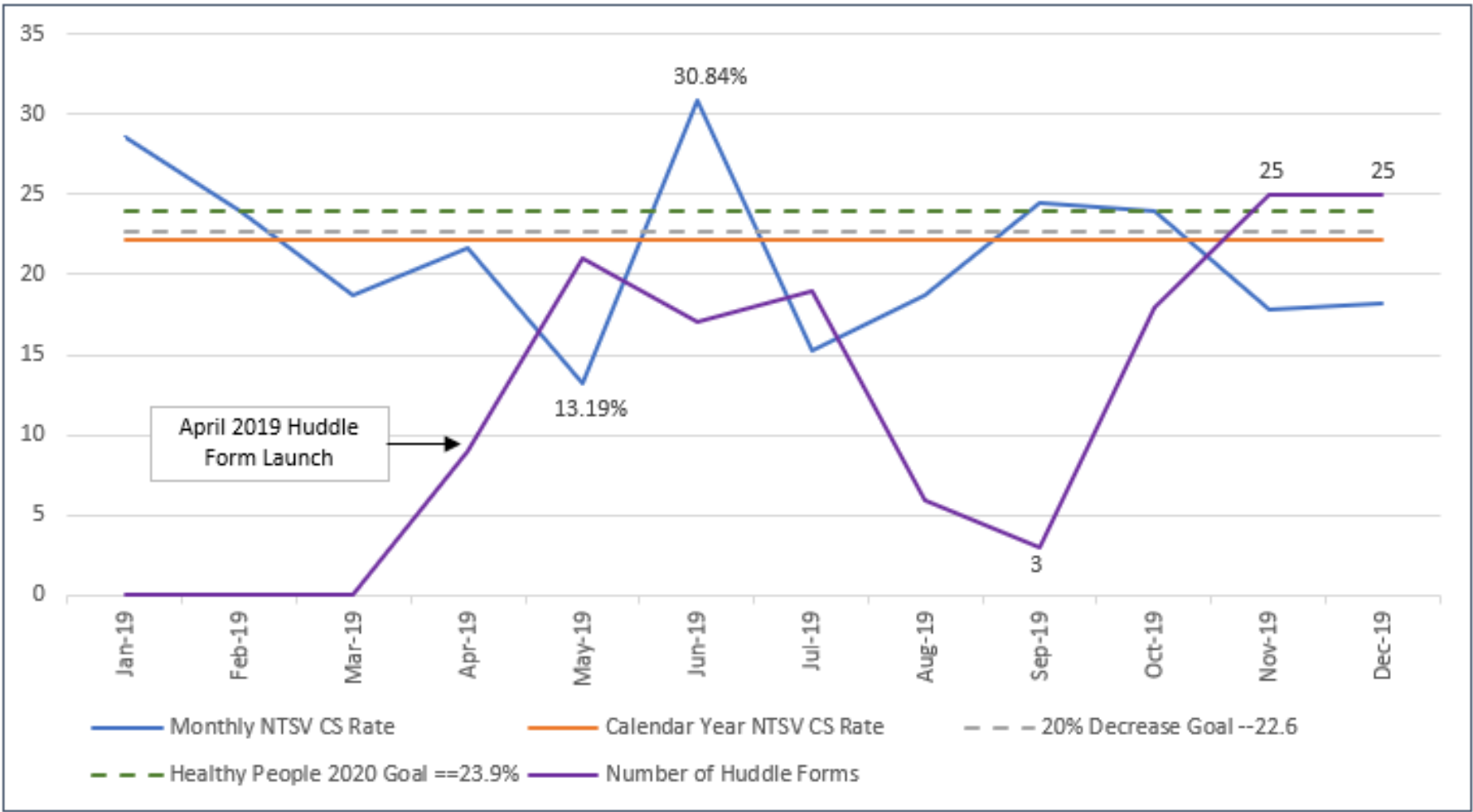
Monthly NTSV CS Rate January 2017 – September 2019



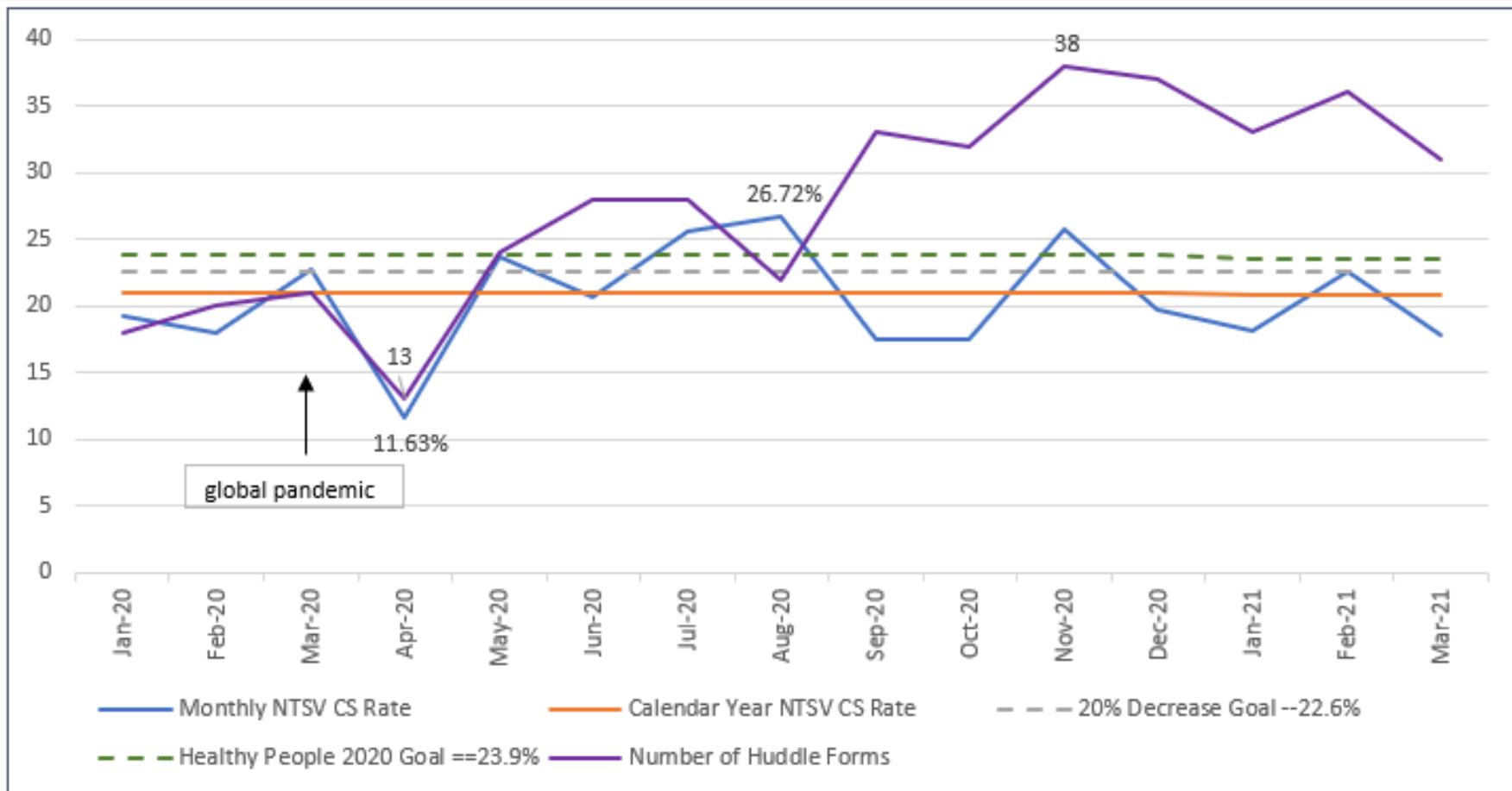
Monthly NTSV CS Rate January 2017 – September 2019



Impact of Pre-Cesarean Huddles

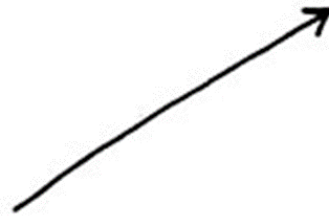


Monthly NTSV CS Rate January 2020 – March 2021



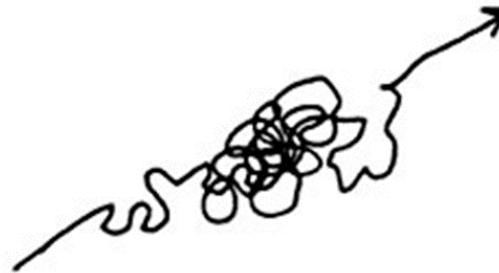
Changing culture is hard work... but we can do it!

Success

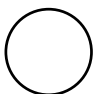


what people think
it looks like

Success



what it really
looks like



Thank you!



Danielle Brennan
BSN, RNC, C-EFM
Nurse Manager L&D and
Transition Nursery
DanielleBrennan@tgh.org



Lindsay Greenfield
MSN, APRN, A-GNP-C
Performance Improvement
Specialist
OB Division
LGreenfield@tgh.org



MERCYHEALTH JAVON BEA HOSPITAL

MICHELE JAHN-SAGER

MercyHealth Javon Bea Hospital

Rockford, IL

year	Total NTSV	NTSV c/s	NTSV % c/sections
2019	646	172	27%
2020	521	165	32%
2021 through March	60	23	38%
Total	1227	360	29.3%

- ▶ We are a level 3 Perinatal Center with NICU, accepting transfers from northern IL and southern WI
- ▶ In July 2020 we lost a low income OB clinic whose patients were managed by midwives
- ▶ At the same time, we stopped accepting 3 of 4 Medicaid MCOs
- ▶ Subsequently, our deliveries have dropped significantly in the past six months, from an average of 190 total deliveries/month to approximately 70 total deliveries/month

What is going well

- ▶ Great excitement and engagement of the nursing staff (84% response to labor culture survey!)
- ▶ Preliminary c/section decision checklist completed
- ▶ Didactic education on “6 is the new 4” and early labor comfort tips disseminated to RNs and providers
- ▶ Education compiled on patient positioning for comfort and labor progression, discussion regarding in person demo and return demo of techniques

What we're struggling with

- ▶ Provider buy-in (only 25% return of labor culture surveys)
 - ▶ We've been told our c/s numbers are appropriate for our population
 - ▶ "I would never let my primip push for over 2 and a half hours"
- ▶ Providing effective education to RNs and providers
 - ▶ Sending an email just doesn't seem effective
 - ▶ Unsure how to proceed to ensure RNs and providers are both receiving the same education in the best format for learning
 - ▶ How do we know that the education has been seen/reviewed?

NEXT STEPS FOR ALL PVB TEAMS

Current activities for your QI Team



- Attend regular QI Team meetings
- Determine if a PVB Grand Rounds/OB Provider Meeting to help achieve nurse and physician buy-in
- Continue to encourage staff to complete the Labor Culture Survey
- Complete baseline data collection for Q4 2019
- Submit monthly data collection for January, February and March 2021

What's next?

- Register for ILPQC Virtual Face to Face

- Complete your hospital storyboard

- Review checklist and huddle toolkit materials

- Review Labor Culture survey results: Coming in June 2021

PVB Grand Rounds



ILPQC is taking requests to schedule ILPQC facilitated **Virtual Grand Rounds!**

Email ILPQC to schedule a meeting for your hospital providers today!

BOOK NOW

Email ellie.suse@northwestern.edu to schedule

Upcoming Monthly Webinars

4th Monday of the Month



Date	Topic
Monday, April 26th 12:30-1:30	Utilizing Cesarean Delivery decision huddles and checklists
May 26th (VIRTUAL)	Virtual Face-to-Face
Monday, June 28th 12:30-1:30	TBD
Monday, July 26 12:30-1:30	TBD
Monday, August 23 12:30-1:30	TBD

Register and Join here:

<https://northwestern.zoom.us/j/91684580832?pwd=eXo3U3VsTIVTOHI5QjRvUjdQeWRtdz09>

COVID-19

COVID-19 Sharing Strategies



OB & Neonatal providers from across the state present cases and share strategies

Where are the HOT SPOTS for COVID-19 in your network?

Friday May 7th, at 12pm

Sharing Covid-19 Cases



- Please send questions, comments and recommendations, cases / willingness to share for future COVID-19 OB/Neo discussion webinars to info@ilpqc.org
- Registration for the **next webinar on Friday, 5/7/21** will be available at https://northwestern.zoom.us/webinar/register/WN_VBb5dGnwT9KoWIOC7zHmcA

ILPQC After Office Hours



We want to hear from you

- Unmute your line to ask a question
- We will be available for 30 minutes after this call for Office Hours
- Get answers to your questions live!



**THANKS TO OUR
FUNDERS**



In Kind Support



Promoting Vaginal Birth (PVB)

APPENDIX