Childbearing

Can Placing a Lactation Consultant in the Obstetric Office Magically Increase Exclusive Breastfeeding Rates?

Cindy A. Bass, MSN, RNC-OB, LCCE, Johnson City Medical Center, Johnson City, TN

Marsha Rodgers, RNC-OB, MSN, Johnson City Medical Center, Johnson City, TN

Hannah R. Baker, RN, BSN, CLC, Johnson City Medical Center, Johnson City, TN

Keywords
breastfeeding
lactation consultants
feeding choice

Paper Presentation

Purpose for the Program

Exclusive breast milk feeding is promoted by health care providers and the Joint Commission. In one organization, the move to exclusive breast milk feeding was not moving as quickly as desired. An innovative idea was trialed and proved successful: placing lactation consultants (LC) in obstetric offices during the prenatal period. Expectant mothers obtained information and education related to breastfeeding while making important, informed decisions about the care of their infants.

Proposed Change

To offer continual visibility of the LC in the obstetric office to remind women of this feeding choice for their infants. While the mother waits to be seen for her routine prenatal visits, the LC has a captive audience. The mother has the opportunity to begin thinking about her feeding choice, is offered the opportunity to ask questions in a nonthreatening atmosphere, and is not required to go anywhere else for breastfeeding consultation for the entire length of her pregnancy. The continual visibility of the LC promotes the idea that breast milk feeding is a normal process.

Implementation, Outcomes, and Evaluation

Leadership identified the need to improve exclusive breastfeeding rates. Awareness of where the LCs made first contact with pregnant women making feeding choices seemed an important part of an innovative plan to improve outcomes. Collaboration between physicians, office staff, LCs, and senior hospital leadership resulted in placing the LCs in the OB offices, so they were available for consultations within the hospital practice setting. A funding opportunity from the U.S. Department of Health and Human Services (HHS), Office of Women's Health provided the extra funding for the project. Data collected provided information that demonstrated lactation services in the offices had a positive effect on breastfeeding rates. Exclusive breastfeeding rates increased from 33% in December 2012 to more than 60% in August 2013.

Implications for Nursing Practice

Providing education throughout pregnancy offers the new mother an opportunity to make an informed decision regarding the feeding choice for her newborn. As she begins to breastfeed her newborn, her confidence is bolstered. Frontline nurses can begin by increasing the mother's breastfeeding knowledge base, and continue to support and promote her feeding efforts.

Improving the Outcomes of Women With Severe Preeclampsia: Exploring Innovations Used by an Inter-Professional Team at a Community Hospital

Beth M. Stephens-Hennessy, RNC-OB, EFM, MS, CNS, Sutter Memorial Hospital, Sacramento, CA

Laura Senn, RN, MS, CNS, Sutter Memorial Hospital, Sacramento, CA

Keywords
severe preeclampsia
hypertensive crisis

Childbearing
Paper Presentation

Purpose for the Program

We describe how our facility implemented the California Maternal Quality Care Collaborative (CMQCC) recommendations for identification and treatment of severe preeclampsia in the perinatal areas and the emergency department (ED). We are a community based, nonacademic hospital, delivering 5,000 newborns per year with a 24-bed high-risk maternity unit. The goal is to implement strategies to improve care and reduce morbidity and mortality.

Proposed Change

To implement a four-part change based on evidenced-based research: (a) Standardize the blood pressure assessment method used by nurses to obtain the reportable values. As suggested by CMQCC, we found that the methods used by the registered nurses (RNs) varied, (b) treat patients with blood pressure greater than 160 systolic or 105 diastolic with intravenous (IV) antihypertensive medication within 30 minutes, (c) debrief the process for each patient who required antihypertensive medication, and (d) provide the patient who has a diagnosis of severe preeclampsia with specific discharge instructions and arrange for follow-up within 3 to 10 days.

Implementation, Outcomes, and Evaluation

Using the Plan Do Study Act (PDSA) model, we formed a multidisciplinary team, including physician leaders, to review and implement the

recommendations. We started with identification of how a severe preeclmaptic patient was coded. We worked with our colleagues in health information management to ensure that these patients were coded in a way that allowed us to use the data that was generated. We abstracted 6 months of data before starting the program, so that we could measure our changes. Comparing our baseline data to the benchmarks, we identified opportunities for improvement. Medical doctor and RN education needed to be multifaceted. We used everything from posters, computer-based learning, read and sign packets, and lectures that included case scenarios. Policies were updated and a preeclampsia order set was developed. Case management assisted with setting up outpatient follow-up for these patients. The data collection occurred concurrently with admission to the perinatal or ED unit. Our data were posted on a monthly basis after the education was complete. Balance measures were included and reported. We continue to look at our practice and systems issues through a debriefing process to achieve the benchmarks.

Implications for Nursing Practice

Standardization of blood pressure measurement, identification of hypertensive crisis, activation of a team to respond, expedited treatment with IV antihypertensive medications, debriefing of the process, and revising and hardwiring best practice.

The Modern Woman's Labor Curve

Beth M. Stephens-Hennessy, RNC-OB, EFM, MS, CNS, Sutter Memorial Hospital, Sacramento, CA

Keywords
Friedman's curve
partogram
NTSV
labor support

Childbearing Paper Presentation

Purpose for the Program

To describe the use of the partogram as a tool for decision making during labor, review the origins of the partogram and the recent research related to it, and discuss how the change from use of the Friedman curve to the partogram was implemented at a community based, nonteaching, tertiary care birthing center.

Proposed Change

To develop communication points where the registered nurse (RN) and medical doctor (MD) review the progress of the labor and implement any associated interventions.

Implementation, Outcomes, and Evaluation

One hundred charts of nulliparous, term, singleton, vertex (NTSV) cesarean delivery patients were retrospectively reviewed. The labors were plotted on a partogram and on the Friedman curve. Communication points between the RN and MD were identified. Consideration for additional time for a body mass index greater than 35 was reviewed. The chart audits revealed that 20% of the women who had NTSV cesarean deliveries because of failure to progress could have been given more time in labor if the partogram was used and extra time for obesity was applied. RN and MD education regarding the use of the partogram consisted of lectures, staff meetings, and handouts. RNs completed a partogram on all patients in labor. All partograms were reviewed for communications and interventions when the patient's labor varied from the partogram. Balance measures were applied, including Apgar scores, maternal temperature, postpartum hemorrhage, and length of hospital stay. None of the balance measures was increased because of implementation of the partogram. While evaluating the use of the partogram through the plan-do-study-act (PDSA) cycle, it was discovered that the combined use of the partogram with the patient's involvement improved the patient's satisfaction in relation to the health care providers' involvement in her care.

Implications for Nursing Practice

Using the partogram requires the labor and delivery RN to actively include the patient in the progress of her labor. The partogram assists the RN in implementation of labor support and nursing interventions at specified times during the labor. It also improves the communication between the RN, MD, and patient.

Improved Birth Outcomes With Implementation of a Perinatal Quality and Patient Safety Collaborative

Raquel Walker, MSN, RNC-MNN, RN-BC, Roper St. Francis Healthcare, Charleston, SC

Purpose for the Program

In February 2012, the Roper St. Francis Healthcare (RSFH) Perinatal Quality and Patient Safety Collaborative was formed to replace the Perinatal Care Committee. The committee functioned as a reporting mechanism of adverse events instead of a way to examine clinical competency, data analysis, process improvement, and evidence-based practice. Taking a proactive rather than a retrospective approach, RSFH Perinatal Quality and