Reducing Liability in Preterm Labor Patient

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Hot Topics

- Standardization
- Scope of Practice
- AWHONN MFTI
- PLAT
- Competency and skill set

Standardization

- Timely and appropriate interventions
- Optimal maternal-fetal safety
- Hospitalization of only those patients at greatest risk for preterm delivery

Standardization

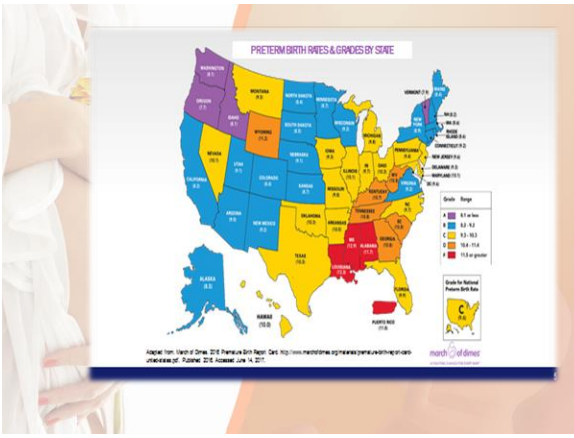
- Effective transport of preterm labor patients to higher, more appropriate levels of care
- Avoidance of unnecessary treatment & interventions and medications

- https://www.youtube.com/watch?v=URgTohx1bOc
- ..\HOLOGIC\Video Clip.pptx

Standardization to Improve Outcomes

- Protocols and checklists should be recognized as a guide to the management of a clinical situation or process of care that will apply to most patients.
- Obstetrician-gynecologists should be engaged in the process of developing guidelines and presenting data to help foster stakeholder buy-in and create consensus, thus improving adherence to guidelines and protocols.

PLAT (Preterm Labor Assessment Toolkit)



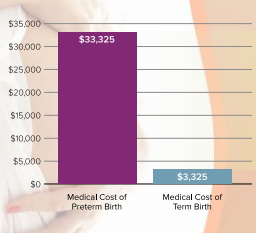
March of Dimes Report Card

Economic Consequences of Preterm Birth

- Health Impact
  - Long-term complications
- Economic Impact
  - Medical
  - Educational
  - Lost productivity
- Societal Impact

The High Cost of Preterm Birth

The estimated annual societal economic cost of preterm birth in the U.S. was $26.2 billion, or more than $51,000 per premature infant



These 2005 costs show that the medical cost of a preterm birth is

10 times

the cost of a uncomplicated term birth

Behrman RE, et al, eds. Preterm Birth: Causes, Consequences and Prevention. Institute of Medicine (US) Committee on Understanding Premature Birth and Assuring Healthy Outcomes. Washington, DC: National Academies Press; 2007.

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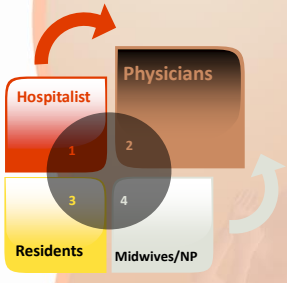
Scope of Practice

1. Joint Commission
2. Nurse Initiated Protocols
3. Standing Orders
4. Policies and Procedures

Institutional Structure



Nurse Initiated Protocols

Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders only if the hospital:

(i) Establishes that such orders and protocols have been reviewed and approved by the medical staff and the hospital's nursing and pharmacy leadership;

(ii) Demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;

(iii) Ensures that the periodic and regular review of such orders and protocols is conducted by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols; and

(iv) Ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

Standing Orders

- Protocols for triaging and initiating required screening examinations and stabilizing treatment
  - Rule out rupture of membranes : use of amnisure, A-ROM etc.
  - PLAT : fFN, GBS, U/A and or C&S

Emergency Response

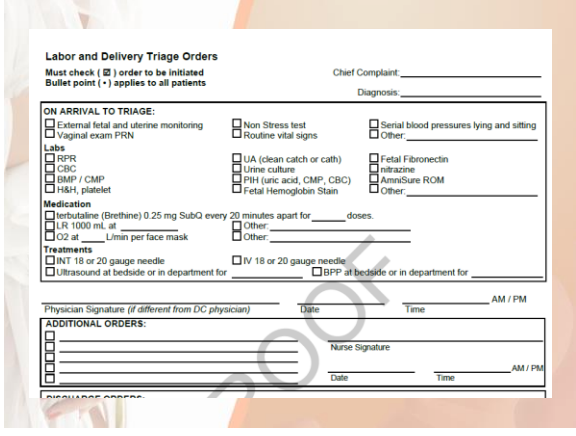
- Standing orders may be initiated as part of a emergency response where it is not practical for a nurse to obtain consent(i.e.; written, authenticated, verbal)

Minimum Requirements of Standing orders

- Each standing order must be reviewed and approved by the hospital's medical staff and nursing and pharmacy leadership before it may be used in the clinical setting.
- For each approved standing order, there must be specific criteria clearly identified in the protocol for the order for a nurse or other authorized personnel to initiate the execution of a particular standing order
  - **Under no circumstances may a hospital use standing orders in a manner that requires any staff not authorized to write patient orders to make clinical decisions outside of their scope of practice in order to initiate such orders.**

Survey Procedures

- Evidence of periodic evaluation and, if needed, modification of the standing order, including whether the order remains consistent with current evidence-based national guidelines, staff adherence to the protocol for initiation and execution
- **Ask staff** providing clinical services in areas of the hospital where standing orders might be typically used, including but not limited to, the emergency department, **labor and delivery units**, and inpatient units, whether standing orders are used.
  - Ask them to describe a typical scenario where a standing order would be used, and what they would do in that case.
- For a copy of the protocol for that standing order. Does their description conform to the protocol?
- **Review a sample of medical records** of patients where a nurse-initiated standing order was used and verify that the order was documented and authenticated by a practitioner responsible for the care of the patient.



Labor and Delivery Triage Orders

Must check (☑) order to be initiated
Bullet point (•) applies to all patients

Chief Complaint: _____

Diagnosis: _____

ON ARRIVAL TO TRIAGE:

☐ External fetal and uterine monitoring
☐ Vaginal exam PRN
☐ Non Stress test
☐ Routine vital signs
☐ Serial blood pressures lying and sitting
☐ Other: _____

Labs

☐ RPR
☐ CBC
☐ BMP / CMP
☐ H&H, platelet
☐ UA (clean catch or cath)
☐ Urine culture
☐ PIH (uric acid, CMP, CBC)
☐ Fetal Hemoglobin Stain
☐ Fetal Fibronectin
☐ nitrazine
☐ AmniSure ROM
☐ Other: _____

Medication

☐ terbutaline (Brethine) 0.25 mg SubQ every 20 minutes apart for _____ doses.
☐ LR 1000 mL at _____
☐ O2 at _____ L/min per face mask
☐ Other: _____
☐ Other: _____

Treatments

☐ INT 18 or 20 gauge needle
☐ Ultrasound at bedside or in department for _____
☐ IV 18 or 20 gauge needle
☐ BPP at bedside or in department for _____

_____ _____ _____ AM / PM
Physician Signature *(if different from DC physician)* Date Time

ADDITIONAL ORDERS:

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Nurse Signature

_____ _____ AM / PM
Date Time

Nurse Initiated Protocol


Labs

(PLAT) Pre-Term Labor Assessment Tool

FETAL FIBRONECTIN
STAT, **Obtain prior to Vaginal Exam** **Obtain if patient is between 24.0 and 34.0 weeks gestation without vaginal bleeding, ROM, or intercourse in the last 24 hours**.

Urine Culture, Clean Catch
STAT, (If indicated)

CULTURE, GROUP B STREP W/ SUSCEPTIBILITY
STAT, (If indicated)

Urinalysis w/ microscopic, automated
STAT, (If indicated)

How Are We Doing?

14 year study looking at antenatal steroid timing relative to delivery

- 23% received optimal timing
- 34% received suboptimal timing
- 52% of mothers who received steroids delivered >35 weeks

Adapted from: Razaz N, et al. Trends in Optimal, Suboptimal, and Questionably Appropriate Receipt of Antenatal Corticosteroid Prophylaxis. *Obstet Gynecol*. 2015;125(2):288-96. doi:10.1097/AOG.0000000000000006.

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ADVANCES IN THE MANAGEMENT OF PRETERM LABOR

fFN in Symptomatic Patients: Negative fFN

Allows for better targeting of hospital resources

NPV for Delivery Within:

7 days = 99.5%

14 days = 99.2%

< 37 weeks = 84.5%

Benefits of a Negative Test

- Less intervention
- Avoid hospitalizations
- Provider and patient reassurance

Adapted from: Peaceman AM, et al. Fetal fibronectin as a predictor of preterm birth in patients with symptoms: A multicenter trial. AJOG. 1997;177(1):13-8. doi:10.1016/S0002-9378(97)70431-9.

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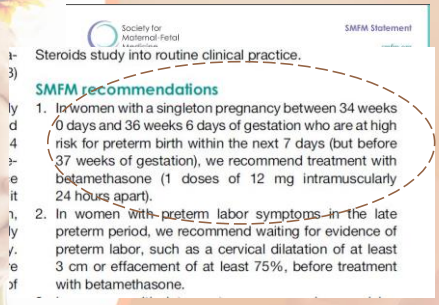
Wellstar PLAT Outcomes

- PLAT allowed proper assessment and clinical disposition in 2 to 4 hours:
- Prompt confirmation of preterm labor by diagnostic criteria allows timely intervention
- Improved our patient satisfaction scores
- For women who did not meet preterm labor diagnostic criteria, PLAT utilized risk assessment screening including TVU and fFN as predictors of preterm birth:
  - **Positive test(s) can help target interventions in women most likely to benefit**
  - **Negative test(s) can help in avoiding unnecessary interventions and provide reassurance**

Steroids and Optimal Timing



Society for Maternal-Fetal Medicine

SMFM Statement

Steroids study into routine clinical practice.

SMFM recommendations

1. In women with a singleton pregnancy between 34 weeks 0 days and 36 weeks 6 days of gestation who are at high risk for preterm birth within the next 7 days (but before 37 weeks of gestation), we recommend treatment with betamethasone (1 doses of 12 mg intramuscularly 24 hours apart).
2. In women with preterm labor symptoms in the late preterm period, we recommend waiting for evidence of preterm labor, such as a cervical dilatation of at least 3 cm or effacement of at least 75%, before treatment with betamethasone.

AWHONN MFTI

- Evidence based tool for acuity
- Assist with tracking and ensuring patients are screened properly from urgent to emergent

AWHONN
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

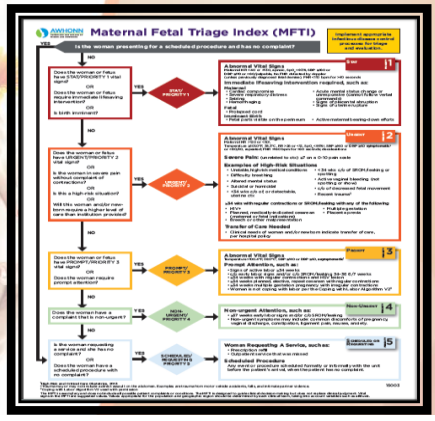
AWHONN: Maternal Fetal Triage Index

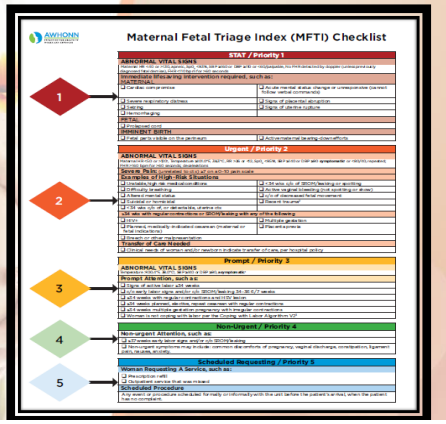
COMMITTEE OPINION

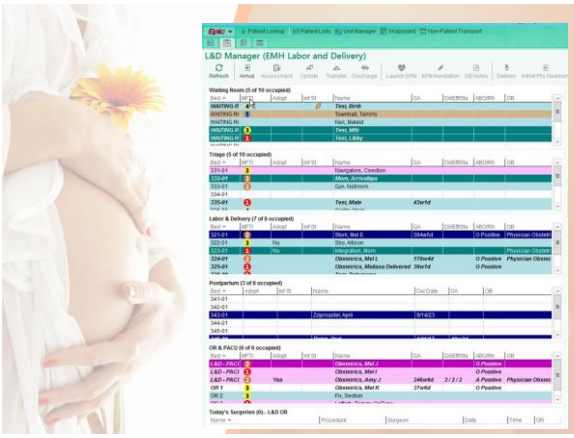
Committee on Obstetric Practice

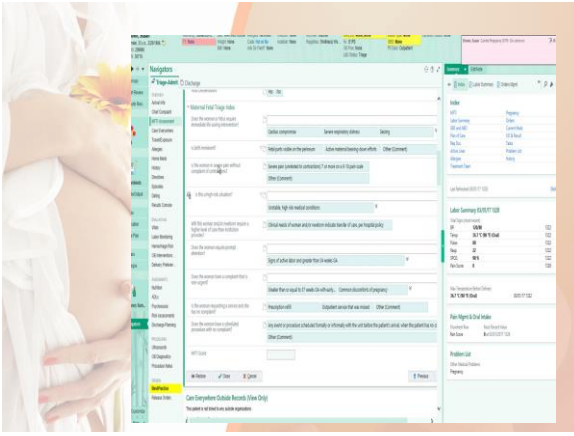
Hospital-Based Triage of Obstetric Patients

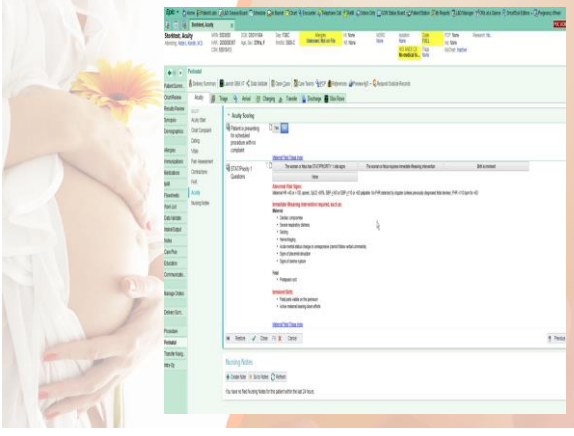
- Validated obstetric triage acuity may improve quality and efficiency of care and guide resource use.
- Triage volume typically exceeds the overall birth volume of a hospital by 20-50%.

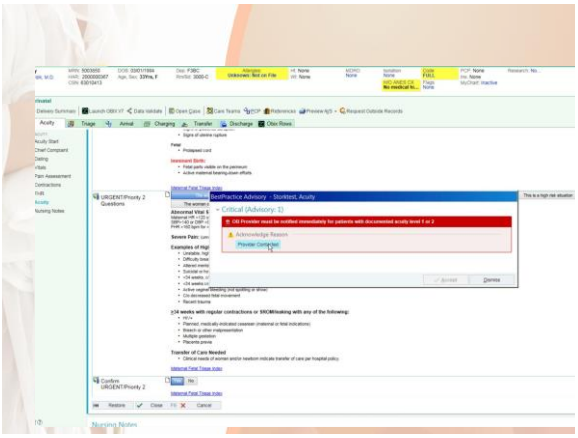




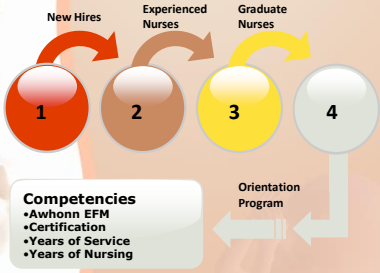

L&D Manager (EMH Labor and Delivery)







Competencies for Triage



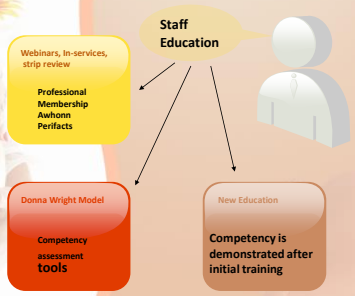
Competency Assessment Requirements

What is required to complete a competency assessment?

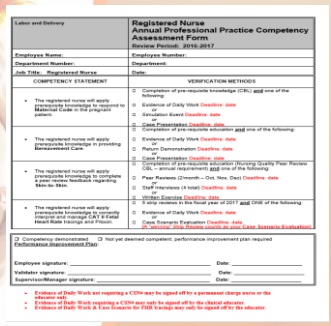
- **Variety of methods**:
  - assessment of information from current and previous employers
  - collecting peer feedback
  - verifying certification and licensure
  - reviewing test results with a written or oral competency
  - observation of skills
- The assessment must be thorough and focus on the particular competency needs for the clinical staff's assignment. Use of a self-assessment, such as a skills checklist, as the sole assessment method does not constitute a competency assessment.

https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=900&StandardsFAQChapterId=131&ProgramId=0&ChapterId=0&IsFeatured=False&IsNew=False&Keyword=

Education -Liability , Education-Liability



Example of Competency Assessment



Labor and Delivery

Registered Nurse Annual Professional Practice Competency Assessment Form

Review Period: 2016-2017

Employee Name: Employee Number:

Department Number: Department:

Job Title: Registered Nurse Date:

COMPETENCY STATEMENT | VERIFICATION METHODS

- The registered nurse will apply prerequisite knowledge to respond to Maternal Code in the pregnant patient.
  - ☐ Completion of pre-requisite knowledge (CBL) and one of the following:
  - ☐ Evidence of Daily Work Deadline: date
  - ☐ Simulation Event Deadline: date
  - or
  - ☐ Case Presentation Deadline: date
- The registered nurse will apply prerequisite knowledge in providing Bereavement Care
  - ☐ Completion of pre-requisite education and one of the following:
  - ☐ Evidence of Daily Work Deadline: date
  - ☐ Review Demonstration Deadline: date
  - or
  - ☐ Case Presentation Deadline: date
- The registered nurse will apply prerequisite knowledge to complete a peer review feedback regarding Skin-to- Skin.
  - ☐ Completion of pre-requisite education (Nursing Quality Peer Review CBL – annual requirement) and one of the following
  - ☐ Peer Reviews (2/month – Oct, Nov, Dec) Deadline: date
  - or
  - ☐ Staff Interviews (4 total) Deadline: date
  - or
  - ☐ Written Exercise Deadline: date
- The registered nurse will apply prerequisite knowledge to correctly interpret and manage CAT II Fetal Heart Rate tracings and Pitocin.
  - ☐ 5 strip reviews in the fiscal year of 2017 and ONE of the following
  - ☐ Evidence of Daily Work Deadline: date
  - or
  - ☐ Case Scenario Evaluation Deadline: date
  - Nursing: Strip Review (must be case Case Scenario Evaluation)

☐ Competency demonstrated ☐ Not yet deemed competent, performance improvement plan required
Performance Improvement Plan)

Employee signature: _____ Date: _____

Validator signature: _____ Date: _____

Supervisor/Manager signature: _____ Date: _____

- Evidence of Daily Work not requiring a CDN may be signed off by a permanent charge nurse or the clinical educator
- Evidence of Daily Work requiring a CDN may only be signed off by the clinical educator
- Evidence of Daily Work & Case Scenario for FHR tracings may only be signed off by the educator.

Safety Concerns for Triage

- Timing of initial assessment
  - *Initial assessment and timing can be improved by utilizing an evidence based triage acuity tool.*
- Appropriate and complete evaluation and the documentation of that care
- Discharge from OB triage without evidence of fetal well-being
- Delay in timely response to a healthcare provider

Safety Concerns for Antepartum Care

- Using the most current evidence-based practices to establish guidelines and protocols.
  - ACOG bulletins
  - AWHONN practice guidelines
    - i;e; 3rd stage management
    - QBL
- We can only be help accountable to information we can obtain.

Safety Concerns for Intrapartum Care

- Multidisplinary plan
- ED to OB work flow
- ACOG Management of PTL as a guide to work flow, medications and treatment options
- 23 weekers Ethical issues, treatment options (are they even available)

References

1. ACOG. (2015, April). Clinical Guidelines and Standardization of Practice to Improve Outcomes. The American College of Obstetric and Gynecologists, 125(4), 1027-1029.
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3. Fuchs IB, e. a. (2004). Sonogrpahic cervical length in singleton pregnancies with intact membranes presenting with threatened preterm labor. Ultrasound Obstetrics Gynecology, 24(5), 554-7.
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