GaPQC

GEORGIA PERINATAL QUALITY COLLABORATIVE

WELCOME TO THE MONTHLY LEARNING WEBINAR

The presentation will begin shortly

General Housekeeping

- Use the chat box to register your name, facility represented and all participating team members.
- To prevent distractions, please mute all phones:
  - Please DO NOT put phones on hold to avoid playing background music we are unable to control.
- Use the chat box for questions during the presentation but please hold comments until the end of the session.
- All collaborative members want to learn from your wins and challenges so please share!

AIM Bundles

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

READINESS

Every unit

- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION

Every patient

- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE

Every hemorrhage

- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

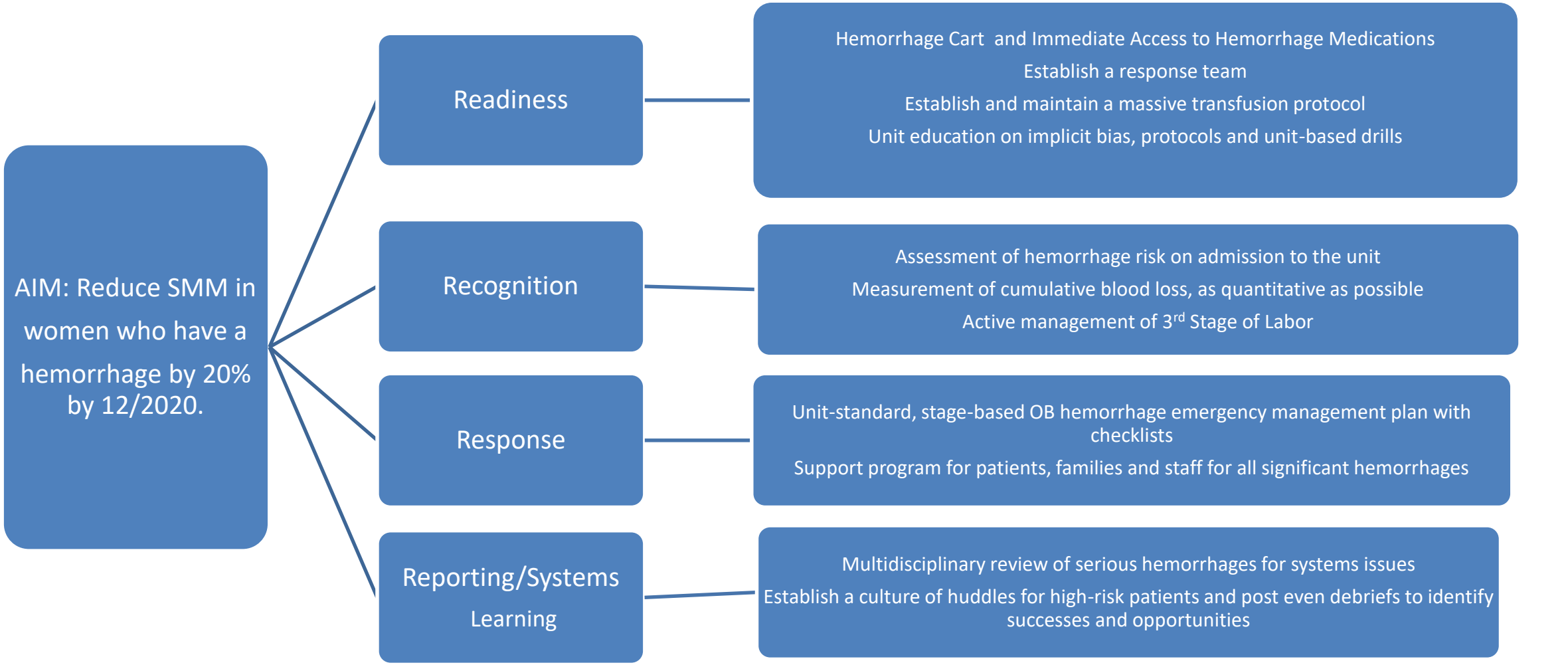
READINESS

RECOGNITION AND PREVENTION

RESPONSE

REPORTING/SYSTEMS LEARNING

Hemorrhage Driver Diagram



GaPQC Hemorrhage Goals by 12/2021

Measure	Type	Goal
Severe Maternal Morbidity No. of women with severe maternal morbidities (e.g. Acute renal failure, ARDS, Pulmonary Edema, Puerperal CNS Disorder such as Seizure, DIC, Ventilation, Abruption) / No. pregnant & postpartum women with postpartum hemorrhage diagnosis	Outcome	20% reduction
Risk Assessment No. of women had a hemorrhage risk assessment with risk level assigned, performed at least once between admission and birth and shared among the team/ no. of women	Process	100%
Debriefs on all cases requiring ≥4 units RBCs or admission to the ICU	Process	100%
Quantified blood loss No. of women who had measurement of blood loss from birth through recovery period using quantitative and cumulative techniques/no. of women	Process	100%

AIM Hemorrhage Structure Measures

S1: Patient, Family & Staff Support	Report Completion Date Has your hospital developed OB specific resources and protocols to support patients, family and staff through major OB complications?
S2: Debriefs	Report Completion Date Has your hospital established a system in your hospital to perform regular formal debriefs after cases with major complications?
S3: Multidisciplinary Case Reviews	Report Completion Date Has your hospital established a process to perform multidisciplinary systems-level reviews on all cases of severe maternal morbidity (including women admitted to the ICU, receiving ≥4 units RBC transfusions, or diagnosed with a VTE)?
S4: Hemorrhage Cart	Report Completion Date Does your hospital have OB hemorrhage supplies readily available, typically in a cart or mobile box?
S5: Unit Policy and Procedure	Report Completion Date Does your hospital have an OB hemorrhage policy and procedure (reviewed and updated in the last 2-3 years) that provides a stage-based management plan with checklists?
S6: EHR Integration	Report Completion Date Were some of the recommended OB Hemorrhage bundle processes (i.e. order sets, tracking tools) integrated into your hospital's Electronic Health Record system?

AIM Hemorrhage Process Measures

P1: Unit Drills	Report # of Drills and the drill topics How many OB drills (In Situ and/or Sim Lab) were performed on your unit for any maternal safety topic?
P2: Provider Education	Provider Education The number of OB MDs and CNMs that completed an educational program on OB hemorrhage?
P3: Nursing Education	Nursing Education How many OB nurses have completed an education program on the OB Hemorrhage bundle elements and unit standard protocol?
P4: Risk Assessment	Risk Assessment The number of mothers had a hemorrhage risk assessment with risk level assigned, performed at least once between admission and birth and shared among the team?
P5: Quantified Blood Loss	Measurement of Blood Loss The number of mothers that had measurement of blood loss from birth through the recovery period using quantitative and cumulative techniques?
P6: Implicit Bias Training	Implicit Bias Training The number of providers, nurses and OB staff who received training on implicit bias?

QBL Measurement and Documentation in the Rural Facility

Presented by: Laree Vickers, RN, CLC
Perinatal Educator, Coffee Regional Medical Center

Introduction to CRMC

- Coffee Regional Medical Center, Inc. is a non-profit, acute care hospital located in Douglas, GA.
- We have 88 inpatient beds with expanded outpatient service areas to promote multi-level patient care.
- Our four main service lines, which are Cardiology, Orthopedics, Oncology, and Women's Health, reach beyond Coffee County to serve the people of South Georgia.
- Fully accredited Cardiac PCI program began in January 2019, and has already exceeded the forecasted numbers for year three.
- Oncology and Infusion services are growing by leaps and bounds, and we are now planning expansions to accommodate the volume.

CRMC
COFFEE REGIONAL MEDICAL CENTER

CRMC Perinatal Unit

- 570 deliveries in 2018. Average 30-50/month.
- Level 1 nursery
- 6 LDRP suites, OB 2 triage beds, 5 WHS beds
- About 25 nurses
- 2 Nurse Practitioners
- 5 OB providers

QBL Timeline

- August 2018:
  - CRMC joined the GaPQC Hemorrhage Initiative
- January 2019:
  - I transitioned to lead role for GaPQC projects.
  - QBL documentation rate was 3.4%
  - Decision to focus first on QBL for vaginal deliveries only.
- February 2019:
  - QBL for vaginal deliveries was 57%; overall QBL was 32%
- March 2019:
  - QBL for vaginal deliveries was 93%; overall QBL 50%
  - Pilot program to test QBL for C-sections.

QBL Timeline

- April 2019
  - QBL for C-Sections officially began.
  - **QBL documentation rate was 100%**

We had to start somewhere!

- In January- Started small with focus on vaginal deliveries.
- Identified obstacles. Asked "Why is this hard, and how can we make it easier?"
  - Staff feedback
  - Working the process

Baby Steps

"You don't have to have everything figured out before you begin. That's the magic of baby steps!" *David Emerald*

Before making QBL documentation mandatory, we wanted to eliminate as many hurdles as possible.

- Scale in every delivery room
  - Up to this point, we had one scale located in dirty instrument room.
- QBL Job Aid
  - Clearly explain and standardize the process
- Individual and group teaching
  - Weighing pads and calculating QBL, rationale behind QBL
- Easy reference cards for dry weights
  - Posted at every computer, on every scale, and badge cards given to nurses.

Baby Steps Continued..

- Standardized documentation process.
  - Centricity I&O tab
- Determined best way to track QBL documentation.
  - Nurses print I&O sheet after completion of QBL and place in folder.
- Staff buy-in.
  - EBL has been the standard practice for many years.
  - Change is sometimes hard.
  - Asked for support even if they didn't agree.

- In February, we officially began doing QBL for vaginal deliveries.
  - Staff incentives.
  - Recognized nurses with 100% QBL documentation
- Initial conversations with OR staff about QBL for c- sections.
  - CRMC's L&D unit doesn't have a c-section room.
  - Researched method for c/s QBL.
  - Met with physician champion and obtained permission to attend all of his scheduled c sections for the purpose of performing QBL.

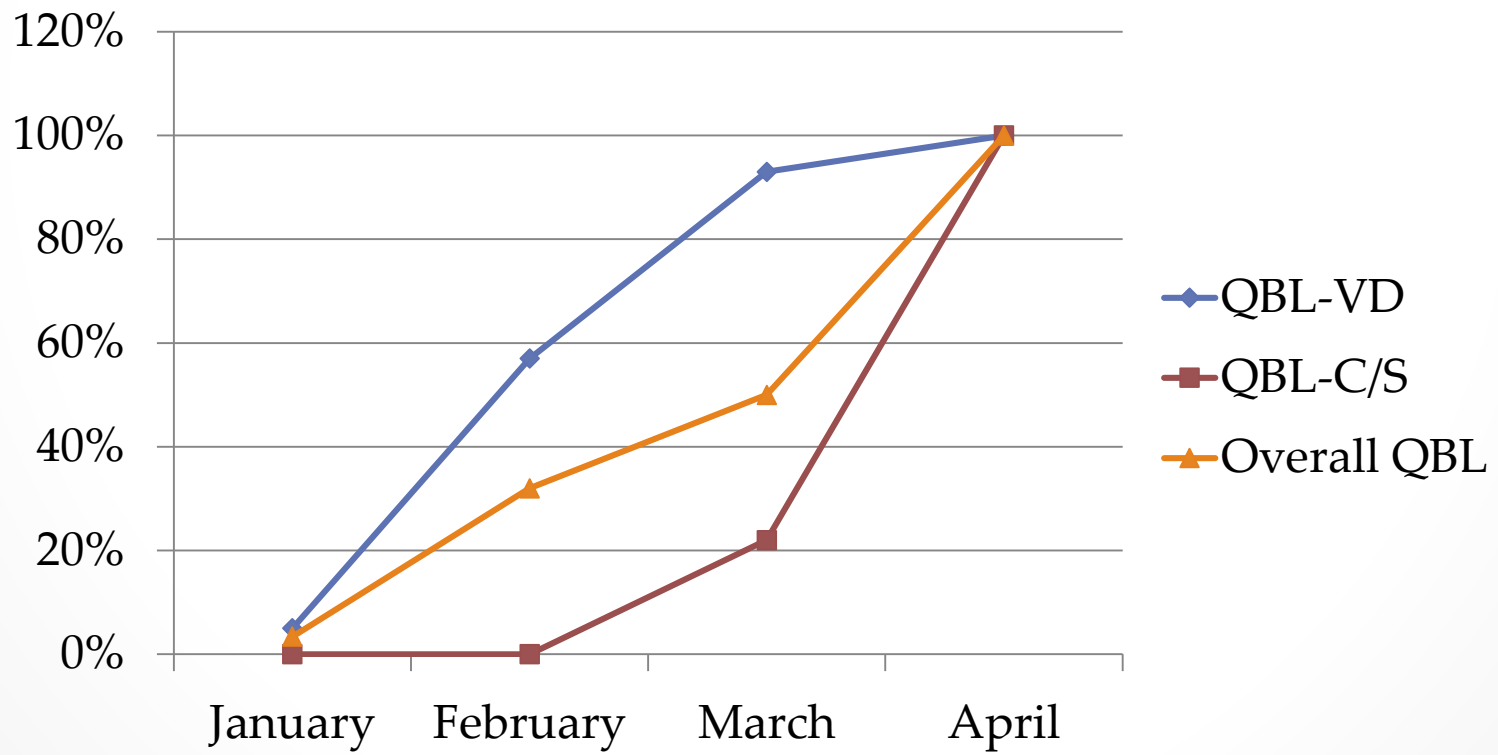
Piloting C-Section QBL

- QBL Pilot for C-Sections began March 1st.
  - I attended the scheduled c-sections of our physician champion.
  - Worked through QBL process over and over to make it as simple as possible.
  - Developed a form to record OR QBL.
  - Met with OR and L&D staff to formulate a plan that would work for both departments.
  - Began educating OR staff on QBL process.
  - Purchased scales for OR c-section room and women's health hallway.
  - Communicated QBL results to MD
    - Results were close to EBL and oftentimes QBL was less than EBL.

Putting It All Together

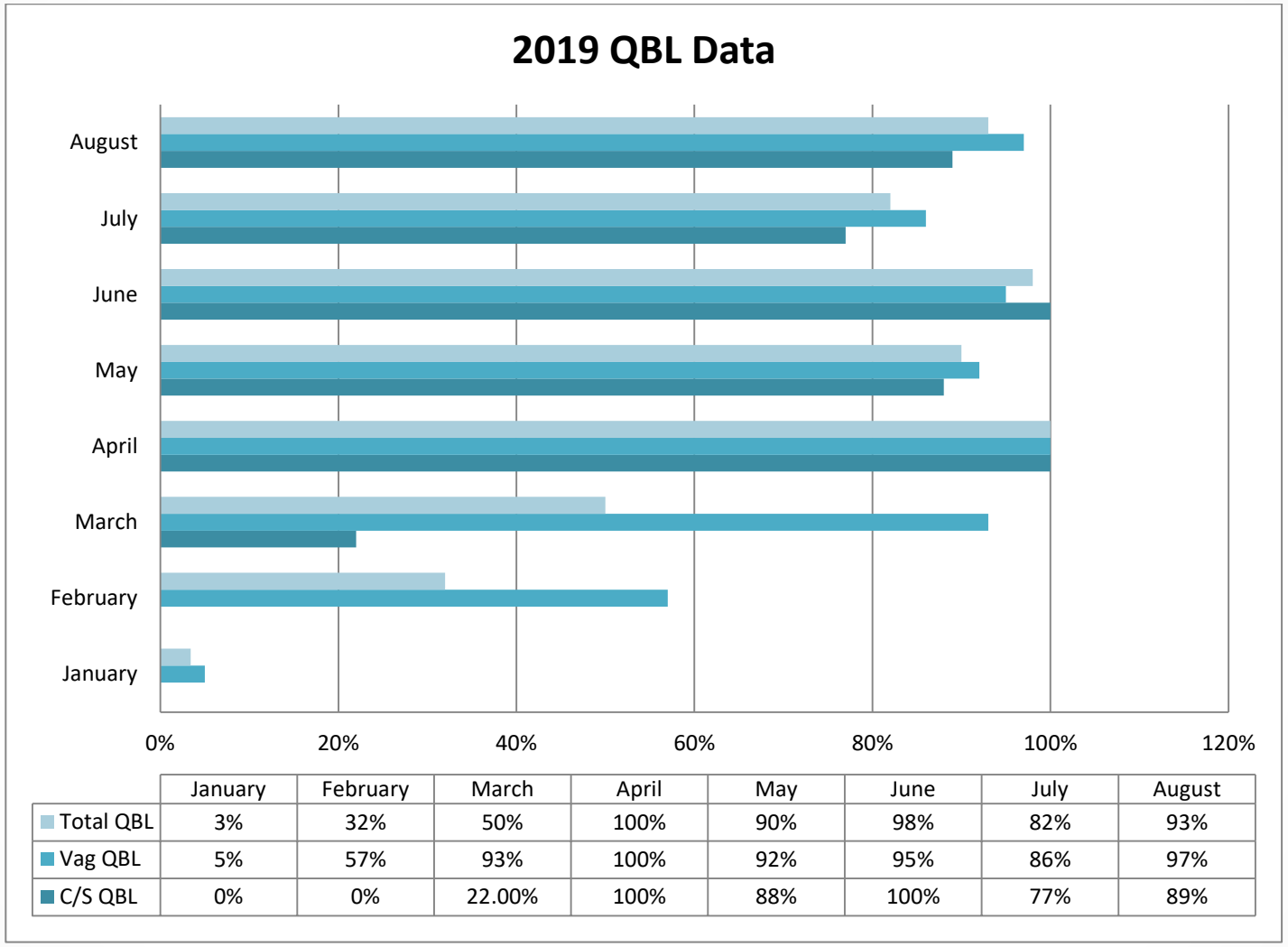
QBL for C-Sections officially began April 1, and we ended the

month with 100% QBL documentation.



Maintaining the Momentum

- We realize that we still have work to do. Our process isn't perfect, and we are always looking for ways to improve.
  - We have established a goal to keep QBL rates above 90%, knowing that it's not feasible to document 100% every month.
  - When QBL isn't documented for a patient, we investigate.
  - Audits are performed at least twice weekly, and staff are kept informed of QBL rates.
  - Continuing education for staff.
  - Monthly updates are sent to department heads for L&D and OR.



	January	February	March	April	May	June	July	August
Total QBL	3%	32%	50%	100%	90%	98%	82%	93%
Vag QBL	5%	57%	93%	100%	92%	95%	86%	97%
C/S QBL	0%	0%	22.00%	100%	88%	100%	77%	89%

*We are expected to maintain ≥90% total QBL.

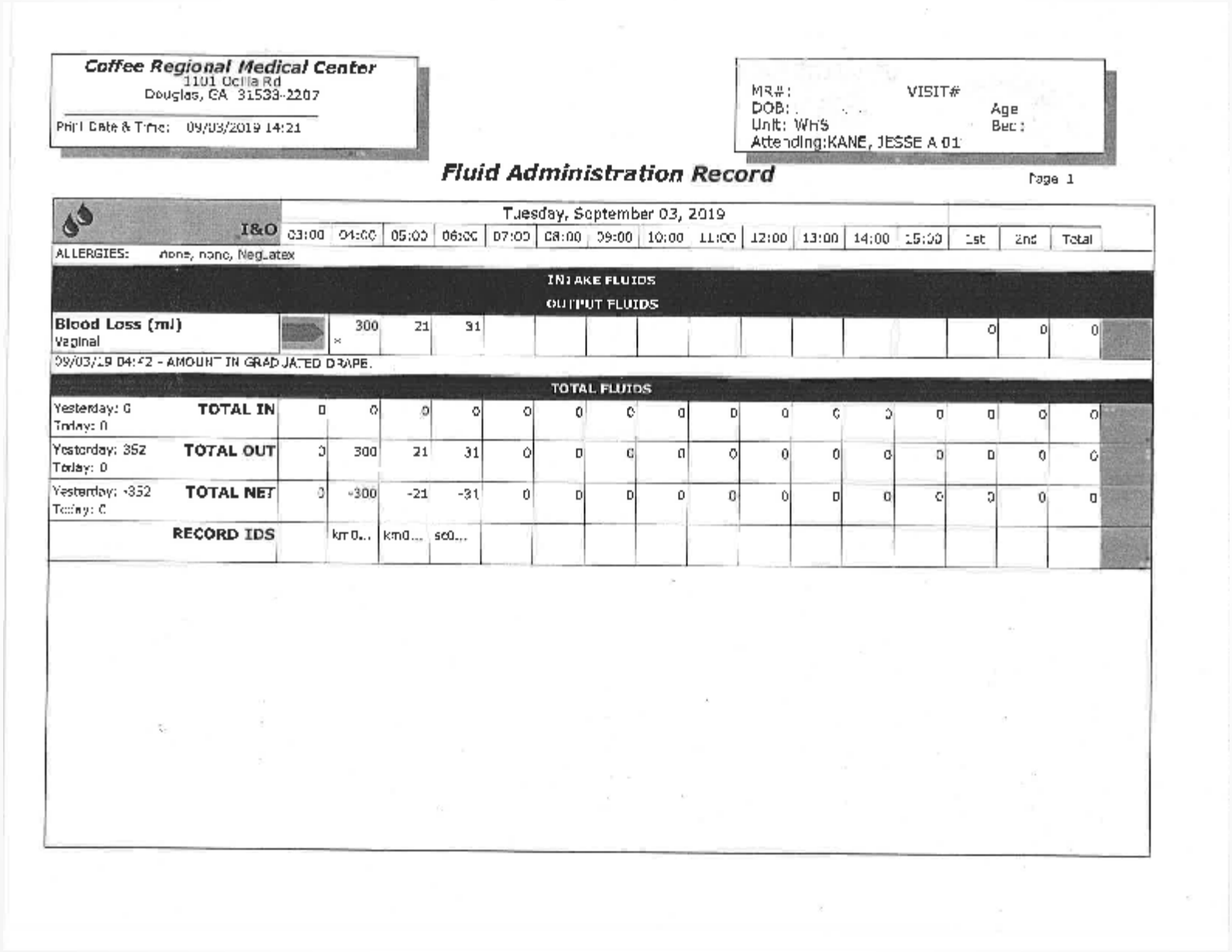
Audits

- All deliveries logged in delivery book.
- QBL folder kept in delivery book for I&O sheet to be placed.
- Look to see if every patient who delivers has a printed I&O sheet with documented QBL for three-hour recovery period.
- If a patient does not have an I&O sheet in the folder, I look in the chart to see if QBL was documented.
- Audit information is documented on the following form.

QBL Audit Form

#	Name	Date	VAG/CS	NURSE	MD	OR QBL	EBL	Total QBL
1	(patient label)							
2								
3								
4								
5								
6								
7								

I&O Form



Coffee Regional Medical Center
1101 Ocilla Rd
Douglas, GA 31533-2207

Print Date & Time: 09/03/2019 14:21

MR#: VISIT#
DOB: Age
Unit: WHS Bed:
Attending:KANE, JESSE A 01

Fluid Administration Record

Page 1

I&O	Tuesday, September 03, 2019															
	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	1st	2nd	Total
ALLERGIES: None, none, Neg_latex																
INTAKE FLUIDS																
OUTPUT FLUIDS																
Blood Loss (ml) Vaginal		300	21	31										0	0	0
09/03/19 04:42 - AMOUNT IN GRADUATED DRAPE.																
TOTAL FLUIDS																
Yesterday: 0 Today: 0 **TOTAL IN**	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Yesterday: 352 Today: 0 **TOTAL OUT**	0	300	21	31	0	0	0	0	0	0	0	0	0	0	0	0
Yesterday: -352 Today: 0 **TOTAL NET**	0	-300	-21	-31	0	0	0	0	0	0	0	0	0	0	0	0
RECORD IDS		krt0...	kmd...	sc0...												

QBL Job Aid

Calculating QBL for Vaginal Deliveries

- Post-partum QBL measurement begins after delivery of the infant and placenta. When the placenta delivers, note the amount of blood in V drape. This amount is counted as “delivery” bleeding and not included with post-partum QBL. **Any additional blood that collects in the V drape after delivery of the placenta should be documented under the “I&O” tab in Centricity.** This amount will be an estimate.
- Pads, chux, and other blood soaked items should be weighed during the three-hour recovery after delivery. Dry weights of items must be subtracted from total weight to obtain QBL. 1gm=1ml blood. Each time items are weighed, QBL should be documented in “I&O.” Centricity will automatically calculate total QBL if entries are made correctly.
- If total blood loss is less than 1000ml and pt is clinically stable, QBL may be discontinued after the three-hour recovery period.
- Print “I&O” form after QBL completion and place in folder in delivery book.

Dry Weights:

Peripad	10g
Chux	56g
4x4	2g
White paper sheet	12g
Vaginal packing	18g
Fitted sheet	674g
Flat sheet	492g
Red bag (small)	21g

Instructions for Calculating QBL for C-Sections

1. Estimate blood content of canister.
    - Mark the canister after infant has been delivered and most of the amniotic fluid has been suctioned. This amount should be considered mostly fluid and not counted as blood. Document on QBL form.
    - Mark canister again at the end of procedure prior to irrigation. Irrigation fluid should not be counted as blood. Document on QBL form.
    - Subtract the first marked amount from the second marked amount to obtain the canister blood estimate. Document on QBL form.

2. Weigh lap sponges.
    - Document counts for lap sponges, lap hangers, and red bags weighed so that accurate dry weight can be obtained. Document on QBL form.
    - Weigh red bag containing laps and lap hanger(s). Document the total weight in grams on QBL form.

The bottom half of QBL form will be completed by L&D staff.

COFFEE REGIONAL MEDICAL CENTER

NON-CHART

C-Section QBL

Completed by OR:

Canister after delivery: _____
Canister prior to irrigation: _____

***Total weight of materials**: _____
Lap count: _____
Lap hanger bags: _____
Red bags: _____

Completed by L&D:

Canister prior to irrigation: _____

Canister after delivery: **-** _____

***Canister blood:** _____

Lap count: _____ x 20 _____
Lap hanger: _____ x 22 **+** _____
Red bag: _____ x 21 **+** _____
***Total dry weight:** _____

Total weight of materials: _____

Total dry weight: : **-** _____

***Lap blood:** _____

Canister blood: _____
Lap blood: **+** _____

QBL: _____

Dry Weights Reference Card

Dry Weights	(g)
Peripad	10
Chux (L&D)	56
Chux (OR)	70
Lap sponge	20
Lap hanger	22
Small red bio bag	21
4x4	2
White paper sheet	12
Vaginal packing	18
Fitted sheet	678
Flat sheet	414
Blue OR towel	84
Pt gown (regular)	410
Pt gown (large)	544
Quilted dry pad	356

Strategies for Success

- Good communication
- Teamwork
- Don’t pretend to have all the answers. Ask for help.
- Staff incentives
- Accountability
- Focus on progress, not perfection.
- Help staff understand “why” we are doing this.

Thank You!!

- Contact me at:
  - Donna.Vickers@coffeeregional.org
  - (912) 384-1900 ext. 2392

Postpartum Hemorrhage

Northeast Georgia Medical Center

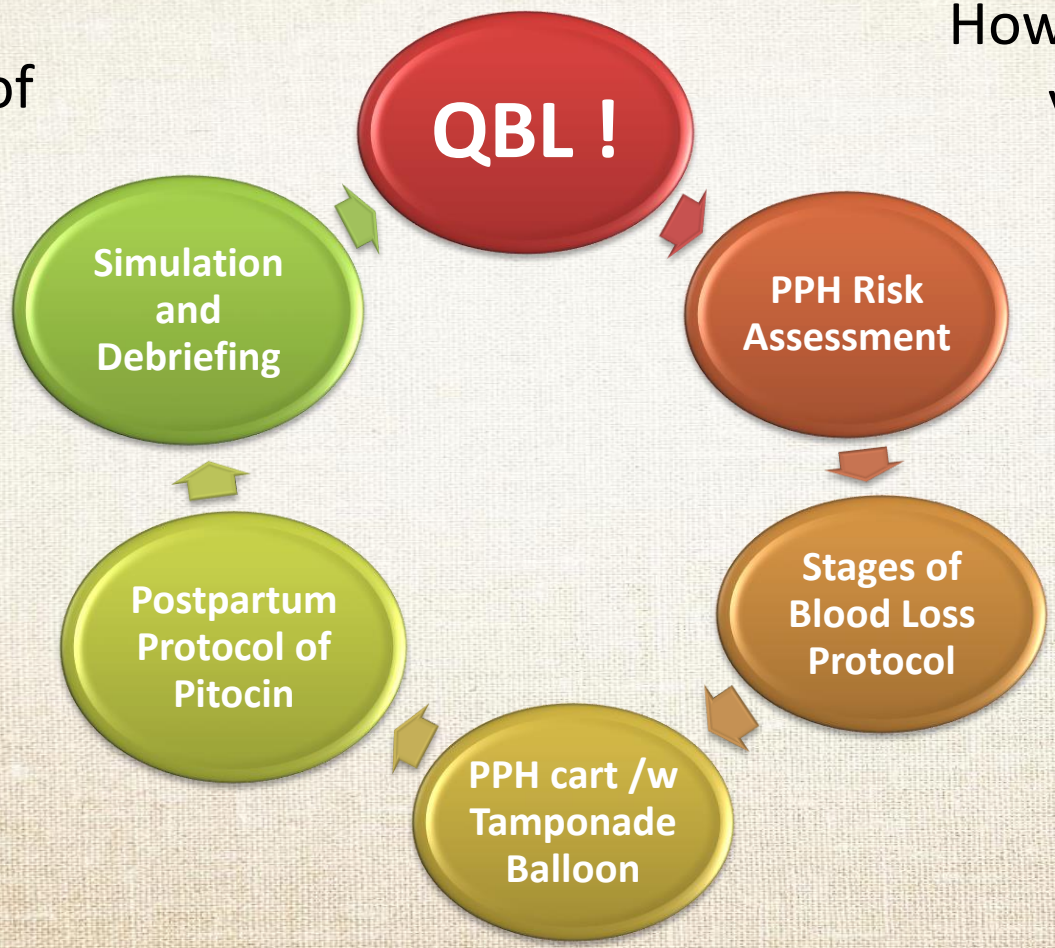
GaPQC- October 2018

Bridgette Schulman, MSNEd, RNC-OB, C-EFM, CPPS

Northeast Georgia Medical Center

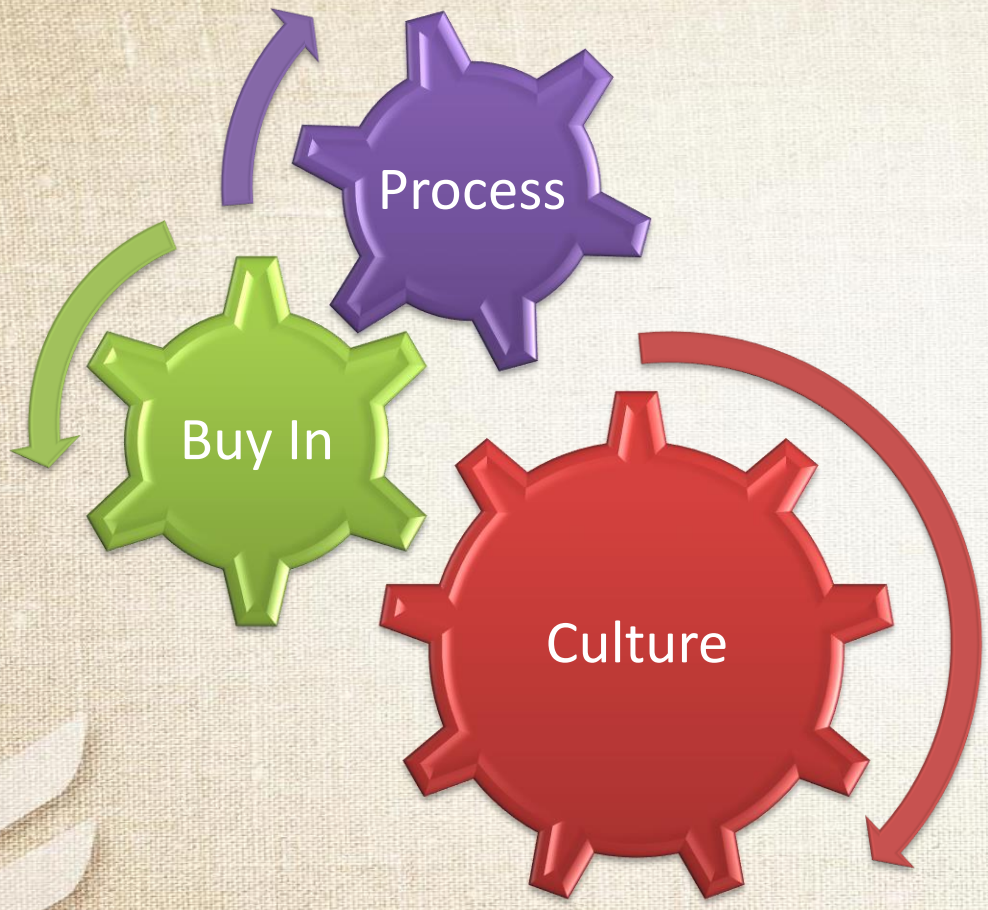
Improving Recognition, Readiness and Response

Who has implemented all of these?



How Many? What are your Barriers?

Getting Started



Process: There are many resources that can are available with step by step process to implement all stages of PPH Bundles

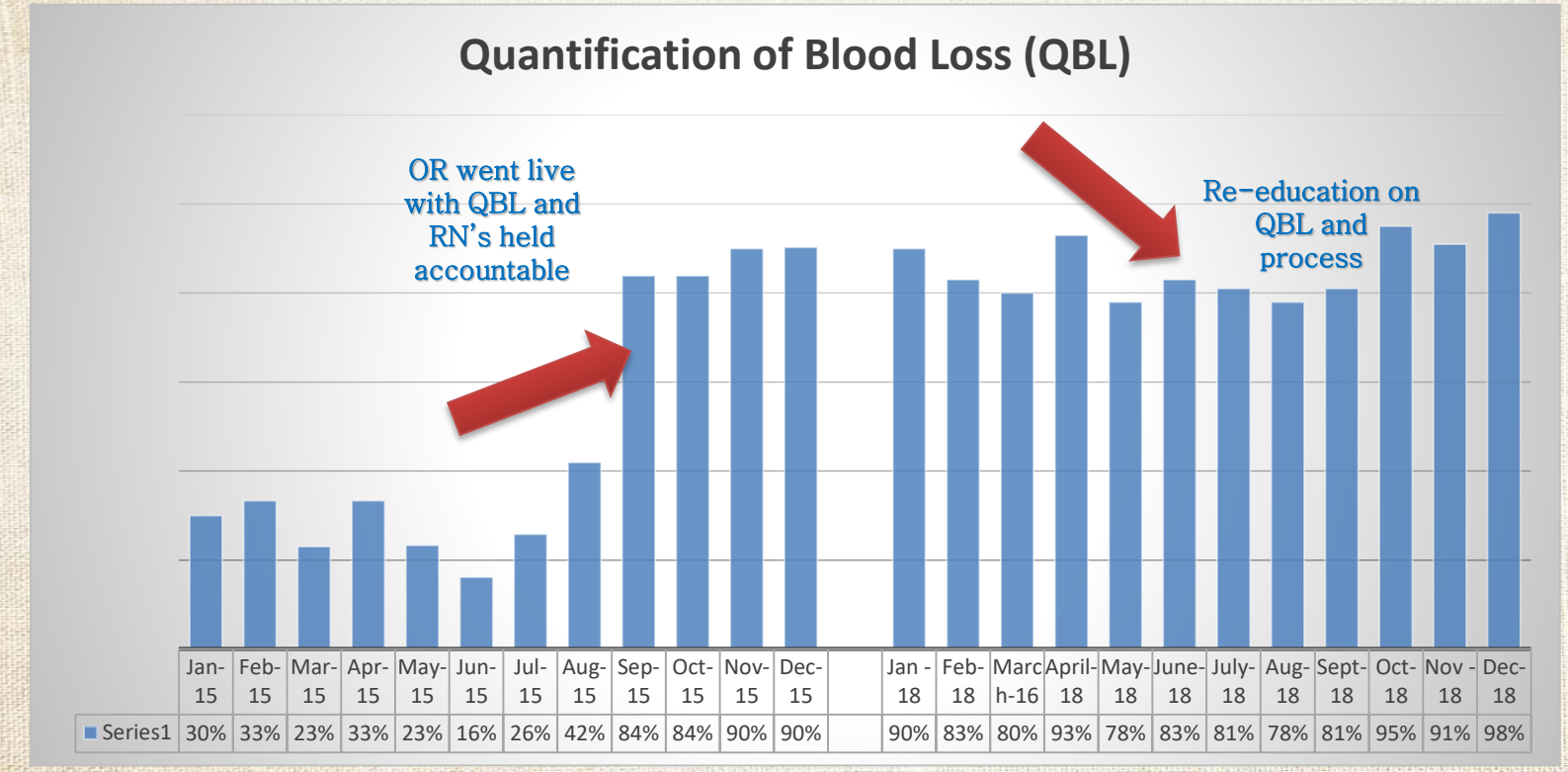
- AWHONN
- CMQCC
- AIM Bundles

Buy In: Directors, Managers, Educators, Physician Champion. CNM representative, Anesthesia, Blood Bank

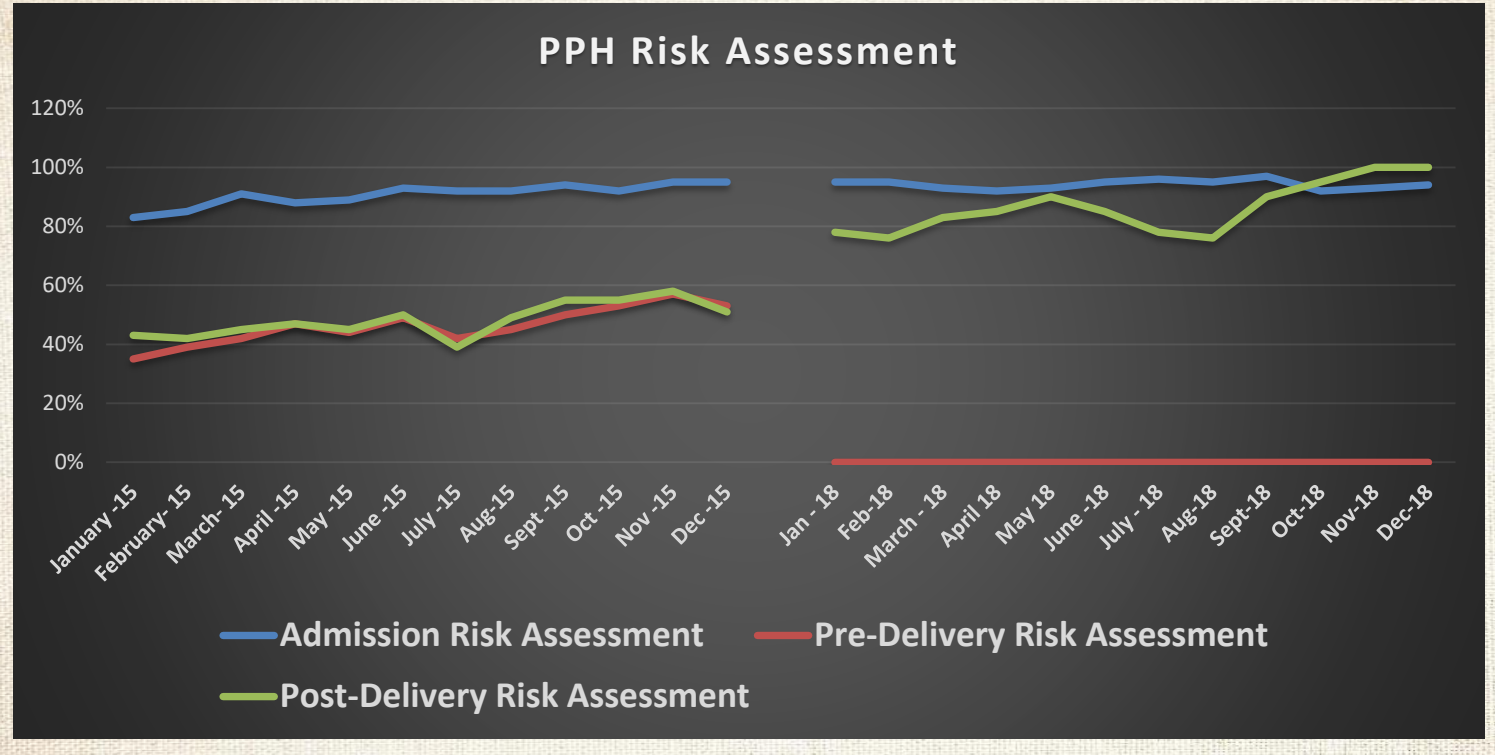
Culture: This one can be the hardest. Remember that providers and nurses have been doing things a certain way for a while and change is hard. Start with the why. Expect bumps in the road

- QBL challenges
- Under buttock drape
- Different process in OR*

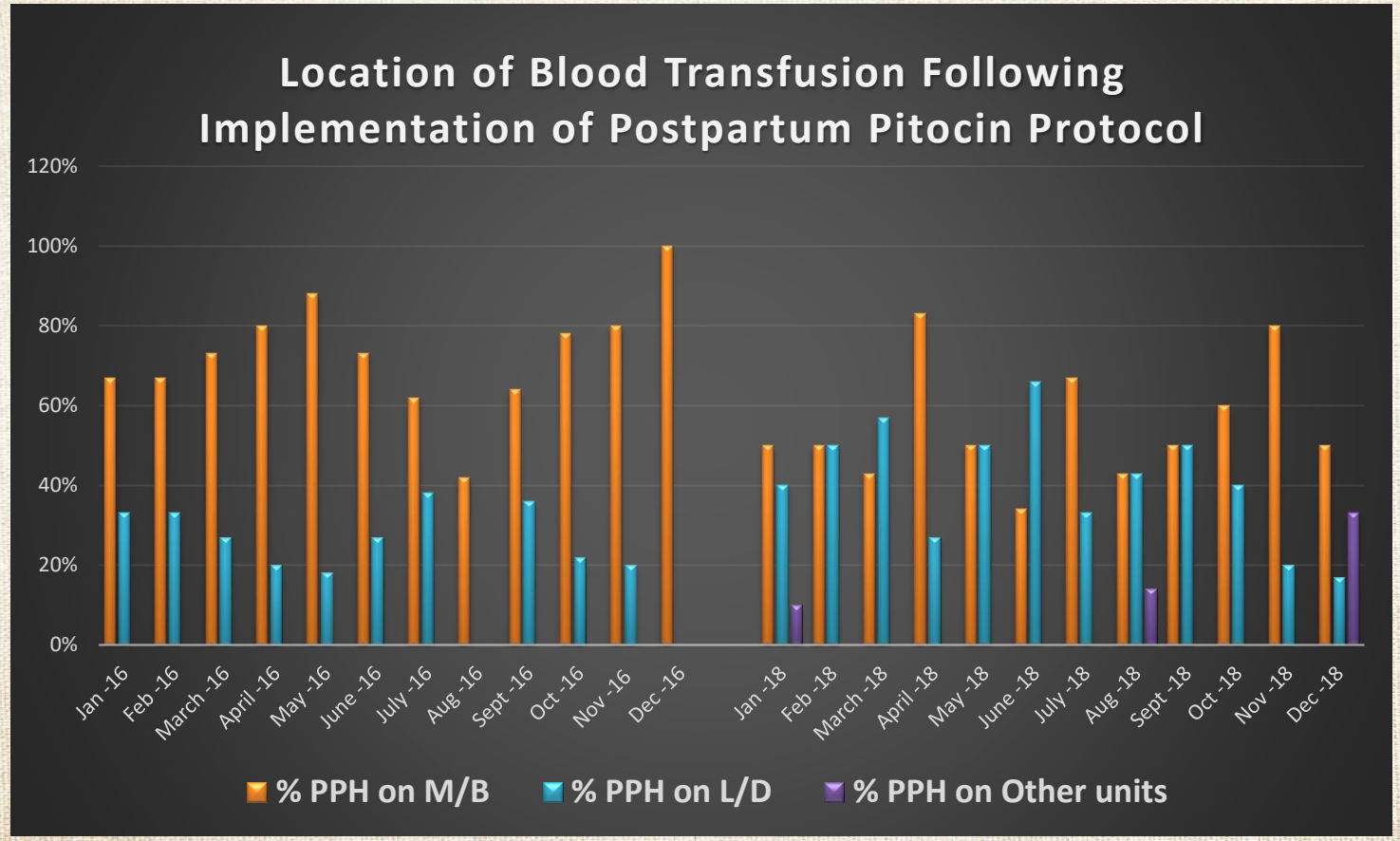
You Don’t Know What You Don’t Measure



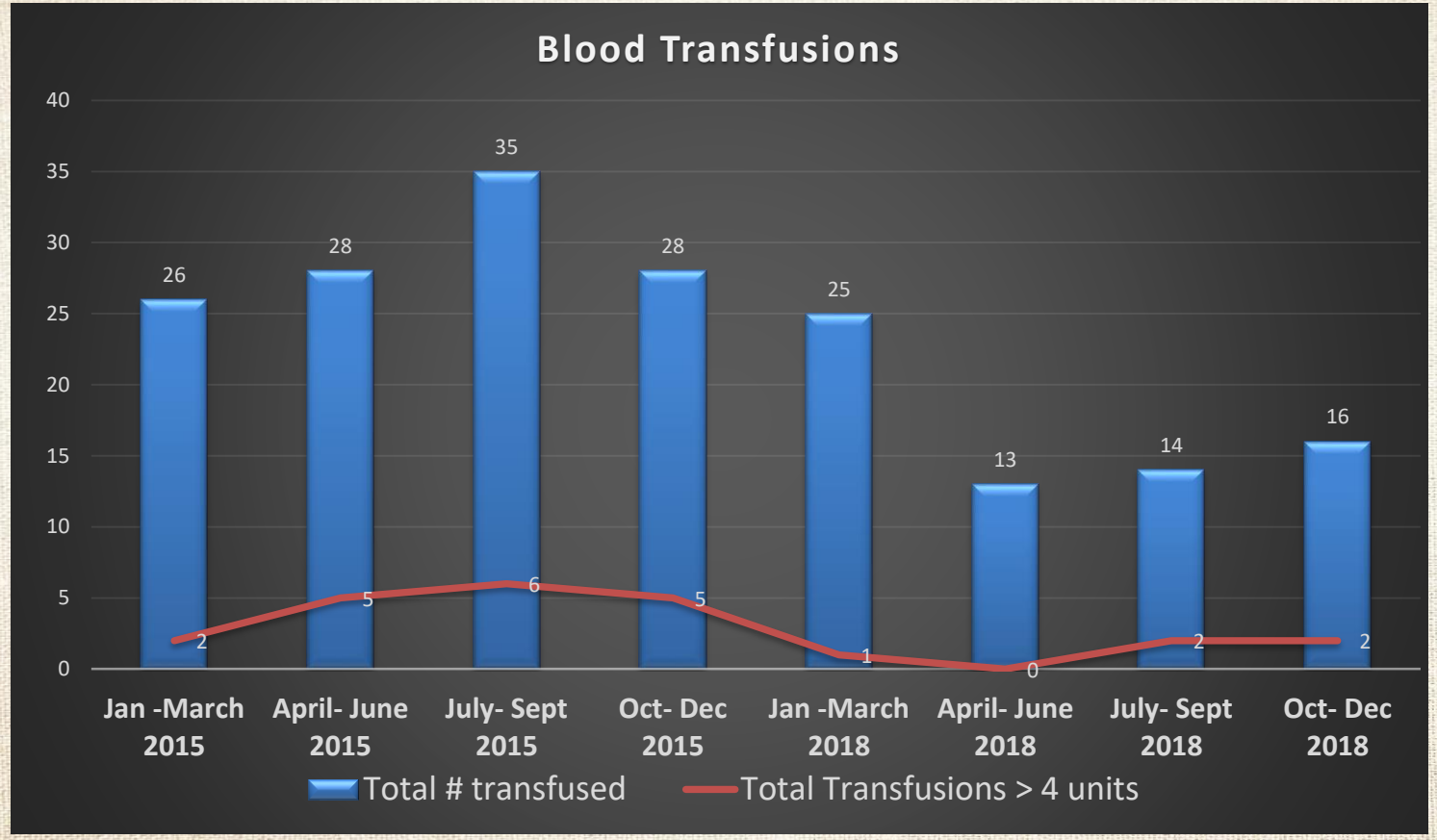
You Don’t Know What You Don’t Measure



You Don’t Know What You Don’t Measure



You Don’t Know What You Don’t Measure



Questions??

Northeast Georgia Medical Center

Hemorrhage Education Plan

- November 5, 2019: Implementing Debriefs
  - Dr. Bernstein, Montefiore Medical Center
  - Hospital Sharing: Emory Decatur
- December 3, 2019: Identification of Patient Risk and Team Communication
- January 7, 2020: Maternal Mortality Review

Report Changes

Process Measures (P)	Description	Reporting time period (QUARTERLY): April 1, 2019 - June 30, 2019		COMMENTS (NOT REQUIRED)
P1: Unit Drills	**Report # of Drills and the drill topics** **P1a:** In this quarter, how many OB drills (In Situ and/or Sim Lab) were performed on your unit for any maternal safety topic?	**P1a:**		
	P1b: In this quarter, what topics were covered in the OB drills? (**Note:** add more numbers for additional topics covered, as needed)	**P1b:**	**1.** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.**	
P2: Provider Education	**P2a**: At the end of this quarter, how many **OB physicians and midwives** (numerator) have completed (within the last 2 years) an education program on **Obstetric Hemorrhage**? How many OB physicians and midwives does your hospital have (denominator)?	**P2a:**	**Numerator**: **Denominator**:	
	P2b: At the end of this quarter, how many **OB physicians and midwives** (numerator) have completed (within the last 2 years) an education program on the **Obstetric Hemorrhage bundle elements and the unit-standard protocol**? How many OB physicans and midwives does your hospital have (denominator)?	**P2b:**	**Numerator**: **Denominator**:	
P3: Nursing Education	**P3a**: At the end of this quarter, how many **OB nurses** (numerator) have completed (within the last 2 years) an education program on **Obstetric Hemorrhage**? How many OB nurses does your hospital have (denominator)?	**P3a:**	**Numerator**: **Denominator**:	
	P3b: At the end of this quarter, how many **OB nurses** (numerator) have completed (within the last 2 years) an education program on the **Obstetric Hemorrhage bundle elements and the unit-standard protocol**? How many OB nurses does your hospital have (denominator)?	**P3b:**	**Numerator**: **Denominator**:	
P4: Risk Assessment	**P4:** At the end of this quarter, how many mothers (numerator) had a hemorrhage risk assessment with risk level assigned, performed at least once between admission and birth and shared among the team? How many mothers did you have this quarter (denominator)?	**P4:**	**Numerator**: **Denominator**:	
P5: Quantified Blood Loss	**P5**: In this quarter, how many mothers (numerator) had measurement of blood loss from birth through the recovery period using quantitative and cumulative techniques? How many mothers did you have this quarter (denominator)?	**P5:**	**Numerator**: **Denominator**:	
P6: Implicit Bias Training	**P6: In this quarter, how many OB providers, nurses and unit staff (numerator) have completed (within the last 2 years) an education program on Implicit Bias? How many OB nurses does your hospital have (denominator)?**	**P6:**	**Numerator:** **Denominator:**	

GaPQC

GEORGIA PERINATAL QUALITY COLLABORATIVE

Questions?