



THE AMERICAN COLLEGE OF NURSE-MIDWIVES HEALTHY BIRTH INITIATIVE™

Reducing Primary Cesareans

ACNM's Reducing Primary Cesareans Success Story

Centra Virginia Baptist Hospital

Virginia

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Profile:

- 2,512 deliveries
- 63% public insurance
- NTSV cesarean rate in 2015: 18.40%
- NTSV cesarean rate decreased to 14.52% by 2016
- NTSV current rate (April 2017): 17.3% (YTD 2017)
- Prior to 2016, no women were assessed for coping in labor, and by the end of the year 31.2% were assessed for coping
- Spontaneous labor and birth also increased after the first year, from 41.6% to 52.7%.

We joined Reducing Primary Cesareans (RPC) Collaborative in 2016 with the goals of lowering our NTSV cesarean rate and improving provider documentation and communication. Our department had already begun the process of increasing the variety of tools for labor comfort by adding more labor balls, peanut balls, exploring the use of nitrous and encouraging use of Intermittent Auscultation for low-risk women. In addition, our midwifery group was encouraging and more openly educating both patients and staff on the benefits of and methods to support physiologic labor. The RPC Collaborative was a natural next step for our hospital, and an opportunity for our midwifery practice to lead this effort.

We chose to implement two bundles: Promoting Comfort in Labor and Promoting Spontaneous Progress in Labor. Both had elements that overlapped which we felt would be mutually beneficial for our needs. When we looked at the indications for admission and cesarean section, many women were admitted in early labor, received early epidural without being offered or utilizing other tools for comfort, and a majority received augmentation during labor. Documentation of clinical indication for augmentation, informed consent, and shared decision making was inconsistent. Based on a self-efficacy survey of nursing staff, staff reported mixed competency to provide various non-pharmacologic comfort measures and felt that policies and practices were less supportive of these methods.

Our provider documentation is all on paper, so our first task was to standardize our documentation forms into a 2-page document that included: an area for indication for

induction with a check-box statement on informed consent, a table format for charting labor progress that allowed for easier tracking/visualization of labor progress over time, a Pitocin augmentation form that included indication for augmentation with a check-box statement on informed consent, and a cesarean indication form that included updated indications based on the ACOG/SMFM 2014 guidelines for preventing primary cesarean. We presented the RPC project, goals, and the rationale to the OB-GYN Department, along with the forms to assist provider documentation and improve consistency and compliance with documentation. This was our primary focus for provider education and improvement in the first year of the Collaborative. At the quarterly department meetings, we continued our education by presenting our data and documentation compliance for augmentation and indication for cesarean, while also meeting with individual providers for one on one discussion. Toward the end of the year, we started a quality review of all operative births with indication for dystocia. This is an on-going process from which we hope to learn how to additionally improve care and documentation on our unit.

For labor comfort, we had a major success by instituting a nurse-led policy and process for patient self-administered nitrous oxide in labor. We educated nurses on updated guidelines and definitions for diagnosing active labor and arrest of labor which allowed them to advocate for patient and be part of clinical decision making team. We also updated the hospital's pain management policy to include the Coping with Labor Algorithm as the primary tool for assessing pain in labor. We began education for staff on coping in labor mid-year 2016, and are moving forward with changing our pain assessment to coping for all women in labor.

Our team in 2016 was comprised of 2 CNMs and 1 OBGYN, representing 2 of the provider groups with privileges at our hospital, 2 RNs, the unit manager, the division director for women's and children's, and one of our quality analysts. In 2017, we invited additional provider representatives from the other two OB practices and have been joined by an OB and a Family Medicine resident, in addition to a childbirth educator, and a RN and unit manager from our affiliate community hospital.

We have tried to focus on utilizing the strengths and roles of each team member to facilitate process change. Our lead midwife and one RN led the initial information/focus groups with nursing staff to find discuss the RPC goals, bundles, and to learn about barriers to implementation in our system. Our midwives and physicians have been champions in facilitating conversations that encourage practice reflection and change among providers. Our administrators have been instrumental in helping move forward new policies that needed approval through other institutional committees.

We have collected data metrics set by the RPC Collaborative for each bundle. In addition, we have maintained a separate data spreadsheet to include: attribution of mode of birth to each birth provider, centimeters of dilatation at admission for women admitted in spontaneous labor or with pre-labor rupture of membranes, indication for induction of labor and cesarean section, and assessment of provider documentation for completeness (i.e. indication for induction and augmentation including documented discussion of risks/benefits with patient, indication for

cesarean according to ACOG/SMFM guidelines, and documentation of labor progress). This data has allowed us to further analyze our practice patterns and opportunities for improvement.

Aside from culture change, which is an on-going process and experience, our major barrier has been that our baseline cesarean rate was already below national and state benchmarks; there is a sense of “why, bother?” We have tried to approach on improving care more broadly, as opposed to focusing solely on the cesarean rate as our primary concern.

Our provider education and conversation has focused on our practice patterns for induction and augmentation, and our inability to evaluate the care provided because of absent or inadequate documentation. We presented the ACOG/SMFM guidelines and current evidence regarding Pitocin augmentation, including the risks/benefits associated with the use of this medication. These efforts have encouraged providers to take pause before augmenting or recommending cesarean. Regarding cesarean, there has been an increased provider patience based on conversations with providers, and improved documentation when cesarean may have been recommended/indicated outside of established parameters.

With the Comfort in Labor bundle, we have focused on increasing the tools that we have available and have been working to educate nursing staff on how to use/offer these tools. Our efforts have been complimented and supported by increased community advocacy and desire for individualized, physiologic care – women are asking for physiologic care and non-pharmacologic coping tools!

At the end of the first year, we achieved a 20% reduction in our NTSV cesarean rate to 14.52%. We began offering nitrous oxide for labor comfort in September 2016, and had 4% use average by the end of the year. Our current rate in 2017 is 11.9%. Prior to 2016, no women were assessed for coping in labor, and by the end of the year 31.2% were assessed for coping, This has continued to increase in 2017. Spontaneous labor and birth also increased after the first year, from 41.6% to 52.7%.

Our advice for people who want to make similar changes in their setting is to be patient. Look at your data to find areas for small victories that may also provide a platform to have broader discussions about patient care. For example, our primary effort for supporting labor progress was a focus on improving and standardizing provider documentation which gave us a platform to discuss guidelines and current evidence on labor duration and dystocia.