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 UN-MUTE YOU FOR DISCUSSION.

IF YOU HAVE A QUESTION, PLEASE ENTER IT IN THE QUESTION BOX OR RAISE YOUR HAND TO BE UN-MUTED.

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

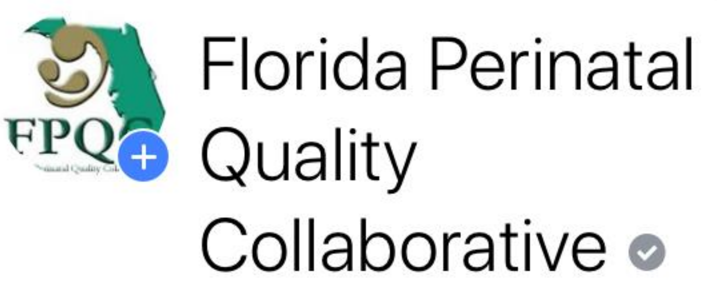
- Schedule PROVIDE 2.0 Grand Rounds and site visit soon!
  - E-mail fpqc@usf.edu
- Labor Support Workshops: Currently scheduled dates are all full

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

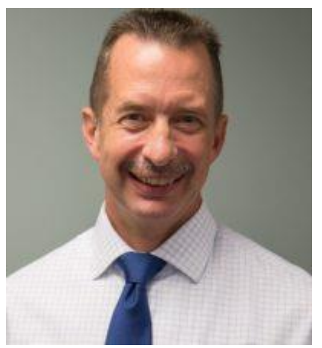
- Join our Maternal Health Discussion Group!
  - Visit us @theFPQC on Facebook and find our "Groups"
  - Direct link: https://www.facebook.com/groups/618131375299397/



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

FPQC Conference, Friday, April 17
Maternal OUD/NAS Focus

- **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 multips)

_____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 if preferable if maternal and fetal statuses permit

____Latent Phase Arrest <6 cm dilation (must fulfill one of two criteria)
Moderate or strong contractions palpated for > 12 hours without cervical change

____IUPC > 200 MVU for > 12 hours

____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

____**Although** not fulfilling contemporary criteria for the labor dystocia as described above, my clinical judgment deems this cesarean delivery indicated

*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 Abnormailities - 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

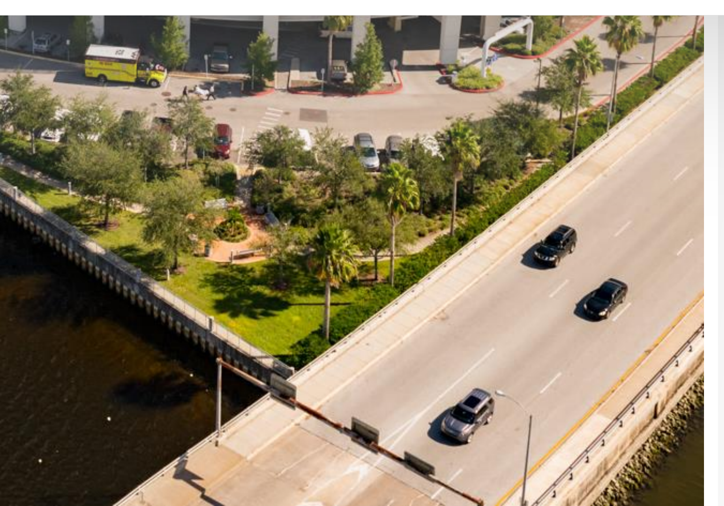
Adapted with permission from Miller Children's and Women's Hospital and the California Maternal Quality Care Collaborative (CMQCC).

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 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.

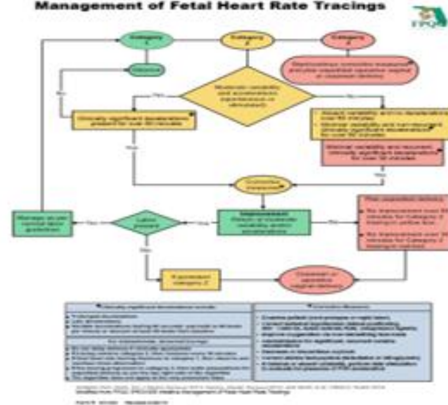
Huddle should occur when a c/s is being considered due to arrest, failed IOL or NRFHT's. Huddles can occur for other reasons as deemed necessary by the providing team.

- Date and time of huddle- ____________________
- G's and P's and Gestational age- ____________ Current room ________
- ROM time ____________ Last Cervical Exam ____________
- Attendees- list names
  - Attending physician* required ____________
  - Safety Nurse &/or Charge Nurse* : required ____________
  - Bedside provider (CNM/Resident) * : required ____________
  - Primary RN (if available) ____________
  - Anesthesia (if available) ____________
- Reason for huddle- (circle all that apply)
  - C/S being considered   NRFHT   Arrest of Dilatation/Labor Dystocia   Maternal Condition   Failed IOL
  - Other ____________
- 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: ____________________

See back of page for Labor Dystocia, Failed IOL and Management of FHR Algorithm.

- Labor Dystocia criteria-
  - Less than 6cm – 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)
  - 6 cm - 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.
  - If 10cm- Primigravida- 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 –
  - If <6cm dilated, were there at least 12 hours of oxytocin after rupture of membranes?
  - If 6-10cm dilated, was there at least 4h with adequate uterine activity or at least 6h with inadequate uterine activity and with oxytocin?
  - If completely dilated, was there 3h or more of active pushing (4h with epidural)?

Management of Fetal Heart Rate Tracings

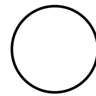


Reference:

Spong, C.Y., Berghella, V., Wenstrom, K.D., Mercer, B.M., and Saade, 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. 2012 November; 120 (5): 1181-1193.

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!

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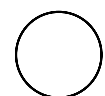
Huddle should occur when a c/s is being considered due to labor dystocia, failed IOL or NRFHT's. Huddles can occur for other reasons as deemed necessary by the providing team.



Make your huddle possible!

❖ **Attendees- list names**

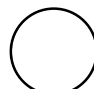
Attending physician*required____

Safety Nurse &/or Charge Nurse* 1 required______________________________________

Bedside provider (CNM/Resident) *1 required ____________________________________

Primary RN (if available) ____

Anesthesia (if available) ____



Creating a culture

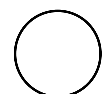
Appealing to:

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

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

FL

US

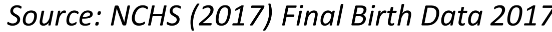
31.0

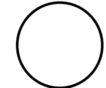
26.0

HP 2020 Goal—23.9%

40
35
30
25
20
15
10
5
0

Utah
South Dakota
Idaho
New Mexico
Alaska
Vermont
Arizona
Hawaii
Wyoming
Colorado
Wisconsin
North Dakota
Oregon
Washington
North Carolina
Indiana
Minnesota
Missouri
Kansas
Maine
Montana
Iowa
Ohio
California
Oklahoma
Delaware
Nebraska
Illinois
New Hampshire
Rhode Island
Massachusetts
Pennsylvania
United States6
Virginia
Arkansas
Michigan
Tennessee
South Carolina
West Virginia
Georgia
Alabama
Connecticut
Maryland
Kentucky
Texas
Nevada
District of Columbia
New York
New Jersey
Louisiana
Mississippi
Florida





Monthly NTSV CS Rate
January 2017 – September 2019

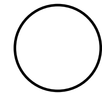
October 2017 PROVIDE Launch

Monthly NTSV CS Rate

Calendar Year NTSV CS Rate

20% Decrease Goal --22.6

Healthy People 2020 Goal ==23.9%

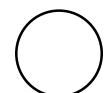


Monthly NTSV CS Rate
January 2017 – December 2019

50
45
40
35
30
25
20
15
10
5
0

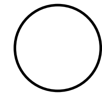
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36

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

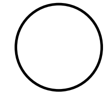
- Created a data base including data from Pre-CS Huddle Forms
- Total forms completed (April 2019-Jan 2020): 160



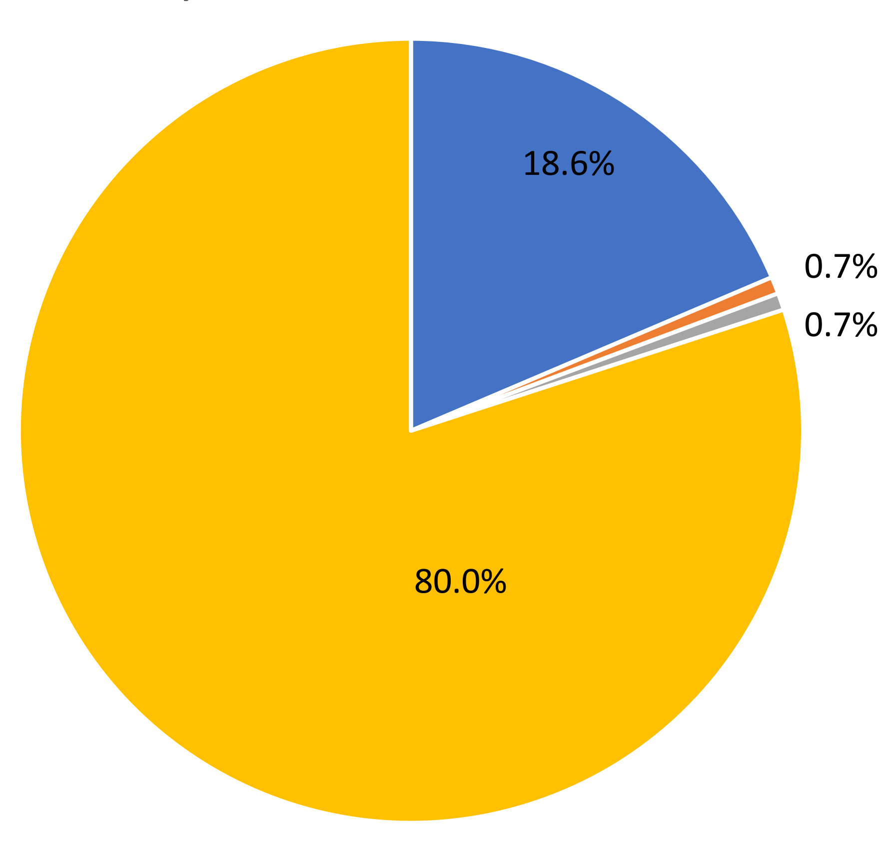
Most Huddles Were Performed for Consideration of Cesarean or Fetal Heart Tracing Concerns

Category	Value
CS being consid...	54.2%
NRFHT	60.6%
Arrest of Dilation/...	26.5%
Maternal Condition	
Failed IOL	15.5%
Other	1.3%

0 25 50 75 100



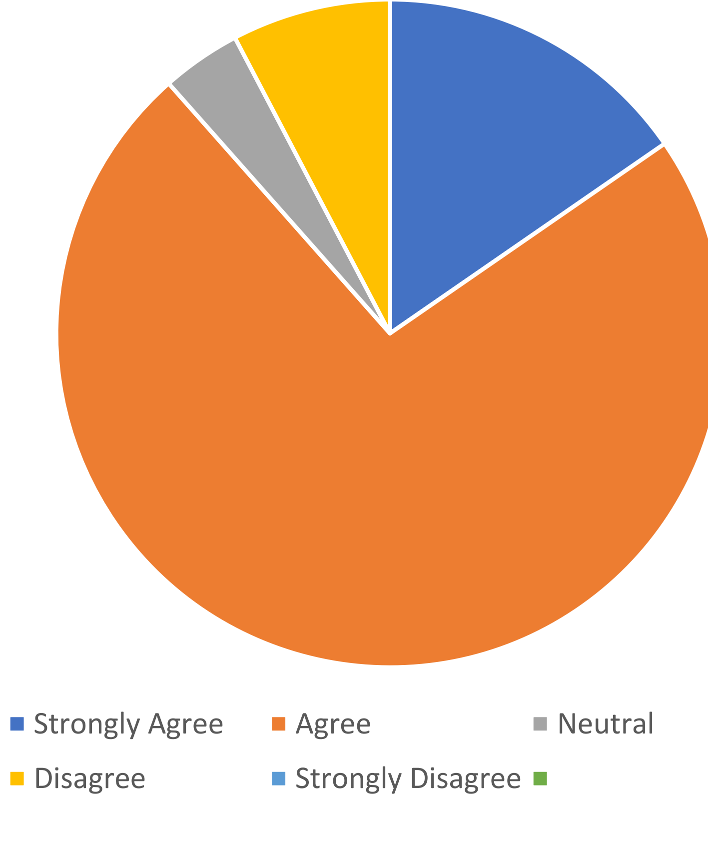
Though Most Huddles Resulted in Cesarean Section, 20% Resulted in a Vaginal Delivery

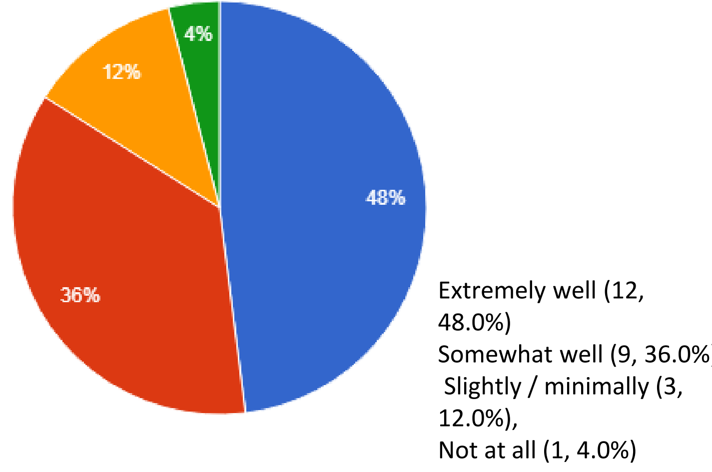


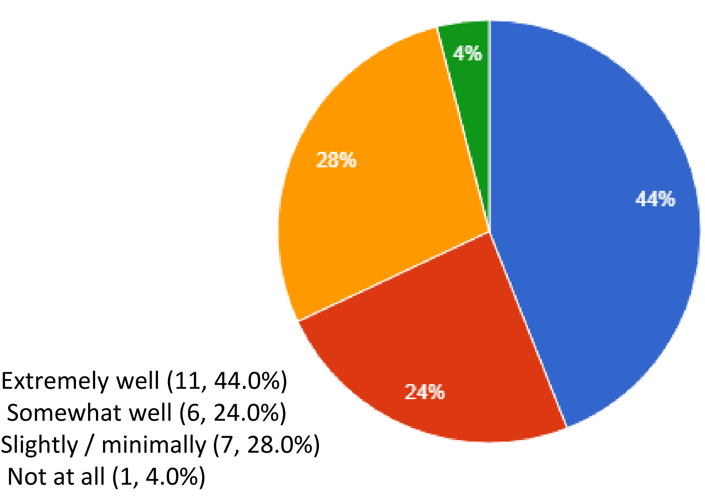
Forceps-Assisted Vaginal Delivery

Cesarean Delivery

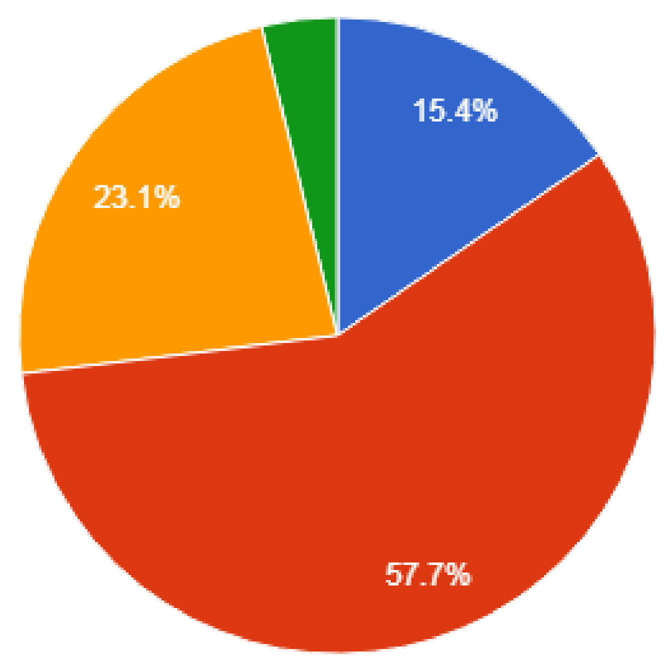
Most Providers Believed That the Huddle Form Improved Communication



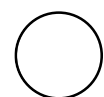




Most Providers Believed That The Huddle Forms Improved Patient Safety



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

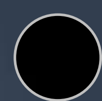
Continue to Do Huddles

3

Continue Modifications

- Feedback-based
- Highlight Our New Focus

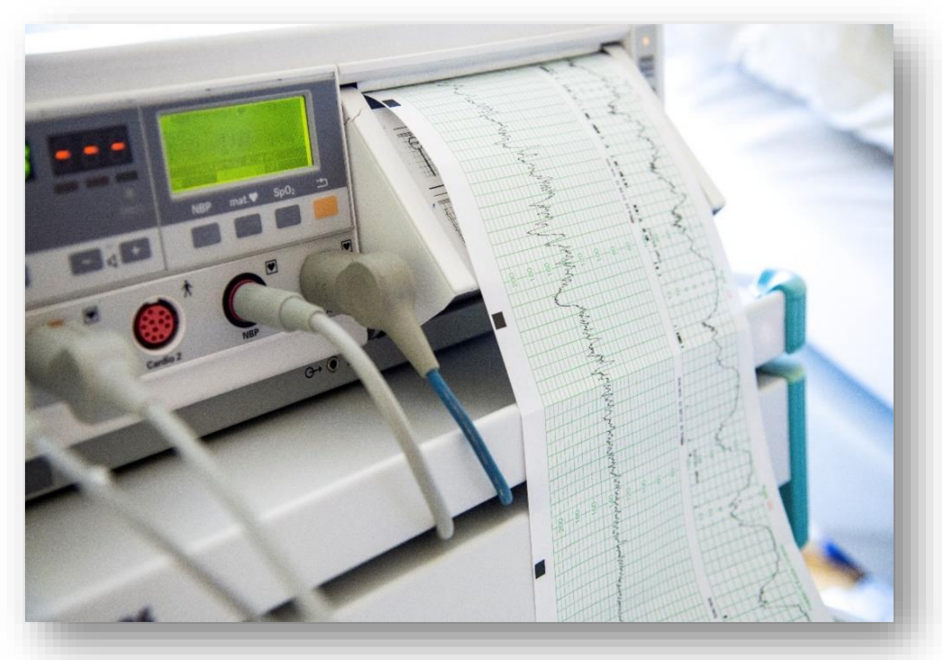
Tampa General Hospital

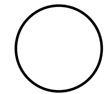


Implement Intermittent Monitoring for Low-risk Patients
Give viable options to help your cause!

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





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

Tampa General Hospital

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

Success

Success

what people think it looks like

what it really looks like

Labor Dystocia Checklist

Winnie Palmer Team

CMQCC Labor Dystocia Checklist (ACOG/SMFM Criteria)

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 $\geq$6 for multiparous women and $\geq$ 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 statuses permit

American College of Obstetrics and Gynecology, Society for Maternal-Fetal Medicine. Obstetric care consensus no. 1: safe prevention of the primary cesarean delivery. Obstet Gynecol. 2014;123(3):693-711.

Spong CY, Berghella V, Wenstrom KD, Mercer BM, Saade GR. 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. 2012;120(5):1181-1193.

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Partnering to Improve Health Care Quality
for Mothers and Babies

Thank You!

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