Promoting Primary Vaginal Deliveries Initiative

Pre-Cesarean Checklists

PROVIDE 2.0 Webinar
February 26, 2020

Partnering to Improve Health Care Quality for Mothers and Babies
Welcome!

Please enter your audio pin on your phone so we are able to unmute you for discussion.

If you have a question, please enter it in the question box or raise your hand to be unmuted.
Welcome!

THIS WEBINAR IS BEING RECORDED AND WILL BE ARCHIVED.

PLEASE PROVIDE FEEDBACK ON OUR POST-WEBINAR SURVEY.
Webinar Agenda

- Announcements
- Lessons Learned from New Jersey
- Advice from Tampa General Hospital
- Implementation Strategies from Winnie Palmer Hospital
news & announcements
Project Announcements

Schedule PROVIDE 2.0 Grand Rounds and site visit soon!

E-mail fpqc@usf.edu

Labor Support Workshops: Currently scheduled dates are all full
Coaching Calls

To begin in April
Will be divided by your chosen Focus Area (Induction, Labor dystocia, FHR concerns)
1 hour long
Regular monthly time for teams working on this same topic to come together and discuss, share, commiserate, learn, check-in, and receive FPQC assistance on their PROVIDE efforts
Any champion from your team can attend
Online Discussion Forums

Join our Maternal Health Discussion Group!

Visit us @theFPQC on Facebook and find our “Groups”

Direct link: https://www.facebook.com/groups/618131375299397/
Save the Date: April 16-17, Tampa
FPQC 2020 Conference

Reducing Cesarean Deliveries – Elliott Main, MD
Clinical Professor, Obstetrics & Gynecology-Maternal Fetal Medicine, Stanford University; Medical Director, California Maternal Quality Care Collaborative

Partnering with Patients and Families – Martin J. McCaffrey, MD
Professor, University of North Carolina; Director, Perinatal Quality Collaborative of North Carolina

Shared Decision-Making in Perinatal Care – Neel Shah, MD, MPP, FACOG
Assistant Professor, Obstetrics, Gynecology and Reproductive Biology, Harvard Medical School; Director, Delivery Decisions Initiative

For More Information, go to www.fpqc.org
Partnering to Help Women with Opiate Use Disorder Reach Their Goals—Michael Marcotte, MD, Dir. Quality and Safety-TriHealth, OB Expert-OPQC, National Expert-MOD

AM Breakout Sessions: Early Steps & NAS, Practical Approaches to Supporting Women with OUD from a Mom-Patient Perspective

PM Breakout Sessions: Community Mapping for Opioid Issues, Tools for Clinical Staff to Engage and Support Women with OUD
And…

☕️ A special poster session highlighting successful community collaborations especially on Friday!
Importance of Checklists: Lessons Learned from New Jersey

Andrew F. Rubenstein, MD, FACOG

Chief Quality Officer – Perinatal Quality Care and Obstetrical Safety
Fetal Medicine Foundation of America

Associate Professor
Department of Obstetrics and Gynecology
Hackensack Meridian School of Medicine at Seton Hall University

Partnering to Improve Health Care Quality for Mothers and Babies
Pre-Cesarean Checklist for Labor Dystocia, Failed induction and Fetal Heart Rate Abnormalities

Patient Name: ___________________ MR#: ___________________
Gestational Age: __________ Date of C-section: ________________
Time: _______________________
Obstetrician: ____________________________
Bedside Nurse: ____________________________
Team Member: ____________________________

Indication for Primary Cesarean Delivery:

**Failed Induction** (must have both criteria if cervix unfavorable, Bishop score < 8 for nullips and <6 for multipps)
- Cervical Ripening used (when starting with unfavorable Bishop scores as noted above). Ripening agent used: ____________________________Reason 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

**Active Phase Arrest** > 6cm dilation (must fulfill one of the two criteria)
- Membranes ruptured (if possible), then:
  - Adequate uterine contractions (e.g. moderate or strong to palpation, or > 200 MVU, for > 4 hours) without improvement in dilation, effacement, station or position
  OR
  - Inadequate uterine contractions (e.g. < 200 MVU) for > 6 hours of oxytocin administration without improvement in dilation, effacement, station or position

**Second Stage Arrest** (must fulfill any one of four criteria)
- Nullipara with epidural pushing for at least 4 hours
  OR
  - Nullipara 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

**Latent Phase Arrest** <6 cm dilation (must fulfill one of two criteria)
- Moderate or strong contractions palpated for > 12 hours without cervical change
- IUPO > 200 MVU for > 12 hours

*As long as cervical progress is being made, a slow but progressive latent phase e.g. greater without cervical change 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.

Fetal Heart Rate Abnormalities - Please check if techniques apply:
- Antepartum testing results which precluded trial of labor
- Category III FHR tracing
- Category II FHR tracing
- Prolonged deceleration not responding to measures
- Other: ___________________________________________________
- Amnioinfusion for repetitive variable fetal heart rate deceleration
- Intrauterine resuscitation efforts such as: Maternal position maternal fluid bolus, administration off O2, scalp stimulation
- Decrease or discontinue oxytocin or uterine stimulants
- Correct uterine tachysystole

Team Huddle – Comments Recommendations

Adapted with permission from Miller Children’s and Women’s Hospital and the California Maternal Quality Care Collaborative (CMQCC).
PROVIDE 2.0
Promoting Primary Vaginal Deliveries

Safe Reduction of Primary Cesarean Delivery

Vanessa J. Hux, MD and Danielle Brennan, BSN, RNC
Pre-Cesarean Huddle Form

A Communication Tool

Pre-Cesarean Huddle Form

The intent of this form/huddle is to define criteria for arrest of dilatation, failed induction and interventions for MMRH by the FHO. It is also meant to explore safe options to prevent cesarean sections in an interdisciplinary setting on the GB unit.

Huddle should occur when a c-section is being considered due to arrest, failed IOL or MMRH. Huddles can occur for other reasons as deemed necessary by the providing team.

- Date and time of huddle:
- Attending/ist name:
  - Attending physician:
  - Surgery name/dr charge name:
  - Bedside provider (CHN/Resident):
  - Anesthesia provider:

- Reason for huddle (circle all that apply):
  - C/S being considered: MMRH
  - Arrest of Dilatation/Labor dystocia
  - Minimal Condition
  - Failed IOL
  - Other

- Any agreed upon interpretation of the fetal heart rate tracing (circle all that apply):
  - Baseline
  - Variability
  - ACOG present (circle all that apply): Early
  - Variability Late
  - Prolonged
  - ACOG present: Yes/No
  - Category of tracing: 1 2 3

- Interventions done that day (circle all that apply):
  - *Fentanyl
  - *Nitrous
  - *Nitric oxide
  - *Morphine
  - *Hydramnios
  - *Amnioinfusion
  - *Amniotic fluid: Variable
  - *Oxytocin
  - *Insulin
  - *Cortisol
  - *Corticosteroids
  - *Cervical dilatation
  - *Cervical dilatation
  - *Cervical dilatation

- Birth outcomes:
  - See back of page for Labor Dystocia, Failed IOL and Management of FHR Algorithm.

References:

- American College of Obstetricians and Gynecologists Committee on Hospital Care:

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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!
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.
Make your huddle possible!

- **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) __________________________________________
Creating a culture

Appealing to:
Integrity- it’s the right thing to do for our patients
Compassion- the way to show you care is by providing evidence based care
Safety- it’s the best thing for this and future pregnancies

It takes time and persistence!
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

October 2017 PROVIDE Launch

- Monthly NTSV CS Rate
- Calendar Year NTSV CS Rate
- 20% Decrease Goal —22.6
- Healthy People 2020 Goal ==23.9%
Monthly NTSV CS Rate
January 2017 – December 2019

- Monthly NTSV CS Rate
- Calendar Year NTSV CS Rate
- 20% Decrease Goal --22.6
- Healthy People 2020 Goal ==23.9%
- Number of Huddle Forms
Evaluating Our Huddle Data

- Created a data base including data from Pre-CS Huddle Forms
- Total forms completed (April 2019-Jan 2020): 160
Most Huddles Were Performed for Consideration of Cesarean or Fetal Heart Tracing Concerns

- CS being considered: 54.2%
- NRFHT: 60.6%
- Arrest of Dilation: 26.5%
- Maternal Condition: 15.5%
- Failed IOL: 15.5%
- Other: 1.3%
Though Most Huddles Resulted in Cesarean Section, 20% Resulted in a Vaginal Delivery
Most Providers Believed That the Huddle Form Improved Communication

The PreCS Huddle Form Has Improved Communication

- Strongly Agree (48%, 12)
- Agree (36%, 9)
- Slightly / minimally (12%, 3)
- Not at all (4%, 1)

Facilitating clear communication

- Extremely well (48%, 12)
- Somewhat well (36%, 9)
- Slightly / minimally (12%, 3)
- Not at all (4%, 1)

Communicating the plan of care to the patient

- Extremely well (44%, 11)
- Somewhat well (24%, 6)
- Slightly / minimally (28%, 7)
- Not at all (4%, 1)
Most Providers Believed That The Huddle Forms Improved Patient Safety

Counts/frequency: Strongly agree (4, 15.4%), Agree (15, 57.7%), Neutral (6, 23.1%), Disagree (1, 3.8%), Strongly Disagree (0, 0.0%)
Challenges and Barriers to the Huddle Form

Challenges
- The form is too long (16.7%)
- I can’t voice my options openly (16.7)
- No one listens (33.3%)
- I feel attacked (16.7)
- Other (41.7%)

Barriers
- I forget (48%)
- Not enough time (36%)
- I don’t like it (8.0%)
- I can’t find the form (4%)
- It is challenging to get everyone together (64%)
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
Continuous monitoring:

- Increases the likelihood of cesarean
- Has not been shown to improve neonatal outcomes (e.g. reduce rates of CP)
- Restricts movement (and normal physiologic processes and coping)
- Potentially reduces nursing interaction/ labor support

Implement Intermittent Monitoring for Low-risk Patients
Give viable options to help your cause!
IA Evidence

Cochrane Review (13 RCTs, n>37,000)

Increased risk of C-S, V/FAVD | No difference in perinatal mortality, CP or Apgars <7 @ 5 mins. | Neonatal seizures rare, but slightly more in IA group.

“Given that available data do not clearly support EFM over IA, either option is acceptable in a patient without complications.” ACOG, 2009

“IA is the preferred method of fetal surveillance for healthy low risk women in labor” SOGC
Changing culture is hard work… but we can do it!

What people think it looks like

What it really looks like
Labor Dystocia Checklist

Winnie Palmer Team

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Appendix K
CMQCC Labor Dystocia Checklist (ACOG/SMFM Criteria)

1. Diagnosis of Dystocia/Arrest Disorder (all 3 should be present)
   - Cervix 6 cm or greater
   - Membranes ruptured, then
   - No cervical change after at least 4 hours of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hours of oxytocin administration with inadequate uterine activity

2. Diagnosis of Second Stage Arrest (only one needed)
   - No descent or rotation for:
     - At least 4 hours of pushing in nulliparous woman with epidural
     - At least 3 hours of pushing in nulliparous woman without epidural
     - At least 3 hours of pushing in multiparous woman with epidural
     - At least 2 hour of pushing in multiparous woman without epidural

3. Diagnosis of Failed Induction (both needed)
   - Bishop score ≥ 6 for multiparous women and ≥ 8 for nulliparous women, before the start of induction (for non-medically indicated/elective induction of labor only)
   - Oxytocin administered for at least 12-18 hours after membrane rupture, without achieving cervical change and regular contractions. *Note: At least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal status permit


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for Mothers and Babies
Thank You!

This webinar has been recorded and will be available at FPQC.org

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