

Objectives

Upon completion of this activity, the learner will be able to:

1. Define placenta accreta and other types of placental invasion and describe the associated consequences.
2. Describe components of a program designed to provide multidisciplinary care of women with placenta accreta.
3. Evaluate outcomes of a program designed to provide multidisciplinary care of women with placenta accreta.

Continuing Nursing Education (CNE) Credit

A total of 1.3 contact hours may be earned as CNE credit for reading "Creating a Multidisciplinary Placenta Accreta Program" and for completing an online posttest and participant feedback form.

To take the test and complete the participant feedback form, please visit <http://learning.awhonn.org>. Certificates of completion will be issued on receipt of the completed participant feedback form and any processing fees.

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Creating a Multidisciplinary Placenta Accreta Program CNE

Christina Tussey & Carol Olson

ABSTRACT

Objective: To develop a formalized comprehensive placenta accreta (PA) program to improve maternal and neonatal outcomes associated with a PA birth.

Design: To develop a clinically innovative PA program, goals were identified and teams were created to collaboratively address best practices in each phase of clinical patient care, along with the financial and marketing aspects necessary for a sustainable program.

Setting/Local Problem: A Level 3 perinatal center in the Southwestern United States.

Implementation: A diverse multidisciplinary team addressed each aspect of care associated with a PA birth, including team members from the main operating room; trauma surgery; blood bank; interventional radiology unit; NICU; and gynecology-oncology, anesthesia, and urology departments.

Measurements: Pre- and postprogram clinical outcome measures were examined including estimated blood loss at birth, postbirth ICU transfers and length of stay, and postpartum length of stay.

Results: Clinical outcomes after program implementation showed decreased blood loss at birth (from an estimated 6,350 ml to 1,300–1,400 ml), reduced postbirth ICU length of stay (from approximately 3 days to less than 1 day, with many women bypassing ICU transfer altogether), and shortened postpartum length of stay (from 8 days to 4 days).

Conclusion: With implementation of this PA program, women receive a proactive approach to care that includes education, holistic care, and an organized team approach to birth made possible by the innovative care delivery model, structures, and processes. Standardized checklists and workflows help each clinician understand their role in the process, and resources are directed effectively and efficiently. Multidisciplinary, multispecialty collaboration results in decreased variation in care with associated improved patient outcomes.

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KEYWORDS: accreta, invasive placentation, multidisciplinary team, placenta accreta management

CLINICAL IMPLICATIONS

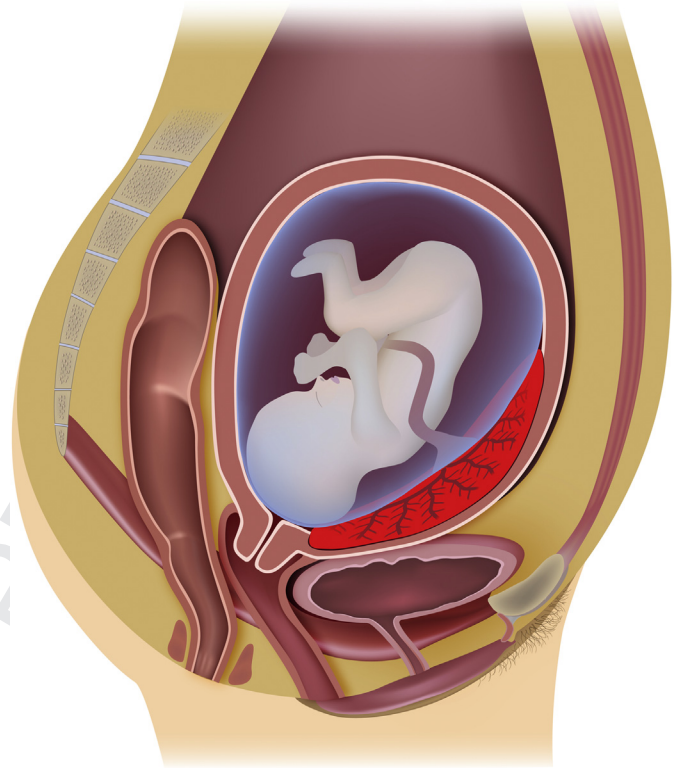
- Health care providers need to be aware of the high-risk complexity of placenta accreta (PA) and use defined protocols in the care of women with PA.
- Leaders in tertiary facilities can create an organized, multidisciplinary program to meet the needs of this high-risk population in an effort to achieve the best possible outcomes for women and neonates.
- Women with PA should receive a proactive approach to care that includes psychosocial support and preparation, education, holistic care, and an organized team approach to birth made possible by an innovative care model, structures, and processes.
- Standardized checklists and workflows help clinicians understand their roles in the process, and resources are directed effectively and efficiently at achieving the best outcomes.
- Multidisciplinary, multispecialty collaboration results in decreased variation in care with associated improved patient outcomes.

Introduction

Placenta accreta (PA), an abnormality in the degree of placental implantation into the myometrium, was a rare finding approximately 35 years ago. [Breen, Neubecker, Gregori, and Franklin \(1977\)](#) reported the average PA incidence rate from 1871 to 1972 to be 1 in 7,000 pregnancies; however, current figures indicate an increase to 1 in 533 births ([Fitzpatrick et al., 2012](#); [Wu, Kocherginsky, & Hibbard, 2005](#)). The danger of a morbidly adherent placenta occurs at birth when the placenta, now embedded within the myometrium, fails to separate, resulting in a potentially massive postpartum hemorrhage. The risk for PA increases for women with myometrial disruption from a prior cesarean birth or who have a history of uterine surgery. Cesarean birth alone is an independent risk for PA, and the rate of cesarean births rose from 5% in 1970 to 32.2% in 2014 ([Hamilton, Martin, Osterman, Curtin, & Matthews, 2014](#); [Placek & Taffel, 1980](#)).

Additionally, a corresponding risk factor for PA is seen in women with placenta previa (a condition in which the placenta is located in the lower uterine segment and covers the cervical os) and a history of previous cesarean birth, which increases with the number of prior cesarean births. Evidence indicates that the risk for an accreta increases 3.3% after the first cesarean, 11% after the second, 40% after the third, 61% after the fourth, and 67% after the fifth or greater ([American College of Obstetricians and Gynecologists \[ACOG\], 2012](#); [Fitzpatrick et al., 2012](#); [Silver et al., 2006](#)). For this reason, it is recommended that all women

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with a previa undergo a complete assessment of the placenta to identify the increasing likelihood of an accreta ([Silver et al., 2015](#)).

Results of studies conducted during the past two decades indicate a 10-fold increase of the incidence of PA

PA has become an increasingly important contributor to morbidity related to repeat cesarean births. It has been noted that postpartum hemorrhage occurs in 3% of all vaginal and cesarean births ([Marshall et al., 2017](#)). Among births complicated by postpartum hemorrhage, 76.6% can be attributed to uterine atony, and 23.4% are nonatonic. In one study, PA was identified as the most common cause of massive bleeds, with uterine atony being the most common cause for moderately severe bleeds ([Green et al., 2016](#)). The median blood loss due to PA is 2 L ([Tan et al., 2013](#)). Emergency hysterectomy results in an additional 1.8-L blood loss compared with elective cases ([Tan et al., 2013](#)). PA is the second most common indication for an emergency peripartum hysterectomy ([Palova, Redecha, Malova, Hammerova, & Kosibova, 2016](#)). In a review article, [Balayla and Bondarenko \(2013\)](#) summarized 34 studies and 508,617 births and confirmed 865 cases of PA. The ominous and very suspicious hint of a diagnosis of PA is profuse third-stage postpartum hemorrhage and placental retention, especially when there was no antenatal screening for detection for PA. According to Balayla and Bondarenko, blood transfusions

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