

**Reducing Primary Cesarean Births Initiative
Success Story
University of Minnesota Medical Center &
University of Minnesota Masonic Children's Hospital**

Co-leads:

Becky Gams
Carrie Neerland

We applied to participate in the Reducing Primary Cesareans Collaborative for the first cohort, beginning in 2016. We chose to implement the Promoting Spontaneous Progress in Labor bundle.

- Originally, our AIM was to reduce our NTSV C/S rate by 3% in 2016 and another 3% in 2017.
- Our NTSV rate of C/S in 2015 was 29.3% compared to 26.1% in 2016.
- Overall, this is a 10.1% decrease in one year
- The Healthy People 2020 NTSV C/S goal is 23.9%. We aim to reduce at least 10% in 2017 in order to meet the HP 2020 goal.
- We had 2,200 births in 2014
- Approximately 60% of our patients have public insurance

Our team is multidisciplinary, including:

- Advanced Practice Nurse Leader and Nurse Midwife – co-leaders
- Clinical Development Specialist
- Labor and Delivery and Mother/Baby Nurses
- Nurse-Midwives
- Three DNP Midwifery Students
- Obstetricians
- Anesthesiologist
- Residents/Medical Students
- Nursing Administration
- Medical Director

Principles of change management were utilized to implement the bundle. This involved developing a team charter, building a multidisciplinary team, collecting data to support PDSA (Plan, Do, Study, Act) cycles, and developing the infrastructure for data collection and running reports out of the electronic medical record.

The initiative was incorporated into already-established processes, such as standing meetings and a shared mental model about promoting spontaneous labor progress and physiologic labor evolved. Methods to support communications about the project were

THE AMERICAN COLLEGE OF NURSE-MIDWIVES HEALTHY BIRTH INITIATIVE™

Reducing Primary Cesareans

incorporated into current structures. For example, RPC is a standing agenda item at the monthly Obstetric Interdisciplinary Team meetings and bimonthly Nursing Staff Meetings. In addition, bulletin boards are used to display metrics on the Birthplace units, including the Mother/Baby unit. As team members were recruited, thought was given about selecting key champions within their disciplines for various aspects of the project.

To support physiologic labor, two new guidelines were developed: Labor Support, Mobility and Upright Positioning Guideline and Early Labor Assessment and Management Guideline. These guidelines set the expectations for labor assessment and support of upright positioning in labor as well as patient selection and use of the new labor lounge and birth slings. In addition, the existing Electronic Fetal Monitoring Guideline was revised to include the use of intermittent auscultation. The Spong (2014) Preventing the First Cesarean and the Clark (2013) Management of Category II Fetal Tracing algorithms were used to support decision making for cesarean births. A labor dystocia huddle process was developed by a small work group. The purpose of the huddle is to review the algorithms prior to proceeding with cesarean birth and to ensure documentation of the decision making process. All cesarean births for the indication of labor dystocia are reviewed by a resident and medical student to determine if the criteria for dystocia are met. If a case is not in compliance, it is reviewed by the OB Case Review team and shared with providers for further education.

These new guidelines and processes were introduced through various modalities for nursing and provider education. For example, for Labor Positioning, Mobility and Upright Support, a video on the use of labor slings was created and included in the nursing on-line education. Hands-on upright labor support education and intermittent auscultation were incorporated into labor and delivery classes for new nurses and at two system-wide nursing conferences. Competency checklists for the set up and use of birth slings were created and designated champions checked off each labor and delivery nurse for initial education. This was repeated at 6 months. Competency sessions also included intermittent auscultation and use of the labor lounge.

For provider education, information about use of the labor lounge, upright labor positioning and support and intermittent auscultation were presented in OB Provider Meetings and morning rounds. Any presentations were shared via emails and per request. Use of patient whiteboards was encouraged to enhance communication of stage of labor with patients. The Labor Dystocia Huddle process and template note content were reviewed during an OB Interdisciplinary Team meeting and was built into the electronic medical record (EMR) as a standardized template.



THE AMERICAN COLLEGE OF NURSE-MIDWIVES HEALTHY BIRTH INITIATIVE™

Reducing Primary Cesareans

Data collection and synthesis was initially challenging and time consuming but was important for the initiative. In the beginning, data was collected manually using forms. Simultaneously, the team worked closely with IT to automate the process. This decreased the data collection time from 8 minutes to approximately 30 seconds per chart! Working closely with the EMR team, the delivery summary was enhanced to capture data required by the project: 1:1 labor support, predominant method of fetal surveillance, dilation at epidural placement, CNM care, and use of nitrous oxide. Other enhancements included adding intermittent auscultation drop downs, and finally, a delivery log report to capture the data required. The data was submitted to the RPC data center and results are shared regularly. One particular person in IT spent time mentoring the site co-leaders in exporting data to excel to facilitate further data analysis.

Embedded in the project were three separate DNP midwifery projects, which supported various aspects of the bundle: implementation of IA, implementation of the Labor Lounge, and implementation of upright positioning and mobility in labor. The projects were crucial to the initiative in a several ways including supporting culture change, additional data collection and analysis for each project, educational content and mentoring by colleagues, and knowledge dissemination through poster presentations at nursing and midwifery conferences. A celebration inviting high level administrators and team members was held to showcase the efforts and success of the team.

Future plans are to continue participating in the RPC collaborative. In addition, we want to continue to push towards realizing the Healthy People 2020 goal for NTSV CS of 23.9%. Key strategies include the use of a labor partogram in our medical record and to explore opportunities for doula services. As these internal changes continue, support to other hospitals in the collaborative and within our hospital system will be offered. Information will be shared widely.

Our advice to those wishing to make similar change is to utilize existing resources, find champions within different disciplines, team with students from different disciplines, communicate frequently and celebrate successes.