IHI Perinatal Improvement Community: Change, Changes, and more Changes!

It takes a Community!
Your Perinatal Faculty Team

Sue Gullo, Director
Virginia (Ginna) Crowe, IA
Peter Cherouny, Faculty Chair
Betty Janey, PM
Evan Bittel, PC

Randall J. Morgan
Kim L. Armour
Tara E. Bristol
Deb Bell-Polson

Also not pictured:
Cheri Johnson
Martha Leighton
AGENDA

• Overview and History of IHI Perinatal Community  
  (15 min) Dr. Peter Cherouny, Lead Faculty
• Introduction to Current Teams  
  (5 min) Sue Gullo, MS, BSN, RN IHI Director
• Emory Healthcare  (15 min)
• Georgetown Hospital System  (15 min)
• Consider Enrolling! Betty Janey, IHI Program Manager
Perinatal Improvement Community
An IHI Collaborative

History
- Started in 2004
- Significant unexplained variation in the system of care
- Majority of errors are system driven
- Communication failures drive patient risk
- Lack of prospective quality assessment
Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-2013</td>
<td>IMPACT then Learning Community. Oxytocin Deep Dive- Labor Deep Dive-Advanced Bundles- Gestational Age Reliability</td>
</tr>
<tr>
<td>2011-2013</td>
<td>Louisiana State Effort initiated with DHHS supporting 14 hospitals. 2012 Effort expands with collaboration with LHA HEN</td>
</tr>
</tbody>
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# Perinatal Care Community Measurement Strategy

<table>
<thead>
<tr>
<th>IHI Perinatal Care Community Measurement Strategy</th>
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</thead>
<tbody>
<tr>
<td><strong>Recommended Measures</strong></td>
</tr>
<tr>
<td><strong>Annual / Bi-annual Structure Assessments</strong></td>
</tr>
<tr>
<td><strong>Monthly Outcome &amp; Structure Measures</strong></td>
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<tr>
<td><em>Perinatal Harm</em></td>
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<tr>
<td><em>Patient and Family Centered Care (Structure/Narrative)</em></td>
</tr>
<tr>
<td><strong>Initial Weekly or Monthly Process Measures</strong></td>
</tr>
<tr>
<td><em>Augmentation Bundle Composite / Compliance</em> (Oxytocin)</td>
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<tr>
<td><em>Elective Induction Bundle Composite / Compliance</em> (Oxytocin)</td>
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<tr>
<td><strong>Advanced Weekly or Monthly Process Measures</strong></td>
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<tr>
<td><em>Vacuum Bundle Composite/Compliance</em></td>
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<tr>
<td><em>Advanced Augmentation Bundle Composite/Compliance</em></td>
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<tr>
<td><strong>Optional Measures</strong></td>
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<tr>
<td><strong>Outcome, Balance or Process Measures</strong></td>
</tr>
<tr>
<td><em>Antenatal Steroids (TJC PC-03)</em></td>
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<tr>
<td><em>Health care-associated BSI in newborns (TJC PC-04)</em></td>
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<tr>
<td><em>Exclusive Breast Milk Feeding (TJC PC-05: PC-05a)</em></td>
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<tr>
<td><em>Cesarean and Elective Delivery (NQF)</em></td>
</tr>
<tr>
<td><em>Prophylactic Antibiotic in C-section (NQF)</em></td>
</tr>
<tr>
<td><em>Patient and Family Satisfaction</em></td>
</tr>
<tr>
<td><em>Time Between Decision to Incision</em> (Test Measure)*</td>
</tr>
<tr>
<td><em>Transfer to Higher Level of Care: Term Delivery (Test Measure)</em></td>
</tr>
<tr>
<td><em>Gestational Age Reliability</em></td>
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</tbody>
</table>

- **Oxytocin Deep Dive**: *Perinatal Harm*<sup>*</sup>, *Patient and Family Centered Care (Structure/Narrative)*
- **Labor Deep Dive**: *Elective Delivery prior to 39 weeks Rate (Initial) / Time Between (Rare Event) (TJC PC-01)*
- **Culture of Safety Survey**: *Cesarean Rate for low-risk first birth women (TJC PC-02)*, *Neonate Transfer to Higher Level of Care: Elective Delivery*
Perinatal Community:
Reducing Harm, Improving Care, Supporting Healing

- **Perinatal Leadership**
  - Manage for Quality
  - Change the Work Environment
  - Enhance the Patient and Family Relationship

- **Reliable Processes**
  - Understand & Manage Variation
  - Eliminate Waste

- **Effective Peer Teamwork**
  - Reduce Variation
  - Improve Work Flow
  - Change the Work Environment

- **Respectful Patient Partnership**
  - Design for Partnership
  - Invest in Improvement

* See Perinatal Community Measurement Strategy
Perinatal Improvement Community: An IHI Collaborative

Our great challenge involves

Making Systems Work

- Reliable design strategies
  - Systems are designed to get exactly the results they achieve
- Improve communication
- Standardize what is standardizable
- Simplify where appropriate
- Identify unexplained variation and work toward eliminating it
**Perinatal Building Blocks: Reducing Harm, Improving Care, Supporting Healing**

- **Patients on Improvement Teams**
- **Common EFM Language and Training**
- **Consistent (across disciplines) Credentialing Standards**
- **Vacuum Bundle**
- **Establish a multi-disciplinary team training program**
- **Establish Huddles, Multi-disciplinary rounds**
- **Engage Patients and Families**
- **Reduction Variation - Meds, Emergencies**
- **Implement Techniques for Effective Communication**
- **Design Interventions From Trigger Tool findings**
- **Care is Transparent**
- **Collaborative And Supportive Culture**

**Timelines**

- **12-36 months and beyond......**
  - Engage Patients and Families
  - Consistent (across disciplines) Credentialing Standards
  - Collaborative And Supportive Culture

- **12-24 months..........**
  - Common EFM Language and Training
  - Establish a multi-disciplinary team training program
  - Establish Huddles, Multi-disciplinary rounds
  - Care is Transparent

- **3 - 9 months..........**
  - Deep Dive Pre-work
  - Perinatal Oxytocin Bundles
  - Perinatal Trigger Tool

- **3 months to 36 months and beyond....**
  - Patients on Improvement Teams
  - Common EFM Language and Training

- **1-3 months ..**
  - Deep Dive Pre-work

- **3-6 months...**
  - Perinatal Oxytocin Bundles
  - Perinatal Trigger Tool

**Key Points**

- Effective Team with Active, Supportive Leadership
- SLT and Board Support of Perinatal Leadership & Improvement Team
What is a “Deep Dive”? 

- An evaluation of care practices intense enough to give a clear understanding of the current practices of care
- This includes a random sampling/evaluation so the assessment includes most (all) providers, all days and all times
- **Structure and Process** Measures
What is a clinical bundle?

- A group of clinical events that should happen every time a given process occurs
- Individual elements based on solid science
- Initial emphasis is on process rather than outcome
All Teach, All Learn

- Members influence the content and work with faculty to stay ahead of the “next new thing” by leading to the “next new new thing”.
# IHI Perinatal Community Care Bundle Sequencing

## Elective Induction Bundle (Initial-Oxytocin)
- GA > 39 weeks
- Pelvic Assessment
- Recognition and management of tachysystole
- Recognition and management of FHR Status (Category I-normal)

## Augmentation Bundle (Initial-Oxytocin)
- EFW documented
- Pelvic Assessment
- Recognition and management of tachysystole
- Recognition and management of FHR Status (Exclusion of Category III)

## IHI Oxytocin Bundles (2004)
- Basic Oxytocin Bundles Defined as patient who receives Oxytocin for elective induction or augmentation. Focus on eliminating elective delivery prior to 39 weeks, adoption of team definition and reliable execution of component indicators.

## Advanced Non-Medically Indicated Bundle
- Defined: Patient without a medical indication for delivery.
- Confirmation of term gestation.
- Pelvic Assessment
  - Favorable Bishop Score *(locally defined)*
- Recognition and management of complications of induction method (including tachysystole)
- Recognition and management of FHR Status (Category I-normal)

## Advanced Indicated Induction Bundle
- Defined: Patient with a medical indication for induction
- Acceptable medical indication for labor induction documented (locally defined)
- Pelvic Assessment
- Recognition and management of complications of induction method (including tachysystole)
- Recognition and management of FHR Status (Exclusion of Category III)

## Advanced Augmentation Bundle
- Defined:
  - EFW documented
  - Pelvic Assessment
  - Recognition and management of tachysystole
  - Recognition and management of FHR Status (Category I-normal) (Exclusion of Category III)
  (May include amniotomy, nipple stimulation, acupunctur, and Oxytocin)

## IHI Advanced Bundles (2010)
- Accept 39 weeks as minimal GA for elective delivery.

  *Bishop score of more than 8 in the nulliparous patient, the probability of vaginal delivery after labor induction is similar to spontaneous labor.*

- Focus moves to pharmacologic or mechanical initiation of labor - no longer focused on (just) Oxytocin.

  Evidence Based Gestational dating is core**

## Vacuum Bundle (2008)
- Alternative labor strategies
- Prepared patient
- High probability of success
- Maximum application time and number of pop-offs predetermined
- Exit strategy available

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Institute for Healthcare Improvement, 2010 updated 2013

**RETIRED 7.1.13**
**Elective Labor Induction Bundle**

- Confirmation of fetal maturity
- Category I EFM
- Absence of tachysystole with increases in pitocin/Response to tachysystole
- Pelvic assessment
Advanced Elective (Indicated) Labor Induction Bundle

- Gestational age > 39 completed weeks
- Category I EFM
- Absence of tachysystole with increases in pitocin/Response to tachysystole
- Pelvic assessment
Advanced Augmentation Bundle

- Estimated fetal weight
- Category I and some Category II EFM
- Absence of tachysystole with increases in pitocin/Response to tachysystole
- Pelvic assessment
Neonatal Advantage Bundle- 1st Hour

- NRP- vigorous infant at term (37 weeks or greater)
- Identification of risk of Infection/Sepsis
- Skin to Skin
- Initiation of Breastfeeding
- Delayed Bath

DRAFT……stay tuned for the resources and supporting documents to be posted to www.ihi.org
Perinatal Improvement Community: An IHI Collaborative

Summary

- Systems are designed to get the results they achieve
  - If you want different results the system needs to be changed
- Focus on the structure and process of care
  - Reliable design strategies to consistently get the care to the bedside that we intended
- Data for improvement, not for punishment
- Measure, measure, measure
  - The need to know that change results in improvement
- Leadership and ownership
The Conflict of Change: Are we there yet?

The movement in national OB imperatives
- Elective deliveries (PC-01)
- Primary cesarean sections (PC-02)
  - Elective inductions
  - Admission criteria
  - Labor definitions
The Conflict of Change: Are we there yet?

- The movement in national OB imperatives
  - Decreasing the hospital and provider variation
  - Minimizing misuse of our tools
    - Increasing where underused
    - Avoiding overuse
  - Clarifying definitions where required
  - Reliably delivering care

Spong CY et al. 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;120:1181
Preventing the first cesarean section
Recommendations

Failed Induction of Labor
\- Failure to generate regular contractions and cervical change after at least 24 hours of oxytocin administration with AROM (if feasible)
Preventing the first cesarean section

Recommendations

**Active phase arrest**
- 6 cm or greater dilation with membrane rupture and no cervical change for
  - 4 hrs or more of adequate uterine contractions
  - 6 hrs or more if contractions inadequate

**Second stage arrest**
- No progress (descent or rotation) for
  - 3 hrs or more in nulliparous w/o epidural
  - 4 hrs or more in nulliparous with epidural

Spong CY et al. 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;120:1181
Preventing the first cesarean section
Recommendations

Are you conflicted yet?

Spong CY et al. 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;120:1181
The Conflict of Change: Are we there yet?

- Success is a continuous journey
- Openness is a start and must be fully embraced
- Fear the silence, not the conflict
Hear from our Community Teams!

- Introducing…
  - Emory Healthcare and Georgetown Hospital System!
Join the Community!

What is in a membership?

- **12** months of interactive learning
- **7** expert faculty at your fingertips
- **5** levels of engagement each month
- **2** Face to Face meetings
- **1** Community
# 2013-2014 Schedule of Calls

<table>
<thead>
<tr>
<th>Call Type</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>Coaching Calls:</strong></td>
<td>1 day/month, 4 time blocks, Open to all</td>
</tr>
<tr>
<td><strong>All Team Calls:</strong></td>
<td>1 day/month, 90 minutes</td>
</tr>
<tr>
<td><strong>Workgroup and/or Special Calls:</strong></td>
<td>Ad-hoc content specific calls</td>
</tr>
<tr>
<td><strong>Community Kick-off Call:</strong></td>
<td>End of September 2013</td>
</tr>
<tr>
<td><strong>Community Wrap-up/Celebration Call:</strong></td>
<td>End of August 2014</td>
</tr>
</tbody>
</table>
How to Become a Member...

- Complete the enrollment form on ihi.org and send to bjaney@ihi.org by September 1, 2013 (start of collaborative year)
  - All teams registered by August 1st will receive $100 discount to membership fee

Membership Fees
- $15,000 per year per team
- A reduced rate of $7,500 per team per year applies
  - Federally-qualified health centers
  - Physician practices comprising of fewer than 20 physicians
  - Hospitals with an average daily census of fewer than 50 beds
Business case for joining collaborative:  
(aka how to fund your membership)

- Approach underwriters and risk management.
- Incorporate into credentialing
- Work with IHI to break up payments
- Use these slides!
- Schedule a call with organizational leadership and IHI to bolster support
Improving Perinatal Care
2010-2012

Family Caring for Family

GEORGETOWN HOSPITAL SYSTEM
Georgetown Hospital System

Vision

Evidence Based Practice

39 Weeks Elective Delivery Initiative

Collaboration

Georgetown Memorial Hospital

Waccamaw Community Hospital

Teamwork

Family Caring for Family

You're safe in our hands.

Communication

Patient as Active Team Member

Harm Reduction

Dr. Christine Gerber, Dr. Lisa Maselli, Nira Daleda, Cheryl Kilbourne, Elaine Kitchen, Julie Casselman, Renee Shore, Janel Moseley
IHI Perinatal Collaborative

GHS AIM Statement 2012-2013

It is our AIM to be a leader in improving and providing safe, quality, family centered Perinatal Care in our communities and region. We will utilize reliable design, teamwork, and patient partnership combined with National Standards of Care and Evidence Based Practice.

Goals:

- Improve reliability of documentation in the Augmentation Bundle in order to consistently have 95% compliance within 6 months (4/1/2013)
- Implement Advanced Induction Bundles by 4/1/2013
- Continue monitoring 39 week Initiative and Induction to C/S rate to evaluate opportunities for improvement throughout the year.
- Measure and monitor infant and maternal outcomes with the implementation of Baby Friendly (beginning 10/1/2012 and ongoing)
- Further address Harm Analysis: Incidence of Episiotomy, 3rd / 4th degree lacerations, and infant categories throughout the year.
PERINATAL IMPROVEMENT PROJECT
OUR PROGRESS

- Significant sustained improvement in Elective Induction Bundle from 71% compliance in 2010-2011 to 97% in 2012

- Pitocin Augmentation Bundle compliance improved from 59% in 2010-2011 to 91% in 2012

- Improvement in Operative Vaginal Delivery Bundle compliance from 63% in 2011 to 90% in 2012
Our Progress – continued

- GHS is among the first hospitals in South Carolina to actively address the National Initiative to Reduce/Eliminate Elective Deliveries Prior to 39 Weeks. Our rate in 2011 was 4-5% but in 2012 it was less than 1%.

- Analysis of C/Section following Induction of Labor rate. To further evaluate obstetrical practice our rate for 2012 was 18% compared to a national average of 53%.
AIM: Pitocin Administration
Augmentation/Induction Bundle
Compliance \(\geq 95\%\)
Vacuum Bundle \(\geq 95\%\)
Induction Compliance

GOAL: 95%

Nov 2009: 41%
Dec 2009: 33%
Jan 2010: 21%
Dec 2011: 83%
Jan 2012: 100%
July 2012: 96%
Dec 2012: 96%
Augmentation Compliance

Goal: 95%

- Nov 2009: 56%
- Dec 2009: 50%
- Jan 2010: 67%
- Dec 2011: 83%
- Jan 2012: 100%
- July 2012: 89%
- Dec 2012: 85%
Operative Vaginal Delivery/Vacuum Bundle

Goal: 95%

Jan 2011: 67%
Feb 2011: 83%
Mar 2011: 33%
Dec 2011: 100%
July 2012: 87%
Dec 2012: 93%
AIM: Revise Harm Analysis Reports and Follow-up; Maintain Goal <5%

Family Caring for Family
3rd & 4th Degree Laceration

With Operative Vaginal Delivery National Average: 15%
3rd & 4th Degree Laceration National Average: 5.0%
With Spontaneous Vaginal Delivery National Average: 3.0%
Cesarean Sections From Inductions

National Average: 53%

July-11: 7%
August-11: 15%
Sep-11: 6%
3rd Qtr-11: 9%
Oct-11: 14%
Nov-11: 30%
Dec-11: 27%
4th Qtr-11: 24%
Jan-12: 16%
Feb-12: 8%
Mar-12: 14%
1st Qtr-12: 27%
Apr-12: 50%
May-12: 17%
Jun-12: 25%
Jul-12: 17%
Aug-12: 13%
Sep-12: 16%
3rd Qtr-12: 17%
Oct-12: 13%
Nov-12: 13%
Dec-12: 13%
C-SECTION QUARTERLY TOTALS

GHS

C-Section Rate National Average: 34%

Primary Rate National Average: 21%
AIM: Maintain Zero Incidence of Elective Deliveries Prior to 39 Weeks
2011-2012 Season
Our Wins!

• Significant/Sustained Improvement:
  Elective Induction Bundle- 71% in 2011 to 97% in 2012; 
  Augmentation Bundle - 59% in 2011 to 85% in 2012
• Reduced Elective Delivery Prior to 39 Weeks:
  4-5% in 2011 to less than 1% in 2012
• 12 month Induction to C/S Analysis showed rate of only 18%
• Implementation of Multidisciplinary Drills
• Creation of Perinatal Safety Clinical Specialist position
Lewis W. Blackman
Patient Safety Champions Award

Our Perinatal Leaders
Dr. Christine Gerber
Dr. Lisa Maselli

“Professionals whose passion has resulted in successful implementation of unit, practice and system-wide changes that promote patient safety and quality improvement”.

South Carolina Hospital Association
Our most difficult moments…..

• Managing Physician resistance
• Implementing Hard Stops for Elective Deliveries Less than 39 Weeks
• Reaching consensus/agreement with definitions to move to Advance Bundles
Our plans for the next phase of the Journey…..

• Further address Harm Analysis: incidence of episiotomy; 3\textsuperscript{rd}/4\textsuperscript{th} degree lacerations
• Continue monitoring 39 week Initiative and Induction to C/Section rate
• Pursue Baby Friendly designation
• Initiating a Centering Program in our major obstetrical provider practice – Carolina OB/GYN. Received March of Dimes grant for program.
• Pursue Center of Excellence designation
**Evidence Based Resources:**

American College of Obstetricians and Gynecologists: Practice Bulletins #9, 20, 17, 70, 76, 97, 106, 107, 433; Washington, DC: ACOG


Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN) Position Statements; Washington, DC


Perinatal Improvement Community

Emory University Hospital Midtown
May 2013
System characteristics

1. May 1, 2012 to April 30, 2013
   Total number of deliveries = 3657
   Overall Cesarean Section rate = 28.7%
   Primary C/S rate = 15.4%
   Repeat C/S rate = 13.3%

2. 11 bed LDR, 7 bed triage, 3 ORs, 2 bed recovery room, 8 bed high risk/ante partum, 39 bed postpartum/GYN

3. Level III Neonatal facility
Demographics

- Mixed faculty and private medical staff
- Resident training program
- Nursing, medical and P.A. students
- Inner city location with mixed socioeconomic clientele
- High risk patient population
Team Picture
Perinatal Harm 03/2006 to 10/2012
Top 3 Learning's
1. We are not always documenting the interventions with FHR decelerations
2. Oxytocin is not being decreased in 2\textsuperscript{nd} stage of labor
3. SVE is not always being documented within 2 hours of oxytocin start
4. We need to add FHR Categories to our computer documentation

Top 3 Surprises
1. We are not consistent as a unit in diagnosing when labor starts /refer to ACOG’s definition of labor
Elective deliveries less than 39 weeks gestation
37 to 38.6 weeks gestation

% Elective Deliveries
Numerator = Singleton Patients with elective deliveries completed
Denominator= Patients delivering newborns with ≥ 37 and < 39 weeks of gestation

*May 2007 Patient & Staff Education started
*Dec 2009 Policy
*Jan 2010 AHRQ Patient Education brochure

Hard Stop
Elective Delivery Scheduling Process
Quality Enhancement Committee support
GHA HEN EED participation 2012-2013

C/S Scheduling Process in OP OR

Emory University Hospital Midtown
Labor & Delivery

6/25/2013
Nulliparous Cesarean Section Rate
Jan-12 to Apr-13

Laboring down used by some providers since 2009

Second Stage labor down bundle implemented

% Nulliparous Cesarean Sections
Numerator= All nulliparous patients with Cesarean Sections
Denominator= Nulliparous patients delivered of a live term singleton newborn in vertex presentation ≥ 37 weeks gestation.

6/25/2013
Perinatal Safety Work
2012-2013

• Journey to “Baby Friendly Designation”
• NRP drills
• EBL & Laceration Documentation accuracy between provider and nurse
• Participation in the GHA HEN EED initiative and continued surveillance for no elective deliveries less than 39 weeks gestation
• Research study: Skin to Skin rewarming of newborns after first bath-Non randomized clinical trial completed. Practice changes being implemented
• Labor Deep Dive
• Infant Fall Prevention Initiated- No falls since November 2011
• Second Stage Bundle Roll Out with all Staff
## Baby Friendly Scorecard

<table>
<thead>
<tr>
<th>EUHM Women’s Health</th>
<th>Target</th>
<th>FY13</th>
<th>FY13</th>
<th>FY13</th>
<th>FY13</th>
<th>YTD</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Jan</td>
<td>Feb</td>
<td>March</td>
<td>April</td>
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<tr>
<td>Establish Breastfeeding Policy (Step 1)</td>
<td>80%</td>
<td>90%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Staff Education on Policy (Step 2)</td>
<td>80%</td>
<td>24%</td>
<td>27%</td>
<td>36%</td>
<td>38%</td>
<td>38%</td>
</tr>
<tr>
<td>Prenatal Instructions Completed (Step 3)</td>
<td>80%</td>
<td>64%</td>
<td>66%</td>
<td>50%</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>Skin to Skin Contact after Birth (Step 4)</td>
<td>80%</td>
<td>17%</td>
<td>7%</td>
<td>27%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>Breastfeeding Assistance Offered for Mothers (Step 5)</td>
<td>80%</td>
<td>48%</td>
<td>68%</td>
<td>49%</td>
<td>73%</td>
<td>59%</td>
</tr>
<tr>
<td>Breastfeeding Exclusivity (Step 6 / TJC Core Measure)</td>
<td>Monitor</td>
<td>27%</td>
<td>23%</td>
<td>31%</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>Rooming In for 23 of 24 Hours (Step 7)</td>
<td>80%</td>
<td>31%</td>
<td>35%</td>
<td>40%</td>
<td>40%</td>
<td>36%</td>
</tr>
<tr>
<td>Feeding on Demand Education Given to Mothers (Step 8)</td>
<td>80%</td>
<td>48%</td>
<td>49%</td>
<td>38%</td>
<td>49%</td>
<td>46%</td>
</tr>
<tr>
<td>No Pacifiers or Artificial Nipples (Step 9)</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding Support Group Recommended (Step 10)</td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>80%</td>
<td>82%</td>
<td>73%</td>
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Aim Statement

By July 1, 2013, The Emory University Hospital Midtown Women’s Health Services will:

• Sustain 98% or higher compliance with the perinatal oxytocin bundles

• Sustain 100% compliance with our policy of no elective deliveries less than 39 weeks

• Implement the Instrumented Delivery Bundle, including a policy and procedure, documentation checklist, and audit tool.
Our Goals include:

- Emergency Team Training Drills (Staff and Physicians need dedicated time)
- Adding a patient/family team member
- Vacuum Bundle
- Decrease Nulliparous C/S rate
- Continue with Second Stage Bundle
- Physician credentialing for Fetal Monitoring
- Decrease discrepancies between provider and nurse EBL and Laceration documentation
- Perinatal Harm Plan of Action to decrease rate
Tests of Change

• Improve process of mother-baby handoff (Accepting RN ready, room ready, information communicated etc)

• Decrease discrepancies between nurse and provider documentation for EBL and Lacerations

• Improve Process for Skin to Skin at delivery
It’s a Journey