Partnership for Patients
Safe Deliveries Roadmap
Webcast
February 21, 2014

Advancing Patient Safety in Maternity Care:
A Roadmap from Prenatal to Postpartum

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
Mara Zabari, Executive Director of Integration Partnership for Patients
Washington State Hospital Association

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Project Leaders

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Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
Today’s Objectives

• Updates on the Safe Deliveries Roadmap project.
• Hear from Evergreen Healthcare about their *Intentional Management of First and Second Stage Labor Program* to reduce Cesarean Section rates due to failure to progress, fetal intolerance of labor, and failure to descend.
• Ask questions and discuss strategies for optimizing labor interventions.
Presenters

Mary Kay Ausenhus, MSN, WHNP-BC
Women’s Services Manager
Evergreen Healthcare

Jennifer McKinlay, RNC - OB
RN Project Lead
Evergreen Healthcare

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
Partnership for Patients

• **40** – Percent reduction in harm

• **20** – Percent reduction in readmissions

• **14** – by 2014

Saving Lives

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
10 Targeted Strategies

**Infection Reduction:**
1. Catheter-associated urinary tract infections (CAUTI)
2. Central line-associated blood stream infections (CLABSI)
3. Surgical site infections (SSI)
4. Ventilator-associated pneumonia (VAP)

**Nursing Care:**
5. Injuries from falls and immobility
6. Pressure ulcers

**High Risk:**
7. Adverse drug events
8. Obstetrical adverse events
9. Venous thromboembolism or blood clots (VTE)

**Continuity of Care:**
10. Prevention of readmissions

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OB Adverse Events

- Partnership for Patients: 2012 – 2013
  - Early Elective Delivery Prior to 39 Weeks
  - Episiotomy
  - Safe Deliveries Roadmap

- Partnership for Patients: 2014
  - Early Elective Delivery Prior to 39 Weeks
  - Episiotomy
  - Safe Deliveries Roadmap
  - Pre-eclampsia
  - Hemorrhage

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Washington State Hospital Association
Safe Deliveries Evidenced-Based Roadmap

Pre-Pregnancy
- Increased use of preconception care services
- Improved health entering pregnancy
- Reduced risk from complications due to previous pregnancies

First Month
- Healthier mothers and babies

Pregnancy
- Fewer infant abnormalities and disabilities
- Less maternal and fetal complications
- More educated patients

Delivery
- Less maternal morbidity and mortality
- Fewer early deliveries
- Higher Apgar scores
- Fewer NICU admissions
Labor Management Bundle

Safe Deliveries Roadmap Website

http://www.wsha.org/0513.cfm%20

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
HOT OFF THE PRESS!

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTHCARE PROVIDERS

The American College of Obstetricians and Gynecologists (the College) and the Society for Maternal-Fetal Medicine with the assistance of Aaron E. Caughey, MD, PhD; Alaine C. Cahill, MD, MSCI; Jeanne-Marie Guise, MD, MFM; and Dwight J. Rouse, MD, MFM. The information reflects emerging clinical and scientific advances as of the date issued. It is subject to change, and should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations inherent to the institution or type of practice.

OSTETRIC CARE

CONSENSUS

Number 1 • March 2014

Safe Prevention of the Primary Cesarean Delivery

Abstract: In 2011, one in three women who gave birth in the United States did so by cesarean delivery. Cesarean birth can be life-saving for the fetus, the mother, or both in certain cases. However, the rapid increase in cesarean birth rates from 1996 to 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused. Variation in the rates of multiparous, term, singleton, vertex cesarean births also indicates that clinical practice patterns affect the number of cesarean births performed. The most common indications for primary cesarean delivery include, in order of frequency: labor dystocia, abnormal or indeterminate (formerly, nonassuring) fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia. Safe reduction of the rate of primary cesarean deliveries will require different approaches for each of these, as well as other, indications. For example, it may be necessary to revisit the definition of labor dystocia because recent data show that contemporary labor progress rates at a rate substantially slower than what was historically taught. Additionally, improved and standardized fetal heart rate interpretation and management may have an effect. Increasing women's access to nondrug interventions during labor, such as continuous labor and delivery support, also has been shown to reduce cesarean birth rates. External cephalic version for breech presentation and a trial of labor for women with twin gestations when the first twin is in cephalic presentation are other of several examples of interventions that can contribute to the safe lowering of the primary cesarean delivery rate.

Background

In 2011, one in three women who gave birth in the United States did so by cesarean delivery (1). Even though the rates of primary and total cesarean delivery have plateaued recently, there was a rapid increase in cesarean rates from 1996 to 2011 (Fig. 1). Although cesarean delivery can be life-saving for the fetus, the mother, or both in certain cases, the rapid increase in the rate of cesarean births without evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused (2). Therefore, it is important for health care providers to understand the short-term and long-term tradeoffs between cesarean and vaginal delivery, as well as the safe and appropriate opportunities to prevent overuse of cesarean delivery, particularly primary cesarean delivery.

Balancing Risks and Benefits

In 2011, one in three women who gave birth in the United States did so by cesarean delivery (1). Even though the rates of primary and total cesarean delivery have plateaued recently, there was a rapid increase in cesarean rates from 1996 to 2011 (Fig. 1). Although cesarean delivery can be life-saving for the fetus, the mother, or both in certain cases, the rapid increase in the rate of cesarean births without evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused (2). Therefore, it is important for health care providers to understand the short-term and long-term tradeoffs between cesarean and vaginal delivery, as well as the safe and appropriate opportunities to prevent overuse of cesarean delivery, particularly primary cesarean delivery.
Labor Management Bundle Measures

Safe Deliveries Roadmap Website
http://www.wsha.org/0513.cfm%20

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
Roll-out

- On-boarding: (July – December)
  - Readiness assessment
  - Education

- Algorithm and checklist testing: LEAPT group (December – March)

- Data Collection (April)

- Implementation: (April)
Request for Data Submission

Safe Deliveries Roadmap

As a member of the Washington State Hospital Association (WSHA) Safe Deliveries Roadmap initiative, WSHA and the Washington State Perinatal Collaborative are inviting you to participate in a groundbreaking project to collect and analyze data on current OB best practices. Through a partnership with the CMQCC Maternal Data Center (CMDC), this system will use existing data to create Safe Deliveries Roadmap measures benchmark reports for your hospital and system. The benefits to your hospital are:

- Administered by Dr. Elliott Main, one of the nation's leading experts, actively involved in multiple state and national Maternal Quality Measurement committees including NQF, ACOG/AMA and the Joint Commission.
- Reduces overall chart abstraction costs by utilizing preexisting data sets such as patient discharge data for multiple high-interest and required perinatal measures by CMS, Leapfrog, and the state Medicaid program (e.g. 95% reduction in chart abstracted elements needed for Early Elective Delivery).
- Provides state-of-the-art electronic hospital interface that enables drill down to provider and patient level data.

The CMDC was selected after experts in obstetrics and the state evaluated a number of systems.

Enrollment:
Due by Friday, February 28, 2014.

1. Attend the Next Steps Webcast, January 9, 2014, 7:00 - 8:00 a.m. to learn more about the CMDC data system. Connection information below.
2. Print out this form, complete the information below, and send it with your enclosed check made payable to WSHA.

Cost:
- Critical access hospitals: $2,500*
- Non-critical access hospitals: $8,500*
*Subsidized by WSHA

Connection information: Registration is not necessary.
1. Go to: [http://wsa.webex.com](http://wsa.webex.com)
2. Session Password: roadmap (all lower case).
3. Audio connection information: 1-877-668-4490 Session number will appear on the screen. When dialing in, please include your "Attendee ID" code which will appear in the pop-up screen.

For questions, please contact Mara Zabari, Executive Director – Integrated Care Partnership for Patients
360-216-2520 or mara@wsa.org

☐ YES, I would like to participate in the Safe Deliveries Roadmap Data Collection
☐ Enclosed is a check, payable to WSHA

Please send this form with your check enclosed to:
Washington State Hospital Association
Attn: Mara Zabari
300 Elliott Avenue West
Suite 300
Seattle, WA 98119

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
Safe Deliveries Roadmap
Outcome Measures Submission

- Enrollment in full CMDC ($2,500 CAH, $8,500 non-CAH)
- Enrollment in limited CMDC ($3,500)
- No cost option: submit numerators and denominators to WSHA

Enrollment/decision by February 28th
Data Specifications

WSHA HEN
DRAFT Data Submission Guidelines and Data Elements

In order to generate periodical performance metrics for the WSHA-HEN program, hospitals may elect to submit data to the Washington Maternal Data Center (WMDC), an online data aggregation and quality improvement tool developed by the California Maternal Quality Care Collaborative (CMQCC), and housed at Stanford University School of Medicine.

Summary guidelines and timelines:
- Participating hospitals will submit administrative and clinical data files to the WMDC on a monthly basis.
- Submissions should be based on discharge date and are to be made on a calendar month basis, representing discharges from the first day of the month through the last day of the month for the given reporting period.
- You may submit multiple months in a single file, but please ensure the files represent the entire month for each month you are submitting (no partial-month data).
- The files should be submitted within 50 days of the close of the reporting period. For example, data for March 1 - 31 is due on May 20.
- All data submissions will be made via the WMDC’s secure web-based tool housed in dedicated server environments maintained by Stanford University School of Medicine, Information, Resource, and Technology (MIDFRT) Group.

Data Elements

The data elements to be submitted fall into three categories, which will be submitted as separate files:
- Patient Discharge Data (LB-04 format): See Section B.
- Maternal Clinical Data: See Section C.
- Newborn Clinical Data: See Section D.

WSHA is working with the State Department of Vital Records to utilize Birth Certificate Data, such that several of the data elements currently required in the clinical data files may become optional in the future.

Records to be Submitted:

- Hospitals may choose between submitting all patient records or limiting the submission to delivery-related discharges. If you choose to limit the submission to delivery-related discharges, please use the list model in Section A below to filter your data. If you submit all discharge records, CMQCC will apply the filters for you.
- Some fields are optional for CMQCC. Optional fields are highlighted in blue and marked with an “O.” If you choose not to submit data for these fields, please take care to format blank values as specified in the file format section.

File Format

WA-MDC will consult with a technical working group (composed of Washington hospitals intending to participate) to determine whether the patient discharge data file format will be the AIX X12N0005101X223 (used for CHARS data submissions) or a CSV file format.

WSHA PARTNERSHIP FOR PATIENTS
<table>
<thead>
<tr>
<th>Perinatal Pay for Performance Quality Metrics</th>
<th>Leapfrog</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Delivery 37 to less than 39 weeks gestation per deliveries 37 to less than 39 weeks with medical exclusions removed (target &lt;5%) (Joint Commission definition)*</td>
<td></td>
</tr>
<tr>
<td>Normal newborn admission screen prior to discharge (target ≥80%)</td>
<td></td>
</tr>
<tr>
<td>DVT prophylaxis (SCDs) prior to cesarean delivery (target ≥80%)</td>
<td></td>
</tr>
<tr>
<td>Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery rate (new measure, no target for 2014, to set target for 2015) (Joint Commission definition)*</td>
<td></td>
</tr>
<tr>
<td>Meets volume standard for high risk deliveries ≤ 1500 grams (threshold 50 deliveries/year)</td>
<td></td>
</tr>
<tr>
<td>Antenatal steroids prior to delivery 24-32 weeks gestation (target ≥80%) (Joint Commission definition)*</td>
<td></td>
</tr>
</tbody>
</table>

**Medicaid Incentive**
- Elective Delivery 37 to < 39 weeks gestation per deliveries 37 to < 30 weeks with medical exclusions removed (Joint Commission definition) - maximum credit target ≤ 0.1% (submission of cases for Medicaid exception review allowed)*
- Percent of Inductions of Labor with all 3 components documented - maximum credit target > 84% (indication for Induction, Bishop score documented prior to Induction, signed consent specific to risks/benefits of Induction of labor)*

**Joint Commission**
- Elective Delivery 37 to < 39 weeks gestation per deliveries 37 to < 30 weeks with medical exclusions removed *
- Nulliparous Term Singleton Vertex (NTSV) Cesarean Delivery rate *
- Healthcare-Associated Bloodstream Infections in Newborns *
- Antenatal steroids prior to delivery 24-32 weeks gestation (target ≥80%) *
- Exclusive Breast milk feeding (non NICU) for term singleton neonates *

**CMS - Perinatal Inpatient Quality Reporting (IPQR), Meaningful Use (MU), and National Partnership for Patients (National PIP), Northwest WSHA HEN Partnership for Patients (NW PIP)**
- Elective Delivery 37 to < 39 weeks gestation per deliveries 37 to < 30 weeks with medical exclusions removed (Joint Commission definition) (IPQR, MU), (National PIP), (NW PIP)*
- episiotomy for spontaneous vaginal delivery w/out shoulder dystocia (non-forcps and vacuum) (NW PIP)
- Percent of term Unexpected Newborn Complications NGR 716 (total, severe, and moderate) (MU)**
- Exclusive Breast milk feeding (non NICU) for term singleton neonates, (Joint Commission definition) (MU) *
- Postpartum hemorrhage: Number of blood units transfused and total number of massive blood transfusions (>4 units) per 1000 deliveries ≥ 20 weeks gestation (National PIP), (NW PIP) *
- Percent with Severe Pre-Eclampsia who received timely treatment within 60 minutes and for those with pre-eclampsia diagnosis, number of maternal ICU admissions and number of ICU days per 100 delivering mothers ≥ 20 who gestation (National PIP), (NW PIP) *

**Best Collaborative**
- Implementation of standards for delivery less than 39 weeks gestation. Indication must be on Joint Commission/Washington State Perinatal Collaborative/WSHA project exclusion list. If condition not on list, consultation for second provider opinion and agreement required
- Implementation of standards for elective inductions of labor 39-41 weeks gestation: 1) Favorable Bishop score of 6 or greater; 2) signed consent form specific to risks and benefits of induction of labor compared to spontaneous labor*
- Primary Term Singleton Vertex (TSV) Cesarean Delivery Rate (AHQR 03 33)*
- Implementation of Guidelines for Labor and Delivery Management including:
  1) Delay admission for term spontaneously laboring women who have no fetal or maternal compromise when cervix is less than 4cm
  2) Allow first stage labor arrest cesarean (measuring fetal and maternal status but lack of progress of labor) to be performed only in the active phase (≥5cm cervical dilation)
  3) Allow adequate time in the active phase (4-6 hours) with use of appropriate clinical interventions before making a diagnosis of active phase arrest
  4) Allow sufficient time with appropriate clinical interventions in the 2nd stage before diagnosis of 2nd stage arrest or "failure to descend"

**WSHA Labor Management Roadmap Process, Utilization and Balance Measures (RM Measures):**
- Full term positive vaginal birth per term singleton vertex delivery rate (IPQR, MU), (National PIP), (NW PIP) *
- Maternal Admission to ICU and ICU days harmonized with CMS PIP MU measure expanded Pre-eclampsia measure for any diagnosis in this measure (RM Outcome/Balance measure) *
- Maternal hemorrhage: Total transfusion units and massive transfusion (≥ 4 units) (RM Outcome/Balance Measure harmonized with CMS PIP measures) *
- Maternal length of stay (postpartum) (RM Outcome/Balance and Utilization measure)
- Operative vaginal delivery rate (forceps and vacuum) (RM Outcome Measure)
- Percent of Term Unexpected neonatal Complications (total, severe, and moderate) (RM Outcome and Balance Measure)*

**Process Measures - WSHA Labor Management Roadmap (RM)**
- Compliance with Partnership for Patients Labor Management bundles (RM Process Measures)
- Obstetric trauma with instrument / 100 (AHQR Patient Safety Indicators (PSI) 18)
- Obstetric trauma without instrument / 100 (AHQR Patient Safety Indicators (PSI) 19)
Medicaid Quality Incentive
Safe Deliveries

Elective Deliveries Prior to 39 Weeks
Sustaining measure: percent of patients with Elective Deliveries 37 to less than 39 weeks gestational age

Data collection period:
• July 1, 2013 – December 31, 2013

Induction Appropriateness
Improvement measure: percent of patients undergoing a medical or non medical labor induction with documentation of consent, Bishop Score, and indication

Data collection period:
• September 1, 2013 - December 31, 2013

UPDATE!
Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
HCA Medicaid Quality Incentive
Elective Deliveries Prior to 39 wks – Review Process

• The hospital will conduct an internal review to determine whether the case should be submitted to the Health Care Authority for external review.
  • The internal review should include at least two Obstetric providers from a different provider group(s) than the provider group whose patient is being reviewed.
  • If there is no other internal provider group, the additional providers can be from another hospital.
• If the internal review determines that an external review is warranted, a request for a case review can be submitted to the Health Care.
HCA Medicaid Quality Incentive
Elective Deliveries Prior to 39 wks – Review Process

Request for External Review of Early Delivery

Date of request: _________________

Contacts
Name: ____________________________
Email address: ______________________
Telephone numbers: __________________

Case information:
Date of delivery: ____________________
Delivering provider: __________________
Date of internal review: ________________
Internal reviewers: ____________________

Case Description (feel free to use a second page, however not to exceed 250 words):

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please fax this form to the Washington State Health Care Authority: 360-586-9551.
Attention: Daniel Lessler, MD Chief Medical Officer.
Intentional Labor Management

Mary Kay Ausenhus RN, MSN, WHNP-BC
Jennifer McKinlay RNC-OB

Family Maternity Center
2/21/2014

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
Project Introduction

Opportunity: Reduce C/S rate without negatively impacting maternal/newborn outcomes.
Impact on Cesarean Section Rates

1. **Providers** (Physicians and CNM)
   - Evaluation of scheduled inductions
   - Decision for labor admission
   - Definition of labor dystocia

2. **Nurses** Opportunity to Influence ????

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
Development of Nursing Plan

1. Project leads
   • Staff RN and CNS

2. Literature Review (Potential for RN impact)
   • Washington State Hospital Association Safe Table presentation (3/28/2013)
   • Spong (2012). Preventing the First Cesarean Section....
   • California Maternal Quality Care Collaborative (2011). Cesarean Deliveries, Outcomes and Opportunities for Change...
Presenting 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

Catherine Y. Spong, MD, Vincenzo Berghella, MD, Katharine D. Wendt, MD, Brian M. Mercer, MD, and George R. Saade, MD

With more than one third of pregnancies in the United States being delivered by cesarean and the growing knowledge of morbidities associated with repeat cesarean deliveries, the Eunice Kennedy Shriver National Institute of Child Health and Human Development, the Society for Maternal-Fetal Medicine, and the American College of Obstetricians and Gynecologists convened a workshop to address the concept of preventing the first cesarean delivery. The available information on maternal and fetal factors, labor management and induction, and nonmedical factors leading to the first cesarean delivery was reviewed as well as the implications of the first cesarean delivery on future reproductive health. Key points were identified to assist with reduction in cesarean delivery rates including that labor induction should be performed primarily for medical indication; if done for nonmedical indications, the gestational age should be at least 39 weeks or more and the cervix should be favorable, especially in the multiparous patient. Review of the current literature demonstrates the importance of adhering to appropriate definitions for failed induction and arrest of labor progress. The diagnosis of "failed induction" should only be made after an adequate attempt. Adequate time for normal latent and active phases of the first stage, and for the second stage, should be allowed as long as the maternal and fetal conditions permit. The adequate time for each of these stages appears to be longer than traditionally estimated. Operative vaginal delivery is an acceptable birth method when indicated and can safely prevent cesarean delivery. Given the progressively declining use, it is critical that training and experience in operative vaginal delivery are facilitated and encouraged. When discussing the first cesarean delivery with a patient, counseling should include its effect on future reproductive health.

A CMQCC White Paper

Elliott Main, MD, Christine Morton, PhD
David Hopkins, PhD, Giovanna Giuliani, MBA, MPH
Kathryn Melso, MS and Jeffrey Gould, MD, MPH

Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality

December 2011

Funded by the California HealthCare Foundation, based in Oakland, California.
Areas with the most potential impact

- Failure to progress (1st stage)
- Fetal intolerance to labor
- Failure to descend (2nd stage)

PROJECT GOAL: Reduce Cesarean Section rate for all patients with a potential diagnosis of failure to progress, fetal intolerance to labor or failure to descend.

PROJECT TITLE: Intentional Labor Management
Presentation of the Project

Jennifer McKinlay RNC-OB
Staff RN at Evergreen Health
Lead Project RN

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
Project Development, Rollout

Formation of committee which included L&D RNs and OB Providers (MD and CNM)
  • This was vital in helping to facilitate ideas and provide staff assistance with the promotion of the project.

Preimplementation education:
  • Weekly posters placed in a highly visible nursing area focused on key topics:
    • Week one: Overview of project
    • Week two: Cervical readiness and fetal positioning
    • Week three: Early labor management, maternal positioning & Labor support
    • Week four: Oxytocin management
    • Week five: Fetal monitoring interpretation and NICHD language
    • Week Six: Second stage management

Implementation
  • Lecture presentation of project to RN staff
  • Each RN received a manual that outlined the project and included resources to support the project.
  • Laminated sheets that supported the project were placed in each labor room. These highlighted the key components of the project such as: Bishops score and position recommendations to help facilitate labor and fetal descent. On a daily basis, these were very motivational for the project.
  • A survey accompanied every labor chart for 5 months. The data collected was not statistically significant and not found to be especially helpful, however,

Mid-project update at staff meeting
Why the title????

Intentional Management of Labor at Evergreen

• Incorporating the information from research into clinical practice
• Defining “Intentional”
  • purposeful standardization of nursing care for the laboring patient.
Project Components

1. Awareness of cervical readiness
2. Maternal/fetal positioning
3. Labor support
4. Oxytocin management
5. Fetal monitoring interpretation (NICHD)
6. Second stage management
Awareness of Cervical Readiness

Bishops score
  • Bishops score on admit directs the plan of care
  • Bishops score applies for early, middle and late stage care.

Cervical ripening
  • Added thought process for necessary inductions and SROM not in labor.

Early labor management
  • Friedman curve vs. current research (Spong article...)
  • Delay admission to 4 cm?
## Bishops Score

Bishops Score Calculator

The Bishop’s Score is 8. This score is considered to be UNFAVORABLE for induction. The expected Cesarean rate is 40%.

### BISHOP SCORE

to assess cervical favorability

<table>
<thead>
<tr>
<th>CERVIX</th>
<th>SCORE</th>
<th>BISHOP SCORE MODIFIERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>POSITION</td>
<td>Posterior</td>
<td>Mid-position</td>
</tr>
<tr>
<td>CONSISTENCY</td>
<td>Firm</td>
<td>Medium</td>
</tr>
<tr>
<td>EFFACEMENT</td>
<td>0 - 30%</td>
<td>30 - 50%</td>
</tr>
<tr>
<td>DILATION</td>
<td>Closed</td>
<td>1 - 2 cm</td>
</tr>
<tr>
<td>STATION</td>
<td>-3</td>
<td>-2</td>
</tr>
</tbody>
</table>

Add 1 point for:
- Pre-eclampsia
- Each previous vaginal delivery

Subtract 1 point for:
- Postdate pregnancy
- Nulliparity (no previous vaginal deliveries)
- PPROM (premature preterm rupture of membranes)

Created by Andrea Crossman, RN, www.holisticdoulany.com
With this project we utilized evidence based medicine to reformulate our comfort with a potential extended length of labor.
Definitions from Spong: Labor Progress

Table 5. Definitions of Failed Induction and Arrest Disorders

- Failed induction of labor
  - Failure to generate regular (e.g., every 3 min) contractions and cervical change after at least 24 h of oxytocin administration, with artificial membrane rupture if feasible
- First-stage arrest
  - 6 cm or greater dilation* with membrane rupture and no cervical change for
  - 4 h or more of adequate contractions (e.g., >200 Montevideo units) or
  - 6 h or more if contractions inadequate
- Second-stage arrest
  - No progress (descent or rotation) for
  - 4 h or more in nulliparous women with an epidural
  - 3 h or more in nulliparous women without an epidural
  - 3 h or more in multiparous women with an epidural
  - 2 h or more in multiparous women without an epidural

Maternal/Fetal Positioning

• Fetal lie: Leopold’s, Ultrasound, Vaginal exam

• Maternal positioning
  • Determining fetal lie, guides maternal positioning.*
  • Maternal position change every 20-40 minutes.

*At Evergreen Health, we feel that one of the most powerful changes from this project occurred when nurses consistently assessed fetal lie and then recommended intentional maternal positioning to encourage labor progress.
Labor Support

Presence of a support person
Coaching for success

This project highlighted evidence-based reasons for bedside care.
Continuous support for women during childbirth

Hodnett ED, Gates S, Hofmeyr GJ, Sakala C

Published Online: October 17, 2012

Continuous support in labour increased the chance of a spontaneous vaginal birth, had no harm, and women were more satisfied.

Historically women have been attended and supported by other women during labour and birth. However in many countries, as more women are giving birth in hospital rather than at home, continuous support during labour has become the exception rather than the norm. This may contribute to the dehumanisation of women's childbirth experiences. Modern obstetric care frequently subjects women to institutional routines, which may have adverse effects on the progress of labour. Supportive care during labour may involve emotional support, comfort measures, information and advocacy. These may enhance physiologic labour processes as well as women's feelings of control and competence, and thus reduce the need for obstetric intervention. The review of studies included 23 trials (22 providing data), from 16 countries, involving more than 15,000 women in a wide range of settings and circumstances. The continuous support was provided either by hospital staff (such as nurses or midwives), women who were not hospital employees and had no personal relationship to the labouring woman (such as doulas or women who were provided with a modest amount of guidance), or by companions of the woman's choice from her social network (such as her husband, partner, mother, or friend). Women who received continuous labour support were more likely to give birth 'spontaneously', i.e. give birth with neither caesarean nor vacuum nor forceps. In addition, women were less likely to use pain medications, were more likely to be satisfied, and had slightly shorter labours. Their babies were less likely to have low five-minute Apgar scores. No adverse effects were identified. We conclude that all women should have continuous support during labour. Continuous support from a person who is present solely to provide support, is not a member of the woman's social network, is experienced in providing labour support, and has at least a modest amount of training, appears to be most beneficial. In comparison with having no companion during labour, support from a chosen family member or friend appears to increase women's satisfaction with their childbearing experience.
Why Give Supportive Care?

Maternal anxiety leads to catecholamine release

Catecholamine release leads to maternal shunting of blood to vital organs

Less oxygenation of the uterus causes ineffective uterine activity

Less oxygenation of the uterus leads to less oxygenation to the fetus

Goal is to avoid failure to progress and fetal intolerance to labor by giving supportive care


Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
What is Supportive Labor Care?

Review labor expectations with patient and partner early in care. RN responsible for a calm environment. Include family-centered care.

Be present as part of the team

Intentional frequent position changes

Choose fetal monitoring method appropriately:

• MD order
• Category of fetal tracing
• Maternal vital signs/diagnosis
Oxytocin Management

Appropriate initial dosing

Ongoing adjustment of dose
Sources of Oxytocin

Endogenous Oxytocin

• Maternal source of oxytocin: 2-4 milliunits/minute
• Fetal secretion of oxytocin: 3 milliunits/minute
• Ferguson’s reflex elicits a surge of oxytocin

Exogenous Oxytocin

• Initial receptive phase: 1.5 to 2 hours
• Stable phase: 3.5 to 4.5 hours

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
The Magical Use of Oxytocin

- First 4 hours are “Golden”. Maternal receptor sites most accepting
- Time and dosage play a part in desensitization
- Once desensitized, oxytocin increases can lead to dysfunctional labor
- 90% achieve active labor around 6 milliunits/minute

Goal: use lowest dose to achieve active labor

Presented at Washington State Hospital Association Safe Table Webcast February 21, 2014
Fetal Monitoring Interpretation

• Shared understanding
• Shared NICHD language
• Physiologic interventions

Shared Understanding of NICHD Language

• Moderate variability: evidence of well oxygenated baby
• Minimal variability despite interventions and no accelerations for 60-90 minutes may be indicating acid-base changes.
• Shared definition of decelerations
• Timely nursing intervention and effective communication with care providers is key

Goal: Minimize the incidence of Fetal Intolerance to Labor


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Second Stage Management

- Laboring down
- Length of second stage
  - Spong article
- Positioning
- Collaborative nursing care
Laboring Down

Active Process

Timing: Primip (2 hr.) Multip (1 hr.)

Frequent position changes

Depends on maternal and fetal tolerance

Evidence Based Practice: AWHONN & Minnesota study

Goal: Reach +2 station or natural urge to push


Length of Second Stage

Spong definitions of second-stage arrest:

- No progress (descent or rotation) for
  - 4 h or more in nulliparous women with an epidural
  - 3 h or more in nulliparous women without an epidural
  - 3 h or more in multiparous women with an epidural
  - 2 h or more in multiparous women without an epidural

A new definition to work with

Supported within the Washington State Hospital Association: Perinatal Collaborative, “Safe Deliveries Roadmap”


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Second Stage Positioning

Active process

Consider position changes every 20-30 minutes

Monitor fetal descent

Team effort patient and nurse to achieve “effective” pushing
Collaborative Nurse Care in 2\textsuperscript{nd} Stage*

After one hour of pushing with no progress, primary RN plans to consult with other RN

- Identification of fetal position
- Strategies in pushing positions
- New effective pushing strategies
- Short break?????

*This has been another successful component of this project. Care providers have noticed more collaborative care for successful second stage.

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Collaborative Care

RN to MD
RN to Charge RN
RN to RN
RN to Patient/Family/Support

GOAL: Reducing C/S rate for failure to progress, fetal intolerance to labor and failure to descend.
Evergreen Health Cesarean Section Data

2012 Data:
  • NTSV Cesarean Section Rate: 35% average

2013 Data:
  • NTSV Cesarean Section Rate: 29% average*

*Results reflect collaborative efforts by MD, CNM and Nurses. Intensive work began January 2013. Nurse project rolled out in May.....June NTSV rate was 24.8%.
Conclusion

Formal project ended October 31\textsuperscript{st}
Nurse evaluation of the project revealed:

- Excitement about improved collaborative care
- Standard practice of Leopold's
- Understanding of maternal positioning and importance in facilitating labor progress.
- Improved understanding of fetal wellbeing allowing more patience in the laboring process.

We are excited about our reduced NTSV C-Section rate!

Nurses and Care Providers are equally excited about our changes in care. Care Providers were impressed with a newly engaged nursing staff.

This project has brought obstetrical care beyond protocols to incorporate the art of medical/nursing care.

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WE ATTRIBUTE OUR SUCCESS TO THE FOLLOWING:

• The engaged FMC Staff and Care Providers
• A strategically planned rollout
• Ongoing conversations throughout the department
• A supportive hospital leadership team

Evergreen Health

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References


Meeting Schedule

2014

- Roadmap Monthly (webcast) 7:00 – 8:00 a.m.

| January 9 | July 23         |
| February 21 | August 19      |
| March 26   | September 18   |
| April 23   | October 21     |
| May 20     | November 26    |
| June 12    | December 18    |

- Safe Tables (in-person) 9:00 a.m. – 2:30 p.m.
  - April 1
  - July 24
  - November 18

Cancelled
Thank You!

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Safe Deliveries Roadmap Website
http://www.wsha.org/0513.cfm%20

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