OK - RJB

WHITE PLAINS HOSPITAL
PERINATAL CONFERENCE
JANUARY 27, 2014

IN ATTENDANCE:

MEDICAL STAFF:

Jay Lupin, MD
Maria Abbattista, MD
Jackie Bavaro, MD
Ginger Daly, MD
Bonnie Eilen, MD
Jane Goldman, MD
Chaudhry Hameed, MD
Nabil Khoury, MD
Rebecca Kleban, MD
Lewis Lo, MD
James Pate, MD
Mia Wright, MD
Kevin Meacham, MD

Cathy Keith, CNM
Ingrid Deler-Garcia, CNN
Lucy Milne, CNN

NURSING:

Paul Quinn, RN
Debra Sperling, RN
Jo-Ann Murphy, RN
Jane Ciaramella, RN
Nancy Longworth, RN
Romina Elias, RN
Patty DeSantis, RNC
Karen Silverman, RNC

Invited Guests: Jennifer Heinemann (Director, Account Management, MD CHAT)
Marcia Blieden

The meeting was called to order by Dr. Lupin.

The statistics for the month December, 2013, were presented (See enclosure). There was a total of 141 deliveries, with 6 sets of twins, giving a total number of births of 147. This represents a 13% increase, when compared to December, 2012. There were no stillbirths. There were 147 antepartal visits.

The total number of C-sections was 72, with 42 being primary, and 30 being repeat. The total C-section rate was 51%--up from 46% in December, 2012.
There was a total of 19 NICU admissions, with 1 transfer from well baby nursery. There was 1 transfer to CHONY. There were no Apgar scores under 6 at five minutes.

The meeting was called to order by Dr. Lupin.

The statistics for the 2013, were then presented (See enclosure). There was a total of 1794 deliveries, with 37 sets of twins, giving a total number of births of 1831. This represents a 1.6% increase, when compared to 2012. There were 6 stillbirths. There were 1918 antepartal visits.

The total number of C-sections was 759 with 430 being primary, and 329 being repeat. The total C-section rate was 42.3%--down from 43% in 2012. The primary C/section rate was 23.9% (where the denominator is the sum of all cesareans--primary and repeat--and all vaginal births) and 29.4% (where the denominator is the sum of primary cesareans and vaginal births without previous cesarean).

Marcia Blieden, from IT, was introduced and she discussed upcoming changes and requirements in Meditech, including the need to place past medical and surgical diagnoses. Additionally, she presented an overview of the upcoming Patient Portal.

Jennifer Heineman was introduced. She is the Director of Account Management for MD CHAT. Ms. Heineman discussed MD CHAT, and indicated the importance for use of a secure, HIPPA compliant site for communication between providers, including nursing. Transmission of patient information, including simply their names, represents a HIPPA violation. Ms. Heineman indicated that she was available to register all members of the Department in MD CHAT, and to provide assistance in terms of implementing the process and accessing MD CHAT.

Dr. Lupin then welcomed, and congratulated, Ms Romina Elias as the new Assistant Nurse Manager on the PostPartum Unit. Ms. Elias was well known to the Department both for her prior work on the unit, and the support she provided while working for IT and implementing components of Meditech.

Dr. Lupin discussed the issue of the Primary Cesarean Delivery rate, and the nationwide proposal to decrease the rate. The quoted national rate for primary C/Sections for 2012 was 21.%; the total C/section rate (primary plus repeat) was 32.8%. These numbers may not truly represent the rate because there is a degree of difference in terms of what is included in the numbers--specifically multiples may be excluded in some determinations, while excluded in others. The issue in terms of C/sections is that they are surgical procedures that have both long and short term risks and consequences, including surgical complications; higher costs; and possibly greater numbers of NICU admissions. Guidelines are being developed to decrease monmedically indicated c/sections and elective inductions prior to 39 weeks, as wella s to decrease the primary C/section rate. The department is interested in creating a program to decrease the current C/section rate and this will be presented as the Departmental initiative for 2014.

JCOH has introduced a PERINATAL CARE Measure (see enclosure) which has the intent of decreasing the rate of C/sections in "Nulliparous women with a term, singleton baby in a vertex position." The concept is that there is no outcome benefit for those babies or mothers delivered

in institutions with high rates as compared to those with rates of 15-20%. As with other core measures, this data will be obtained and reviewed. Currently there is no stated desired C/ section rate. JCOH may in the future use the collected data to compare various facilities, and may make lower rates a component of higher reimbursements.

Dr Lupin then discussed the ACOG District 2 developed SAFE MOTHERHOOD INITIATIVE. The point of the program is to promote obstetrical safety and quality by developing evidence based safety bundles for obstetric hemorrhage, severe hypertension in pregnancy and venous thrombo-embolism prevention in pregnancy. These bundles are currently in the development stages, and when the program is available, they will be rolled out to the Department with the intent of universal utilization and reporting. ACOG will provide on site education and assistance in terms of monitoring.

The NY State Department of Health has apparently recommended that all patients have HIV testing done twice during one's pregnancy. These results should be included in the paperwork sent with the prenatal records on each patient. The second testing can be done at 36 weeks--generally at the time that the GBS culture is being done.

Dr. Lupin presented the ongoing Hospital Affiliation status. Discussions and meetings with 5 institutions have taken place--these include NYU; Montefiore; Mt Sinai; Yale; and North Shore. A general discussion was provided on the rationale for an affiliation with a larger institution. All questions were addressed. Members of the Department were further referred to Dr. Palombo, or Susan Fox.

CASE PRESENTATION:

MR# 957901 MD#848

The patient is a 41 y/o P1011 admitted at 39 weeks and 2 days for an elective repeat C/section. The surgery was done under a spinal anesthetic. After delivery of the baby, the placenta was manually removed without difficulty. The uterus was found to be boggy and atonic. A defect in the upper left cornual region was appreciated. Despite various maneuvers, including Pitocin, massage, hemabate and Cytotec, the uterus remained atonic. The decision was made to perform a supracervical hysterectomy, which was readily accomplished. The surgery was well tolerated, and the patient had an unremarkable post operative course. The etiology of the postpartum hemorrrhage was felt to be an atonic uterus.

MR#837653 MD#2041

The patient is a 34 P20103 admitted at 40 weeks and 1 day with SROM and in labor. The patient had previously undergone a C/section for a twin gestation, and she was interested in undergoing a VBAC. She progressed appropriately in labor and gave birth to a normal infant without difficulties. A retained placenta was appreciated and the patient was taken to the OR for a manual removal of the placenta. Despite an attempt, followed by a sharp curettage with a horseshoe curette, and then placement of the Balkri Balloon, the patient continued to bleed. The patient then underwent a supracervical hysterectomy. She was transfused 7 units of packed RBCs and 2 units of FFP. The procedure was well tolerated and the patient subsequently went home in stable condition. The pathology report revealed a placenta accreta.

Both cases were presented to discuss the performance of hysterectomies in situations where acute postpartum hemorrhage occurred. Medical management and surgical management of acute hemorrhage was discussed. Both cases were found to have been managed appropriately.

MR#773956 MD#2184

The patient is a 36 y/o P3003 admitted at 39+ weeks with an elevation in her blood pressure for an induction of labor. Her three prior pregnancies were complicated by PIH. She was admitted for cervical ripening with Cervidil, followed by Artificial Rupture of Membranes and initiation of

Pitocin. The patient received an epidural, and subsequently developed recurrent FHR decelerations. She subsequently underwent a Primary C/section for a nonreassuring FHR pattern and failure to progress, after a total of about 8 hours of labor from the time of AROM. An infant male, weighing 8#1 ounce, with Apgars of 9/9 was delivered--a nuchal cord x 1 was present. The surgery was unremarkable.

The case was presented to discuss the use of Pitocin for induction and augmentation, and to review the current Departmental protocol. The issue of Tachysystole was addressed, and the nursing response was noted in terms of stopping the Pitocin if the pattern were to be appreciated--with or without fetal heart rate abnormalities. The management of this patient was found to be acceptable.

There being no further business, the meeting was adjourned.

Respectfully submitted,

Jay Stephen Lupin, MD
Director, Department of OB/GYN

PERINATAL CONFERENCE ATTENDANCE

DATE: 1/22/14

ATTENDEES: **SIGNATURE**

OB/GYN:

Maria Abbatista,MD
Diane Ainsworth, MD
Jackie Bavaro, MD
Jane Goldman, MD
Ginger Daly, MD
Ingrid Deler-Garcia, CNM
V. D'Amico, MD
Bonnie Eilen, MD
Chaudhry Hameed,MD
Judith Hirsch, NP
Helen Jhang, MD
Cathy Keith, CNM
Nabil Khoury, MD
Rebecca Kleban, MD
Dan Kushner, MD
Keith Lescale, MD
Lewis Lo, MD
Jay Lupin, MD
Kevin Meacham, MD
Jennifer Meyer, MD
James Pate, MD
Lucy Milne, CNM
Stella Onuorua,MD
Pedro Rojas,MD
Christine Vyskocil, MD
Randee Wysoki, MD
Brian Wagner, MD
Mia Wright, MD
Mitra Zameni, MD

NEONATOLGY:

Jesus Jaile, MD
Zaid Awari, MD
Kevin Fletcher, MD
Reeja Vembenil, MD

NURSES:

Paul Quinn
Bonnie Thompson

Debra Sperling
Jane Ciaramella
Nancy Longworth
Stacy Murphy
Cindy Devore
Kristy Helen Napolitano
Maureen Castner
Annette O'Brien
Lisa Burke

ADDITIONAL ATTENDEES:

Romina Elias RE
Karen Silverman RNC
Patty DeSantis RNC IAD
Jo-Anne Murphy RNC

LABOR AND DELIVERY STATISTICS

Month December Year 2013

Year to Date

	2012	2013	Variance
Total Deliveries	1766	1794	+1.6%
Twins / Triplets	45/3	37/0	
Total Births	1816	1831	
Stillborns	6	6	
Antepartal Visits	1922	1918	-.2%
Total Visits	3688	3712	
Total C-Sections	751	759	
Primary C-Sections	437	430	
Repeat C-Sections	314	329	
Total C-Section Rate	43%	42.3%	

LABOR AND DELIVERY STATISTICS

December Month /Year 2013

	2012	2013	Variance
Total Deliveries	125	141	+13%
Twins / Triplets	3/0	6/0	
Total Births	128	147	
Stillborns	1	0	
Antepartal Visits	127	147	+16%
Total Visits	252	288	
Total C-Sections	57	72	
Primary C-Sections	31	42	
Repeat C-Sections	26	30	
Total C-Section Rate	46%	51%	

Apgars < 6 @ 5 minutes: 0
Infant receiving NICU care in house: 19
Transfers in from WBN: 1
Transfer to CHONY: 1

Specifications Manual for Joint Commission National Quality Measures (v2014A)

Release Notes:
Measure Information Form
Version 2014A

****NQF-ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE****

Measure Information Form

Measure Set: Perinatal Care(PC)

Set Measure ID: PC-02

Performance Measure Name: Cesarean Section

Description: Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section

Rationale: The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean section (CS) rates. Some hospitals now have CS rates over 50%. Hospitals with CS rates at 15-20% have infant outcomes that are just as good and better maternal outcomes (Gould et al., 2004). There are no data that higher rates improve any outcomes, yet the CS rates continue to rise. This measure seeks to focus attention on the most variable portion of the CS epidemic, the term labor CS in nulliparous women. This population segment accounts for the large majority of the variable portion of the CS rate, and is the area most affected by subjectivity.

As compared to other CS measures, what is different about NTSV CS rate (Low-risk Primary CS in first births) is that there are clear cut quality improvement activities that can be done to address the differences. Main et al. (2006) found that over 60% of the variation among hospitals can be attributed to first birth labor induction rates and first birth early labor admission rates. The results showed if labor was forced when the cervix was not ready the outcomes were poorer. Alfirevic et al. (2004) also showed that labor and delivery guidelines can make a difference in labor outcomes. Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al., 1989; Goyert et al., 1989; Luthy et al., 2003). The dramatic variation in NTSV rates seen in all populations studied is striking according to Menacker (2006). Hospitals within a state (Coonrod et al., 2008; California Office of Statewide Hospital Planning and Development [OSHPD], 2007) and physicians within a hospital (Main, 1999) have rates with a 3-5 fold variation.

Type of Measure: Outcome

Improvement Noted As: Decrease in the rate

Numerator Statement: Patients with cesarean sections

Included Populations: *ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes* for cesarean section as defined in Appendix A, Table 11.06

Excluded Populations: None

Data Elements:

- *ICD-9-CM Other Procedure Codes*
- *ICD-9-CM Principal Procedure Code*

Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation

Included Populations:

- *ICD-9-CM Principal or Other Diagnosis Codes* for pregnancy as defined in Appendix A, Tables 11.01, 11.02, 11.03 or 11.04
- Nulliparous patients with *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08 and with a delivery of a newborn with 37 weeks or more of gestation completed

Excluded Populations: *ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes*, for contraindications to vaginal delivery as defined in Appendix A, Table 11.09

- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay >120 days
- Enrolled in clinical trials
- *Gestational Age* < 37 weeks

Data Elements:

- *Admission Date*
- *Birthdate*
- *Clinical Trial*
- *Discharge Date*
- *Gestational Age*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Other Procedure Codes*
- *ICD-9-CM Principal Diagnosis Code*
- *ICD-9-CM Principal Procedure Code*
- *Parity*

Risk Adjustment: Yes. Applied through direct standardization. This section has been moved to the ORYX Risk Adjustment Guide. This guide is available to the public on the Joint Commission's website and, in addition, it is available to performance measurement systems via the Joint Commission's extranet site for measurement systems (PET)

Data Elements

- *Birthdate*

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: In order to identify areas for improvement, hospitals may want to review results based on specific ICD-9 codes or patient populations. Data could then be analyzed further determine specific patterns or trends to help reduce cesarean sections.

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

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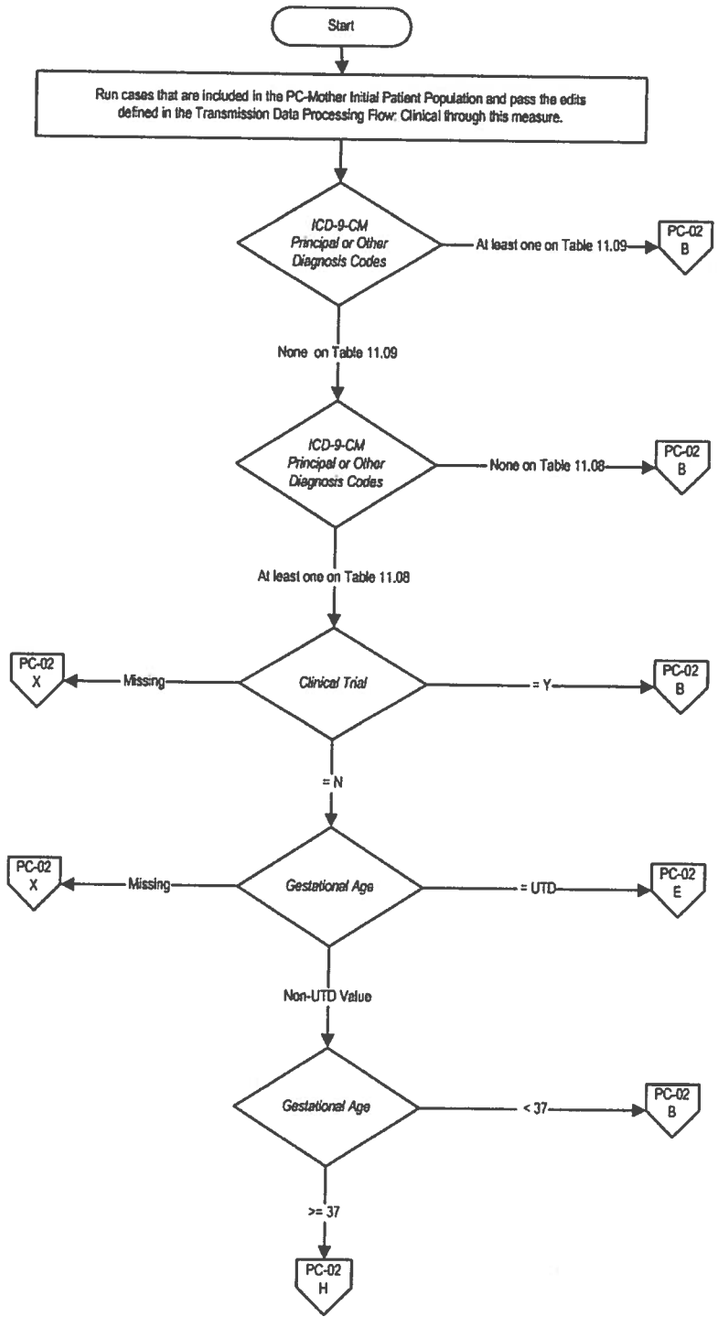
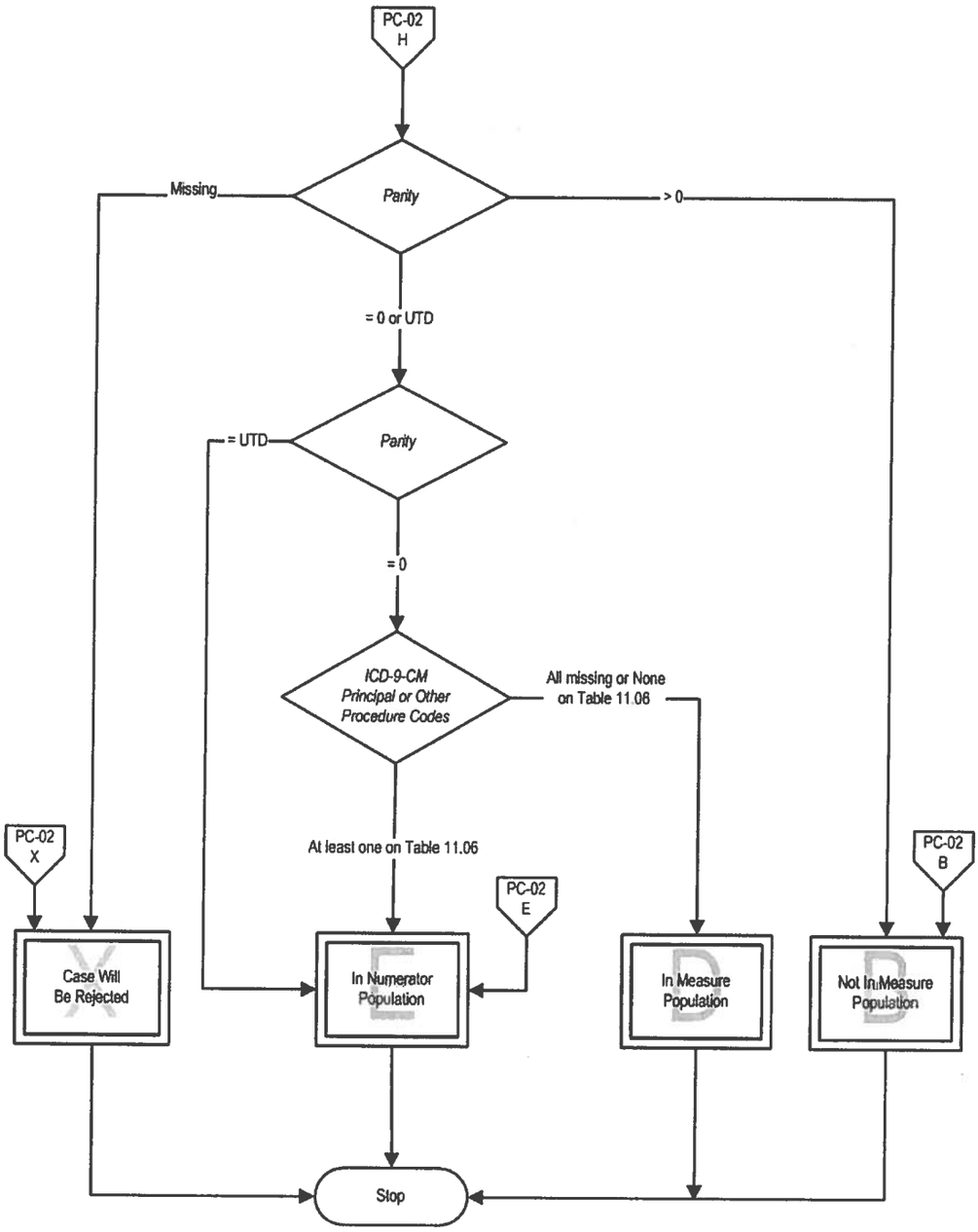
Original Performance Measure Source / Developer:
California Maternal Quality Care Collaborative

PC-02: Cesarean Section

Numerator: Patients with cesarean sections

Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation




PC-02
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WHITE PLAINS HOSPITAL CENTER
DIVISION OF NURSING

DIVISIONAL PROTOCOL: Labor and Delivery

TITLE: Management of Oxytocin Induction and Augmentation

PURPOSE: To insure maternal and fetal well-being throughout the induction or augmentation of labor
LEVEL: Interdependent

SUPPORTIVE DATA:

1. Oxytocin is a nonapeptide found in the pituitary extracts of mammals. It is the most common drug applied in obstetrics. The degree of uterine muscle sensitivity to oxytocin is dependent in part on the number of myometrial oxytocin receptors.
2. Oxytocin induction and augmentation of labor is utilized in the majority of laboring women .(1)
3. Oxytocin is on the Institute for Safe Medication Practices list of high alert Medications. (3)
4. Patient Safety is demonstrated to be improved when standardized protocols and checklists are developed and employed in high risk situations. (1)
5. WPH standard titled Scheduling Induction of Labor will be adhered to.

CONTENT:

PATIENT ASSESSMENT:

The Physician responsibilities:

1. Documentation of the patient's History and Physical.
2. Ensuring delivery of the patient's Prenatal Record to L&D.
3. Initial assessment of the patient as a candidate for an induction or augmentation of labor.
4. Estimated fetal weight.
5. The physician will order oxytocin in the electronic medical record (EMR) for either an induction or augmentation.
6. The Physician/CNM will be in attendance for the initiation of the oxytocin induction / augmentation. Once the patient and her fetus are evaluated to be stable the Physician/ CNM may leave the hospital but must be available by phone, and able to return to L&D within 10 minutes of being called for management of any complications.
7. The physician / CNM will attend for a bedside evaluation and documentation of plan of care if the oxytocin dosage reaches 20 milliunits per minute or at the request of the labor RN.

The RN will be responsible for:

1. Continual and ongoing assessment of maternal and fetal wellbeing throughout the course of induction / augmentation of labor, documenting assessments and communicating those assessments to the physician as appropriate.
2. A systematic assessment of the FHR and documentation of such will occur every 15 minutes. Each FHR assessment will include baseline FHR, variability, periodic and episodic changes if any, uterine activity and changes or trends over time.
3. Monitoring of maternal vital signs.
4. Assessment of need for intrauterine resuscitation of the fetus whenever interpretation of tracing warrants intervention. Intrauterine resuscitation may include:
    - Maternal position change
    - Discontinuation or a decrease in the dosage of pitocin
    - Oxygen by tight face mask at 10 liters
    - IV fluid bolus
    - Amnioinfusion (see Lippincott for procedure)

7. Assessment for uterine rupture. Signs and symptoms include the following:
    - Tachysystole
    - Tenderness
    - Sudden cessation of contractions
    - Vaginal bleeding
    - Non reassuring FHR tracing
    - Maternal hypotension or tachycardia

8. Assessment for water intoxication. Signs and symptoms include:
    - Headache
    - Nausea, vomiting
    - Confusion
    - Decreased urine output
    - Hypotension
    - Tachycardia
    - Convulsions
    - Loss of consciousness

9. Documentation of all assessments and communication of such to the physician.

INTERVENTION:

1. Patient will be admitted to Labor and Delivery (see L&D policy on admission to L&D).
2. Place Patient on the External Fetal Monitor (EFM) to evaluate for fetal wellbeing.

3. Explain the procedure to the patient and her significant other and address all questions.
4. An IV will be established with an 18 gauge angiocatheter (20 is acceptable but 18 preferred). Lactated ringers (LR) will be utilized for the main IV line.
5. Access oxytocin premixed bag (20 units of oxytocin in 1000 ml. LR) from the pyxis after the physician places the order in meditech.
6. Place oxytocin infusion on an infusion pump. Piggyback into the main line at the port closest to the IV insertion site. Document administration through bedside medication verification (BMV) in Meditech as per WPH policy
7. Start oxytocin induction at 2 mu / minute. When using 20 units of oxytocin in 1000 ml the dilution rate is 1mu. = 3 ml.
8. Oxytocin can be increased by 2 mu. every 30 minutes provided interpretation of FHR tracing demonstrated fetal tolerance and maternal assessments are within normal limits.
9. Maternal BP and pulse will be evaluated when either a dose change occurs or when clinically necessary. Blood pressure and pulse should be assessed at a minimum of hourly.
10. Increase the oxytocin dosage until adequate uterine activity is achieved as evidenced by:
    a. Uterine contractions every 2-3 minutes
    b. contraction duration of 40-60 seconds
    c. Palpation of contraction reveals moderate-strong intensity
    d. Montevideo units (MVU) of 150-250 MVUs and a resting tone less than 25 mmHG when using an intrauterine pressure catheter (5)
11. Notify the MD immediately and decrease or stop the oxytocin infusion for any of the following:
    a. tachysystole:
        - more than 5 contractions in a 10 minute period averaged over a 30 minute window
        - contraction frequency closer than every 2 minutes
        - contraction durations that exceed 90 seconds
        - insufficient return of uterine resting tone between contractions via palpation
        - Intrauterine resting tone above 25 mmHg when an IUPC is in place.
    b. Abnormal fetal response (category III tracings)
12. Notify the MD and discuss need for decrease or discontinuation of oxytocin when an indeterminate EFM tracing (Category II) is present.

CORRECTIVE / SAFETY:

1. **IF** the FHR tracing does not meet criteria for a reactive or normal FHR response prior to the induction or augmentation **then** the physician/midwife needs to be informed so that a plan of care can be established after his/her evaluation.
2. **IF** the RN assesses the maternal or fetal response to the oxytocin infusion to be abnormal **then** it is within the RN's clinical responsibility to discontinue or to titrate the infusion, initiate intrauterine resuscitation, followed by MD notification.
3. **IF** tachysystole is assessed, **then** the RN will titrate the oxytocin infusion by the following:

   - **IF** the FHR tracing is ***normal*** during tachysystole
     - Decrease oxytocin by one half the current dosage
   - **IF** the FHR tracing is indeterminate or abnormal during tachysystole
     - Discontinue oxytocin
     - Initiate intrauterine resuscitation measures
     - Notify the physician
     - Terbutaline may be ordered by physician.

5. **IF** the oxytocin infusion has been discontinued for 30 minutes or less, the fetal heart rate (FHR) is normal and uterine activity has returned to normal, **then** oxytocin may be restarted at no more than one half of the rate that resulted in the abnormal FHR or tachysystole. (4)
6. **IF** the oxytocin infusion has been discontinued for more than 30minutes and the FHR is normal and uterine activity has returned to normal **then** oxytocin may be restarted at 2 mu/min. (4)
7. **IF** the oxytocin infusion reaches 20 milliunits per minute **then** the nurse is to request that the physician attend for a bedside evaluation. The physician will document a plan of care. Oxytocin will not be increased beyond 20 milliunits per minute until a bedside evaluation has taken place and plan of care communicated and documented by the MD.
8. **If** the patient is receiving a regional anesthetic **then** the oxytocin infusion will be suspended until the procedure is complete and the fetal heart rate tracing post- procedure is deemed stable. The oxytocin infusion may be restarted once the FHR is stable.

EDUCATION:

1. All nursing staff and physicians will be educated regarding this standard.
2. All RNs will be deemed competent in electronic fetal monitoring interpretation as evidenced by receiving a passing score or completing the annual competency.

DOCUMENTATION:

1. The RN will document intrapartum care directly on the GE QS system.

2. The oxytocin infusion will be documented in the EMR through bedside medication verification in Meditech at the initiation of an oxytocin infusion and then in G.E. for successive dosage changes.
3. A systematic assessment of the FHR tracing and documentation of such will occur every 15 minutes. Each FHR tracing assessment will include baseline FHR, variability, periodic and episodic changes if any, contraction pattern, interval, duration and intensity and changes or trends over time.

INFECTION CONTROL:
Standard Precautions will be followed.
Maternal temperature will be assessed every 2 hours once membranes are ruptured or more frequently depending on clinical situation.

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