Obstetrical Improvement Project Toolkit
Reducing Early Elective Deliveries
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Introduction

Obstetrical Improvement Project
Why Prevent Preterm Birth?
According to the Centers for Disease Control and Prevention, preterm birth affects more than 500,000 babies, or one of every eight infants born in the United States.¹ It is the most frequent cause of infant death, and the leading cause of long-term neurological disabilities in children. Preterm birth can lead to severe health problems, including issues with breathing and feeding, vision impairment, and developmental delays. The brain is the last major organ to mature in babies; the more prematurely a baby is born, the more likely it is that bleeding or other signs of stress will affect the brain. Preterm birth costs the nation’s health care system more than $26 billion each year.

Project Background
Since September 2010, the New York State Department of Health (NYSDOH) has collaborated with its Regional Perinatal Centers (RPCs) and the National Institute for Children’s Health Quality (NICHQ) to improve and ensure the quality of obstetrical and neonatal care related to preterm births through the New York State Perinatal Quality Collaborative (NYSPQC).

The NYSPQC Obstetrical Improvement Project seeks specifically to reduce scheduled deliveries without a medical indication between 36 0/7 and 38 6/7 weeks gestation. Since the project’s inception, participants have had the opportunity to learn from faculty and colleagues; receive individual coaching from faculty members; gather new knowledge on the subject matter and process improvement; share experiences and collaborate on improvement plans; and create strategies to overcome improvement barriers.

Between September 2010 and April 2014, participating RPCs reported a 96% decrease in scheduled deliveries without a medical indication during the specified gestation period, including an 87% decrease in inductions and a 99% decrease in cesarean sections. Additionally, primary cesarean sections decreased by 97%, and documentation of maternal education on the risks and benefits of preterm scheduled delivery increased by 59%.

In early 2012, the project aligned with the NYS Partnership for Patients (NYSPFP) to expand the Collaborative from RPCs to all birthing hospitals in New York State. NYSPFP is a joint initiative of the Healthcare Association of New York State and the Greater New York Hospital Association that was awarded a contract from the Centers for Medicare & Medicaid Services to reduce hospital-acquired complications and preventable readmissions. Ninety-eight New York State birthing hospitals participated in the Collaborative. The expansion of the Collaborative occurred in June 2012 to include Level I, II, and III hospitals. Between the expansion and April 2014, participating RPC affiliate hospitals reported a 91% decrease in scheduled deliveries without a medical indication during the specified gestation period, including an 85% decrease in inductions and a 93% decrease in cesarean sections. Additionally, primary cesarean sections decreased by 94%, and documentation of maternal education on the risks and benefits of preterm scheduled delivery increased by 73%.

NYSDOH is pleased to present the NYSPQC/NYSPFP Obstetrical Improvement Project Toolkit. The materials in the toolkit focus on reducing scheduled deliveries without a medical indication between 36 0/7 and 38 6/7 weeks gestation. This toolkit is being distributed to all New York State birthing hospitals, and is also available on the NYSPQC website (www.nyspqc.org).

The toolkit contains the resources that participants of the NYSPQC/NYSPFP Obstetrical Improvement Project have created since the initiative’s inception, relevant presentations, data and quality improvement tools, web links, and references. The resources created by project participants include: scheduling forms, protocols, provider and patient education tools. We hope that hospitals will be able to use these tools and resources as they continue reducing the occurrence of scheduled deliveries without a medical indication prior to 39 weeks, and sustain the gains already made by hospitals in this area.

The following individuals and organizations were integral to the development of this toolkit: Marilyn Kacica, MD, MPH; Kristen Lawless, MS; Katie Greene, MPH; Peter Cherouny, MD; Pat Heinrich, RN, MSN; NYSPQC Obstetrical Improvement Project hospital teams; NYS Partnership for Patients; Healthcare Association of New York State; Greater New York Hospital Association; and the University at Albany School of Public Health’s Center for Public Health Continuing Education.

The NYSDOH provided financial support to the NYSPQC for the quality improvement activities detailed in this toolkit. Funding was also made possible by grant U38DP003782 from the Centers for Disease Control and Prevention (CDC).

All information, presentations, policies, tools, and forms contained in this toolkit are provided for informational purposes only. The toolkit is not meant to provide medical advice nor is it a substitute for professional medical or clinical judgment.
Educational Presentations

Key components of the NYSPQC/NYSPFP structure are the frequent opportunities for participating facilities to share and learn through Coaching Calls, Learning Sessions, and Educational Webinars. The presentations in this section provide highlights from these events, all of which focused on reducing scheduled deliveries without a medical indication between 36 0/7 and 38 6/7 weeks gestation. These presentations, which can be used to educate hospital staff, are a small selection of those offered to NYSPQC/NYSPFP Obstetrical Improvement Project participants. Additional slides and recordings from these presentations can be found at www.nyspqc.org.

<table>
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<td>• Engaging Physicians in Your Quality Project</td>
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<tr>
<td>• Progress to Date and Sustainability</td>
<td></td>
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</tbody>
</table>
Welcome

- Thank you for joining the call!
- For purposes of attendance, chat the following information to Kristen Farina, NYSPQC Program Coordinator:
  - Name
  - Facility name
  - E-mail address
  - Please mute your line by using the mute button, or by dialing * 6.

---

**Disclosure Slide**

Peter Cherouny, M.D.
Nothing to disclose

---

NYS Partnership for Patients
and
New York State Perinatal Quality Collaborative

September 18, 2012

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**Decreasing Elective Deliveries Prior to 39 Completed Weeks**

Creating the Sense of Urgency for Change

Peter Cherouny, M.D.,
Emeritus Professor, Obstetrics, Gynecology and Reproductive Sciences,
University of Vermont
Chair, Perinatal Community, NYSPQC

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Decreasing Elective Deliveries Prior to 39 Completed Weeks

At the end of the talk, the participant will be able to:

- Identify early term deliveries
- Identify the risks associated with early term birth
- Interpret the evidence based rationale for suggested clinical changes
- Identify strategies to translate evidence into practice for reduction of elective deliveries < 39 weeks
- Develop a plan to address challenges and resistance to implementing clinical changes

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**Late Preterm Delivery**

**Nomenclature**

- Near Term
  
  vs
  
- Late Preterm
  
  (34+0 – 36+6 weeks GA)

---

**Early Term Delivery**

**Why is this important now?**

---

**Early Term Delivery**

**Nomenclature**

- Early Term
  
  (37+0 – 38+6 weeks GA)
  
  vs
  
- Term (fetal maturity confirmed)
  
  (>39 weeks gestational age)

---

**Late Preterm Delivery & Early Term Delivery**

**Total, Very Preterm and Late Preterm Birth Rates**

**United States, 1990–2003**

![Graph showing birth rates](image)

---

**Delivery prior to fetal maturity**

**Complications**

During initial hospitalization:

- Temperature instability
- Hypoglycemia
- Respiratory Distress
- Apnea
- Jaundice
- Feeding Difficulties

---

**Early Term Deliveries**

**Causes of Early Term Delivery**

- Spontaneous Labor and PROM
- Indicated Early Term Delivery
- Elective Delivery
Early Term Deliveries

- Elective Deliveries (Induction and Cesarean Section)
  - Continue to increase
  - Temporally associated with increase in late preterm and early term delivery
  - Population data shows average gestational length 38.9 weeks

Early Term Delivery

- The Problem
  - Gestational dating is core to this issue
    - How reliable is your gestational age criteria?

Early Term Deliveries

- The Problem
  - Elective deliveries performed prior to confirmation of a term gestation
  - The iatrogenic nature of these outcomes
    - Increase in morbidity of well-dated term deliveries
    - Increase in late-preterm deliveries due to dating discrepancies

Early Term Delivery

- Identifying the gap
  - What are the current guidelines
  - Are the guidelines appropriate
  - What is current adherence to that guideline

Early Term Delivery

- Improved dating criteria allows differentiation between each week of gestational age at term
- Gestational dating is core to this issue

Early Term Deliveries

- Original Guidelines for Confirmation of Term Gestation (ACOG 1982)
  - Fetal heart tones have been documented for 20 weeks by non-electronic stethoscope or for 30 weeks by Doppler.
  - It has been 35 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test was performed by a reliable laboratory.
  - An ultrasound measurement of the crown, rump length obtained at 5-12 weeks, supports a gestational age of at least 39 weeks.
  - An ultrasound obtained at 13-20 weeks confirms the gestational age of at least 38 weeks determined by clinical history and physical examination.
  - Amniocentesis and documentation of fetal maturity.
Early Term Deliveries

- Current guidelines for Assessing Fetal Maturity (ACOG Prac Bull #97, August 2008)
  - Fetal heart tones have been documented for 20 weeks by nonelectronic fetoscope or for 30 weeks by Doppler
  - It has been 35 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test was performed by a reliable laboratory.
  - Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater
  - Amniocentesis and documentation of fetal maturity

Early Term Delivery

- Current guidelines for Assessing Fetal Maturity (ACOG Prac Bull #97; August 2008)
  - Ultrasonography may be considered to confirm menstrual dates if there is a gestational age agreement within 1 week by crown-rump measurements obtained in the first trimester
  - An ultrasound obtained in the second trimester at up to 20 weeks by multiple biometric parameters confirms the gestational age of at least 39 weeks within 10 days.
Early Term Deliveries

- Are the guidelines appropriate?
- How do we know they work
- How did we get here

Early Term Deliveries

- Are the guidelines appropriate?
- Small retrospective data from various groups
- More detailed retrospective data sets
- Large retrospective cohort studies from detailed perinatal databases with specific cohort identities
- Very large cohort studies with clear inclusion and exclusion criteria more appropriate for the focused questions asked

Early Term Deliveries

- Are the guidelines appropriate?
- 1284 elective cesarean deliveries
- Relative risks of pulmonary complication (TTN + RDS)

2.6 overall vs VD
5.85 for RDS vs VD

12.9 37±0.38±6 vs ≥ 39+0

Educational Presentations continued

**Early Term Deliveries**

- Are the guidelines appropriate?

- 13,258 Elective Sections
  - 35.8% less than 39 weeks
    - > 29.5% at 38 wks
    - > 6.3% at 37 wks


---

**Early Term Deliveries**

- Are the guidelines appropriate?

- 13,258 Elective Sections

GA
37 36 39
RR 2.1 1.5 1.0


---

**Early Term Deliveries**

- Are the guidelines appropriate?

- 35.8% less than 39 weeks
  - > 6.3% at 37 wks


---

**Early Term Deliveries**

- Are the guidelines appropriate?

- 37-28 29-36 37-39 40-41 41+ Inc POV


---
**Early Term Deliveries**

- Are the guidelines appropriate?
- More likely to be delivered at less than 39 weeks if:
  - Older
  - Thinner
  - Non-Hispanic White
  - Married
  - Diet controlled GDM
  - Non LGA fetus

---

**Early Term Deliveries**

- Are the guidelines appropriate?
- All term singleton live births in the US in 2003 (cephalic, no prior C/S, not pre or postterm)
- Gestational age at delivery by completed week from 37-41 weeks
  - Outcomes: Primary C/S, OVD, fetal death, mortality, NICU admission, respiratory issues, 5' Apgar, HMD, MAS
  - Mechanical ventilation > 30 minutes

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Educational Presentations continued

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**Early Term Deliveries**

- Are the guidelines appropriate?

![Graph showing Early Term Deliveries](image)


---

**Early Term Deliveries**

- Are the guidelines appropriate?

411,560 deliveries reviewed

<table>
<thead>
<tr>
<th>GA</th>
<th>37</th>
<th>38</th>
<th>39</th>
<th>40</th>
<th>41</th>
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</thead>
<tbody>
<tr>
<td>Infant Mort Rate OR</td>
<td>1.9</td>
<td>1.4</td>
<td>1.0</td>
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**Early Term Deliveries**

- Are the guidelines appropriate?

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<tr>
<td>POV OR</td>
<td>2.4</td>
<td>1.4</td>
<td>1.0</td>
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**Early Term Deliveries**

- Are the guidelines appropriate?

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<tr>
<td>CP RR</td>
<td>1.9 (1.6-2.4)</td>
<td>1.3 (1.1-1.5)</td>
<td>1.1 (1.0-1.3)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mooter et al. Cerebral palsy among term and postterm births. *JAMA* 2010;304(9):976-982. 1.68 million births, 37-44 weeks without congenital anomalies

---

**Early Term Deliveries**

- Are the guidelines appropriate?

- What happens after delivery?

---

**Early Term Deliveries**

- Are the guidelines appropriate?

![Graph showing Early Term Deliveries](image)

Mooter et al. Cerebral palsy among term and postterm births. *JAMA* 2010;304(9):976-982. 1.68 million births, 37-44 weeks without congenital anomalies.
**Early Term Deliveries**

- **What about a mature fetal lung profile after amniocentesis?**

<table>
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<tr>
<th></th>
<th>LatePT</th>
<th>Early Term</th>
<th>Term</th>
</tr>
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<tbody>
<tr>
<td>Composite AINO</td>
<td>16 (21.1)</td>
<td>10 (13.2)</td>
<td>11 (4.2)</td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td>18 (23.7)</td>
<td>13 (17.1)</td>
<td>15 (5.7)</td>
</tr>
<tr>
<td>Intravenous fluids (BG)</td>
<td>2 (2.4)</td>
<td>2 (2.6)</td>
<td>0</td>
</tr>
<tr>
<td>Gavage feeds</td>
<td>8 (10.5)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Phototherapy</td>
<td>4 (5.3)</td>
<td>7 (9.2)</td>
<td>3 (1.2)</td>
</tr>
<tr>
<td>Severe asphyxia</td>
<td>15 (19.7)</td>
<td>4 (5.3)</td>
<td>9 (3.3)</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>2 (2.6)</td>
<td>2 (2.6)</td>
<td>2 (0.8)</td>
</tr>
<tr>
<td>Central venous line</td>
<td>1 (1.3)</td>
<td>1 (1.3)</td>
<td>0</td>
</tr>
<tr>
<td>NICU admission</td>
<td>14 (19.4)</td>
<td>4 (5.3)</td>
<td>8 (3.1)</td>
</tr>
<tr>
<td>Oxygen supplementation</td>
<td>1 (1.3)</td>
<td>3 (4.0)</td>
<td>1 (0.4)</td>
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**Early Term Deliveries**

- **Are the guidelines appropriate?**

The ACOG guidelines written in 1988 and reaffirmed in 2008 appear appropriate.

---

**Early Term Deliveries**

- **What about a mature fetal lung profile after amniocentesis?**

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**Early Term Deliveries**

- **Why do we still see over one-third of elective deliveries performed prior to 39 completed weeks?**

---

**Early Term Deliveries**

- **A mature fetal lung test result before 39 weeks of gestation, in the absence of appropriate clinical circumstances, is not an indication for delivery.**


---

**Early Term Deliveries**

4.3 million USA deliveries

- **X 25% induction rate =**
  - 1.08 million Labor Inductions
  - **X 31.3% Cesarean Section Rate =**
    - 1.31 million Cesarean Sections
      - Even low incidence outcomes become important
Early Term Deliveries

4.3 million USA deliveries
- 20,000 perinatal injuries per year
  ➢ 13,000 – 23,400 preventable

New York State
1600–1900/yr
800–950 preventable

- Even low incidence outcomes become important

Balancing Measure

Fetal Death – A Primer

- FMR 6.23 in 2003
  ➢ 51% of Fetal Mortality occurs at 20-27 wks
  ➢ FMR at 20+ weeks is 3.0
  ➢ 80.5% of Fetal Mortality occurs prior to term
  ➢ PMR at term is 1.2
  ➢ False negative rate of antepartum fetal testing is 0.6–1.9/1000
  ➢ In general, a tested high-risk population has about one-half the fetal death rate as an untested low-risk population


Balancing Measure

Fetal Death – A Primer

- Perinatal Mortality rate
  ➢ Fetal MR + Neonatal MR
  ➢ Fetal MR represents 58% of the PMR
  ➢ FMR 6.23 in 2003

Balancing Measure

Fetal Death – A Primer

- 20-27 wks
- 28+ wks


Balancing Measure

Fetal Death – A Primer

- Pre-Study
- Study

Balancing Measure

**Early Term Deliveries**

- Why are there any elective deliveries prior to 39 completed weeks?
- There are several local, regional and national initiatives to eliminate elective deliveries prior to fetal maturity
- In other words, we’re being asked to follow our established guidelines


---

Early Term Deliveries

**Does it work?**

Ohio Perinatal Collaborative

Reduced inappropriate early term deliveries prior to 39 weeks from 25% to <5%.

The Ohio Perinatal Quality Collaborative writing committee. A statewide initiative to reduce inappropriate scheduled births at 36-0-36-6 weeks gestation.

---

**What is:**

- Elective Deliveries <35 Weeks
- Preterm Deliveries <35 Weeks
- Elective Deliveries ≥35 Weeks
- Elective Deliveries ≥35 Weeks

---

**And what can be:**

- Elective Deliveries <35 Weeks
- Preterm Deliveries <35 Weeks
- Elective Deliveries ≥35 Weeks
- Elective Deliveries ≥35 Weeks
**Early Term Deliveries**

- Why isn’t it ZERO?
- What about indicated deliveries?

**NYSDOH Key Drivers**

1. Awareness of risks/expected benefit of late preterm an early term delivery by patients and consumers
2. Dating criteria: optimal estimation of gestational age
3. Hospital and physician practice policies that facilitate ACOG criteria
4. Awareness of risks/expected benefit of late preterm and early term delivery by clinician
5. Culture of safety and improvement

**Early Term Deliveries**

- Changing your path

**NYSDOH Key Drivers**

1. Awareness of risks/expected benefit of near-term delivery by patients and consumers

- Key Changes:
  - Inform consumers of risks/benefits of delivery < 39 weeks
  - Communicate to patient/clinic/hospital dating/ultrasound results
  - Promote need for early dating to practitioners and consumers
  - Public awareness campaign

**Early Term Deliveries**

- Identifying and developing a set of specific and measurable changes that you can implement in order to achieve improvement in elective deliveries prior to 39 weeks

**NYSDOH Key Drivers**

2. Dating criteria: optimal estimation of gestational age

- Key changes:
  - Promote need for early dating to practitioners and consumers as appropriate
  - Develop/Document criteria used to establish EDC
  - Appropriate use of fetal maturity testing
  - Empower nurses/schedulers to require dating criteria
  - Create/Identify administrative support for authorization dispute re: dating
3. Hospital and physician practice policies that facilitate ACOG criteria

- **Key changes:**
  - Document rationale and risk/benefit for scheduled deliveries at 38 1/7 to 38 6/7 weeks gestation
  - Document discussion with patient about the above
  - Both patient and MD sign consent statement for scheduled delivery between 38 1/7 to 38 6/7 weeks
  - Physician awareness campaign: what are the indications for scheduled delivery?
  - Maximize access to Delivery and OR for optimal scheduling
  - Facilitate scheduling policies that respect ACOG criteria

---

4. Awareness of risks and expected benefit of near-term delivery by clinician

- **Key changes:**
  - Prenatal caregivers receive feedback from postnatal caregivers about neonatal outcomes of scheduled deliveries
  - Ensure complete and accurate handoffs OB/Ob and OB/Peds
  - Document discussion with patient about risks/benefit of late preterm/early term delivery
  - Promote need for early dating to practitioners and consumers

---

5. Culture of safety and improvement

- **Key changes:**
  - Continuous monitoring of data and discussion of this effort in staff/division meetings
  - Post data-project outcomes
  - Develop ways to include staff and physician input about communications and handoffs
  - Connect with organizational initiatives on safety and use existing approaches as possible
  - Empower nurses/schedulers to require dating criteria
  - Constant communication among multidisciplinary team

---

*Early Term Deliveries*

What do we need to do:

- Develop hospital-level measurement tools
  - Perform small tests of change in the hospital
  - Eventual result is widespread implementation of improvements in practices
  - Provide the methods for process improvement

---

*Early Term Deliveries*

What do we need to do:

- Develop hospital-level measurement tools
  - Make it easy to comply
  - Work the change into current work flow

---

*Early Term Deliveries*

What do we need to do:

- Communicate
  - Create the urgency
Educational Presentations

Early Term Deliveries

- The Ohio original quality collaborative writing committee. A statewide initiative to reduce inappropriate scheduled births at 36+0-36+6 weeks’ gestation. 25% to <7%.
- Dorovan et al. Infant death among Chile resident infants born at 33-41 weeks of gestation. IMR 37-39.2 weeks, 39-39.9 weeks, 40-40.9 weeks, >41 weeks, total 41,160 deliveries, total 41,160 reviewed.
- Moler et al. General use among labor and postterm births. JAMA 2010;304(9):976-982. 1.65 million births, 37-44 weeks without congenital anomalies, >37 weeks of gestation, 39-40 (1.65), 40-41 (1.04), >41 weeks (1.03).
- References: 1) (1.0-1.3) 2) (1.2-1.6)

Why don’t we feel these numbers...

*Absolute numbers are low
  *Obstetrician doing 300 del/yr
    -100 CS
    -75 IOL
  *Home birth midwife
    -100 deliveries/year
  *5-fold increased neonatal death rate
    -Obstetrician would take 6-12 months to have 1 death
    -Midwife would take 18 months to have 1 death

Why don’t we feel these numbers...

*Absolute numbers are low
  *Obstetrician doing 300 del/yr
    -100 CS
    -75 IOL
  *Home birth midwife
    -100 deliveries/year
  *10-fold increased maternal death rate
    -Obstetrician would take 5-10 years to have 1 death
    -Midwife would take 15-20 years to have 1 death

Why don’t we feel these numbers...

*Absolute numbers are low
  *Relative Risks are low
    *2-4 times a low number is still a low number.

Questions?
Next Steps/Close Out

- First monthly Coaching Call
  - September 25, 2012
    - 2 – 3 p.m.
- Coaching Calls moving forward – Third Tuesday of every month
  - Starting October 16, 2012
    - 11 a.m. – 12 p.m.

Obstetrical Assessment of Current Practices

Contact
- NYSPQC Project Team
- Phone: (518) 473-9883
- E-mail: NYSPQC@health.state.ny.us
Coaching Call, January 15, 2012

Welcome
- Thank you for joining the call!
- Please mute your line by using the mute button, or by dialing * 6.
- For purposes of attendance, chat the following information to Kristen Farina, NYSPQC Program Coordinator:
  - Your name
  - Full facility name
  - E-mail address

NYS Partnership for Patients and New York State Perinatal Quality Collaborative Coaching Call
January 15, 2012

Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00 a.m. – 11:05 a.m.</td>
<td>Welcome and Introductions</td>
<td>Kristen Farina</td>
</tr>
<tr>
<td>11:05 a.m. – 11:30 a.m.</td>
<td>Physician Engagement Strategies</td>
<td>Pete Cherouny, M.D</td>
</tr>
<tr>
<td>11:30 a.m. – 11:45 a.m.</td>
<td>RPC Experience: Physician Engagement</td>
<td>Adriann Combs, RN</td>
</tr>
<tr>
<td>11:45 a.m. – 11:55 a.m.</td>
<td>Learning and Sharing: Team Report Outs</td>
<td>Pat Heinrich</td>
</tr>
<tr>
<td>11:55 a.m. – 12:00 p.m.</td>
<td>Next Steps</td>
<td>Lorraine Ryan Christa Christakis</td>
</tr>
</tbody>
</table>

Engaging Physicians in Your Quality Project

Peter Cherouny, M.D.
Emeritus Professor, Obstetrics, Gynecology and Reproductive Sciences
University of Vermont College of Medicine

Dr. Cherouny has nothing to disclose.

Engaging Physicians In Your Quality Project

- What’s right about this title?
Engaging Physicians In Your Quality Project
- What’s wrong about this title?

Discover a Common Purpose
- Improve patient outcomes
- Reduce hassles and wasted time
- Understand the legal opportunities and barriers
- Understand the organization’s culture

Engaging Physicians in the Patient Safety Agenda

Reframe Values and Beliefs
- Treat physicians as partners not customers
- Promote both system and individual responsibility for quality and safety
- Who is the only true customer?

Framework for engaging physicians in the patient care quality and safety agenda
- Discover common purpose
- Reframe values and beliefs
- Segment the engagement plan
- Use engaging improvement methods
- Show courage
- Adopt an engaging style

Segment the Engagement Plan
- 20/80 rule
- Identify and activate champions
- Educate and inform structural leaders
- Develop project management skills
- Identify and work with laggards
Use Engaging Improvement Methods
- Standardize what is standardizable-no more
- Generate light not heat with data (sensible use of data)
- Make the right thing easy to try
- Make the right thing easy to do

Framework for engaging physicians in quality and safety
- Discover common purpose
- Reframe values and beliefs
- Segment the engagement plan
- Use engaging improvement methods
- Show courage
- Adopt an engaging style
- Operative vaginal delivery
- Pitocin safety
- Shoulder dystocia
- Patient centered care

Show Courage
- Provide backup all the way to the board

Adopt an Engaging Style
- Involve physicians from the beginning
- Work with the real leaders, early adopters
- Choose messages and messengers carefully
- Make physician involvement visible
- Build trust
- Communicate candidly and often
- Value physicians time

CRICO PERINATAL CLAIMS
Harvard Risk Management Foundation 1990-1999
149 claims

- Perinatal diagnosis top 5
  - Severe asphyxia 18
  - Brachial plexus injury 16
  - Placental separation/hemorrhage 6
  - Fetal distress during labor 6
  - Massive aspiration syndrome 6

CRICO PERINATAL CLAIMS
Harvard Risk Management Foundation 1990-1999
149 claims

- Perinatal Injuries-top 5
  - Birth injury 45
  - Birth asphyxia 37
  - Death 25
  - Mobility dysfunction 12
  - Nerve damage 11
Top 5 risk management issues (N=426)
- Insufficient documentation with lack of rationale-107
- Selection and management in labor and delivery-61
- Selection and management of therapy on pregnancy-15
- Technical problems-13
- Failure/delay on ordering diagnostic tests-12

- Top 5 allegations
  - Delayed diagnosis of fetal distress-32
  - Improper labor management-17
  - Improper choice of delivery method-14
  - Improper performance of treatment/procedure-9
  - Improper management of pregnancy-9

Optimizing Provider Engagement
- Know your data and resources.
- Do you know what your elective delivery rate is and have you shared this data?
- Do your providers believe the data?
- Do you see patterns in your data?
- What is your Perinatal Designation Level?

Utilizing Resources
- What is your current OB quality reporting structure?
  - Is it multi-disciplinary?
  - In addition to reporting within the OB structure, where else does the data go?
- What type of data is collected and who reports it?
- Has your RPC discussed this initiative with your perinatal leadership team?
  - Can you use your RPC to facilitate the development of your policy?
  - Can a physician at your RPC help engage providers?
Utilizing Resources

- Can you use a Perinatologist from your RPC to adjudicate difficult cases?
- Can you use resources from the NYSPQC or ACOG to provide education and continued consultation for your providers and staff?
- Have you shared the materials from the California Maternity Care Quality Collaborative, March of Dimes or Strong Start with your staff?

It Takes Teamwork . . .

- **Goal:**
  To facilitate patient safety, physician and patient satisfaction and staff empowerment.

Common Obstacles

- Providers try to “Game the System”
  - Schedule on weekends or nights to avoid the “hard stop”
  - Send patients to ER with an indication that can’t be verified by nurse
  - Hospital hopping
  - Appointed “Hard Stop” physician won’t tell his/her colleagues no
  - Physicians refuse to believe the research and do not comply with the policy

It Takes Teamwork . . .

- Develop a robust policy with the support of Obstetric Medical Leadership
- Educate providers, nurses and support staff about the morbidities associated with delivery at <39 weeks
- Identify the various ways obstetrical procedures could be booked
- Engage the central hospital schedulers in the process
- Celebrate small successes locally and within the entire organization

Other Considerations

- Provider convenience
  - Guarantee attendance at birth
  - Avoid potential scheduling conflicts
  - Reduce being woken at night
  - ... what’s the harm?
  - Amnesia due to rare occurrence
  - The NICU can handle it

Grand Rounds - Education

- Stand alone education does not drive change
- Need to establish a process married with clinical practice to drive change
- Grand Rounds help to inform on the issue of non-medically indicated C-sections and inductions and the change in hospital policy

**Educational Presentations continued**

---

### The “Hard Stop”

- **Definition of a “Hard Stop”**
  - Delivering physicians required to seek permission from designated medical leadership before performing non-medically indicated c-sections or inductions <39 weeks gestational age

---

**Examples of Successful Initiatives**

- Magee-Women’s Hospital (Pittsburgh)
- Intermountain Healthcare (Utah)
- Ohio State Department of Health

---

**THE HARD STOP**

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### Magee-Women’s Hospital Experience

- Magee-Women’s Hospital is the largest maternity hospital in western Pennsylvania, performing more than 9,300 deliveries in 2007.
- A rise in the use of induction, reaching a high of 28% in 2003.
- In 2006, a process improvement initiative changed the induction scheduling process and strictly enforced the guidelines.

---

### HCA Trial of Three Approaches for Reduction of Elective Deliveries <39 weeks

![Graph showing HCA trial results]


---

### Magee Women’s Hospital Experience with Guidelines

<table>
<thead>
<tr>
<th></th>
<th>Baseline 3 mos 2004</th>
<th>Voluntary 3 mos 2005</th>
<th>Enforced 6 mos 2006-7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries</td>
<td>2,139</td>
<td>2,250</td>
<td>10,895</td>
</tr>
<tr>
<td>Elective inductions &lt;39wks (N)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective inductions &lt;39wks (rate)</td>
<td>23</td>
<td>11.8%</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>10.0%</td>
<td>4.3% (p=0.001)</td>
<td></td>
</tr>
<tr>
<td>Elective Nullip Inductions (N)</td>
<td>29</td>
<td>35.7%</td>
<td>33</td>
</tr>
<tr>
<td>Elective Nullip Inductions =&gt;C/S (N)</td>
<td>10</td>
<td>35.7%</td>
<td>5</td>
</tr>
<tr>
<td>Elective Nullip Inductions =&gt;C/S (rate)</td>
<td>10</td>
<td>35.7%</td>
<td>5</td>
</tr>
<tr>
<td>Total Induction Rate</td>
<td>24.9%</td>
<td>20.1%</td>
<td>16.6%</td>
</tr>
</tbody>
</table>

Finch et al. Obstet Gynecol 2009;113:797

---
Magee-Women's Hospital Experience

- The importance of strong physician and nursing leadership cannot be overstated.
- The change in the induction scheduling process that began to enforce the guidelines strictly in late 2006 was spearheaded by the OB Process Improvement Committee, whose members included the hospital’s Vice President for Medical Affairs, the Medical Director of the Birth Center, and the nursing leadership for the Birth Center.

Intermountain Healthcare's Experience

- Intermountain Healthcare is a vertically integrated healthcare system that operates 21 hospitals in Utah and southeast Idaho and delivers approximately 30,000 babies annually.
- Computerized L&D system.
- MFMVs hired by system, but OBs are independent.
- January 2001: 9 urban facilities participated in a process improvement program for elective deliveries.
- 28% of elective deliveries were occurring before 39 completed weeks of gestation.

Common Themes Noted in Intermountain Healthcare's Experience

- Education provided to obstetricians regarding ACOG guidelines, best practice.
- Little change until physicians were held accountable, nurses were empowered, and guidelines were enforced.
- Medical leadership important.

Ohio Perinatal Quality Collaborative

- Reduce inappropriate scheduled deliveries at 36<sup>0/7</sup> to 38<sup>6/7</sup> weeks
- 20 maternity hospitals
- 18,384 births in this gestational window in the 14-month study period
- Of these, 4,780 were scheduled deliveries (26% of the 36<sup>0/7</sup> to 38<sup>6/7</sup> week population)

% Non-medically Indicated Deliveries <39 Weeks, January 1999 – December 2005

Results (1): Fewer Births at 36<sup>0/7</sup>-38<sup>6/7</sup> Weeks Without Documented Medical or Obstetrical Indications
### Results (2): Fewer Births at 36\(^{0/7}\) - 38\(^{6/7}\) Weeks Induced Without Medical or Obstetric Indication

![Graph showing fewer births at 36-38 weeks induced without medical or obstetric indication.](image)

Wouldn't Keeping Women Pregnant for Longer Increase Their Risk of Adverse Outcomes?

- The experience in Ohio and Utah has shown that morbidity remained the same for macrosomia, preeclampsia, and maternal infections.
- Decreases were seen in stillbirth, low Apgar scores, cesarean section for fetal distress, meconium aspiration and postpartum anemia.

### Results (3): Fewer Total Births at 36-38 Weeks (and More Births at 39-41 Weeks)

![Graph showing increased births in 39-41 weeks compared to 36-38 weeks.](image)

### Stillbirths Before and After Implementation of Guidelines at Intermountain Healthcare

<table>
<thead>
<tr>
<th>Weeks of Gestation</th>
<th>Stillbirths Before</th>
<th>Deliveries Before</th>
<th>%</th>
<th>Stillbirths After</th>
<th>Deliveries After</th>
<th>%</th>
<th>Odds Ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>9,051</td>
<td>21</td>
<td>0.43</td>
<td>12,671</td>
<td>28,239</td>
<td>0.43</td>
<td>0.88</td>
<td>0.72-1.09</td>
</tr>
<tr>
<td>39</td>
<td>10,302</td>
<td>29</td>
<td>0.77</td>
<td>51,751</td>
<td>183,380</td>
<td>0.55</td>
<td>0.74</td>
<td>0.60-0.90</td>
</tr>
<tr>
<td>40</td>
<td>9,284</td>
<td>14</td>
<td>0.15</td>
<td>24,183</td>
<td>26,970</td>
<td>0.46</td>
<td>0.96</td>
<td>0.80-1.16</td>
</tr>
<tr>
<td>41</td>
<td>2</td>
<td>5</td>
<td>0.10</td>
<td>5,571</td>
<td>12,146</td>
<td>0.05</td>
<td>1.00</td>
<td>0.55-1.92</td>
</tr>
<tr>
<td>42</td>
<td>18</td>
<td>84</td>
<td>0.15</td>
<td>127,478</td>
<td>243,158</td>
<td>0.07</td>
<td>0.90</td>
<td>0.53-1.56</td>
</tr>
</tbody>
</table>


### Alleviating Obstetricians' Fears About Delaying Delivery

Obstetricians in several of these studies voiced concerns regarding a potential increase in perinatal mortality and maternal morbidity.

### Summary: Reasons to Eliminate Non-Medically Indicated Deliveries Before 39 Wks

- Reduction of neonatal complications
- No harm to mother if no medical or obstetrical indication for delivery
- Now a national quality measure:
  - National Quality Forum (NQF)
  - Leapfrog Group
  - The Joint Commission (TJC)
Additional Strategies to Engage Providers

- Share successes
- Know your data and key morbidities (stillbirths, low apgars, meconium aspiration syndrome)
- Offer to educate the office staff
  - They are remote from the actual deliveries and may not be aware of women’s perception of term and when it is “safe” to deliver

Background

- Approximately 2800 deliveries per year
- Part of New York City Health and Hospital Corporation
- Faculty and Resident Physicians are employees of the Hospital
- I am thankful to be the Associate Chairman and I think of everyone on our team as leaders.

Physician Engagement

- What did we do to engage the MDs?
  - Present as an opportunity to enhance care for patients
    - We presented this program to reduce the rate of prematurity at our institution by stating “we are grateful for the guidance and resources offered by the initiative and are particularly excited about decreasing the incidence of the preterm delivery at our site.”
  - Present the evidence behind the approach
  - Engender true commitment

Implementation

- Redefined Ethics
  - Patients are our family members.
- Verbal Oaths
  - Resident and attending physicians were asked to take a verbal oath promising to document the Bishop Scores prior to all 36 0/7 to 38 6/7 week inductions.
- Mental Stimulation
  - Teaching mental stimulation elements regarding late preterm labor induction. Including retrospective review of cases with the entire team.
Enforcing Policy

- What do you do if MDs attempt to schedule without medical indication?
- The Induction Schedule is reviewed in real time by an oversight group of OB and MFM attendings and MFM resident.
- All inductions between 36 weeks and 38 6/7 weeks of gestation are reviewed.
- Any induction without a medical indication is presented to the MFM and Chairman.

Questions?

Data Use

- Do you use data to inform the MDs how they are doing?
- All data from the Initiative is presented to staff monthly
- Our induction rate has been 0% for medical inductions from 36 0/7 to 38 6/7 weeks
- We have focused on improvements of Bishop score documentation by emphasizing what we call “Best Efforts Practice” and the “value of consistent expectation”.

Next Steps

Lorraine Ryan
Christa Christakis

Thank you to the NYSPQC/NYSPFP Perinatal Collaborative

Next Steps

Data
- Data reporting through the HCS
- December data entry is due Wednesday, January 30
Next Steps

PDSAs
- Continue to share your PDSA cycles and developed project tools by sending them to your NYSPFP Project Manager
- If not participating in NYSPFP, send to Kristen at NYSPQC@health.state.ny.us

Survey

https://www.surveymonkey.com/s/VDGK5G

Next Steps

February Calls
- February Coaching Call
  - February 19, 2013 @ 11 a.m. ET
  - Case definition – Scheduled Delivery
  - Data

Contact

NYSPQC Project Team at DOH
- Phone: (518) 473-9883
- E-mail: NYSPQC@health.state.ny.us

NYSPFP Project Managers
- Contact your hospital’s designated PM
Coaching Call, October 16, 2012

Welcome
- Thank you for joining the call!
- Please mute your line by using the mute button, or by dialing * 6.
- For purposes of attendance, chat the following information to Kristen Farina, NYSPQC Program Coordinator:
  - Your name
  - Full facility name
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Agenda

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<td>11:05 a.m.</td>
<td>Review of Project Case Definition</td>
<td>Dr. Pete Cherouny/ Pat Herrnich</td>
</tr>
<tr>
<td>11:20 a.m.</td>
<td>PDSA Review and Example</td>
<td>Pat Herrnich</td>
</tr>
<tr>
<td>11:30 a.m.</td>
<td>Sharing and Learning Discussion of Lessons Learned from PDSAs</td>
<td>Invited Teams Share PDSAs Discussion - All</td>
</tr>
<tr>
<td>11:45 a.m.</td>
<td>Example of Measures and Reporting</td>
<td>Kristen Farina/ Todd Gerber</td>
</tr>
<tr>
<td>11:55 a.m. – 12:00 p.m.</td>
<td>Next Steps</td>
<td>Lorraine Ryan/ Christa Christakis</td>
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</tbody>
</table>

Case Definition: Our Target Population
Peter Cherouny, M.D.

WebEx Instructions
- If you do not have a mute button on your phone, dial * 6 to mute and/or unmute your line
- Utilize the Chat Box to the right of your screen for any questions
- Please chat to all participants unless you have a specific question for the host
- To “raise your hand”, simply click on the “raise hand” icon on the participants panel — this will show the presenter and the host that you would like to speak
- To cancel a request to speak, click on the “lower hand” icon

Case Definition
- All inductions and cesarean sections that occur prior to the onset of labor between 36 0/7 and 38 6/7 weeks gestation.
- This is not limited to electively scheduled deliveries.
Case Definition

- This includes patients diagnosed with ruptured amniotic membranes who are not in labor and subsequently undergo induction of labor (medically indicated by PROM).
- Induction of these patient vs. augmentation need be defined locally so that there is internal consistency.

Case Definition

- Examples:
  - Patients not in active labor are considered labor inductions (even if medically indicated).
  - Augmentation generally occurs with inadequate or a lack of progress in the active phase of labor.

Case Definition

- Examples:
  - Patient arrives at 36+2 with massive bleeding and a grade 3 abruption placenta would not be a scheduled cesarean section.
  - Patient at 37+5 with minimal bleeding and likely grade 1 abruption whom you elect to induce labor due to a balance of risks/benefits is a scheduled delivery.
  - Any patient with a medical indication where waiting (even a short period of time) is a reasonable medical option.

Model for Improvement: 3 Fundamental Questions

What are we trying to accomplish?  
- AIM

How will we know that changes are an improvement?  
- Measures

What changes can we make that will result in an improvement?  
- Ideas
Test vs. Task
Both are necessary but they are NOT the same!

Tests v. Tasks

A Test:
- Provides quick feedback
- Allows you to try something
- Allows you to make changes
- Helps identify what changes should be made

A Task:
- Is the Vital Behavior that has to happen for the action to take place
- Should be identifiable
- Should be defined
- Might be supported by evidence

What is a test?
- Putting a change into effect on a temporary basis & learning about its impact

Tests v. Tasks

Desired Change – eating a healthier diet.

What it is NOT!
- Data collection
- Implementing a solution
- A project plan OR an action plan
- Rolling out an educational program
- Getting a form, policy, procedure approved by the official committees

Why test?
- Forces us to think small
- Increase your belief that the change will result in improvement
- Predict how much improvement can be expected from the change – and confirm or abandon your prediction
- Opportunity for learning without impacting performance
- Learn how to adapt the change to conditions in the local environment
Why test?
- Evaluate costs and side-effects of the change
- Minimize resistance upon implementation
- Localize a good idea to my practice setting
- Will allow you to see how to adapt and make changes before implementing
- Provides a history for how you came to your end result

The PDSA Cycle for Learning and Improvement

- **Act**
  - Adopt, Adapt, Abandon
  - What changes are to be made?
  - Next cycle?
- **Plan**
  - Objective
  - Questions and predictions (why)
  - Plan to carry out the cycle (who, what, where, when)
  - Plan for data collection
- **Study**
  - Complete the analysis of the data
  - Compare data to predictions
  - Summarize what was learned
- **Do**
  - Carry out the plan
  - Document problems and unexpected observations
  - Begin analysis of the data

Starting the PDSA Worksheet

- **PLAN**
  - Articulate the test - Opening our C/S calendar for 2 scheduled deliveries on Saturdays
  - How well practiced for change is in improvement?
  - Driver: Hospital and physician practice policies that facilitate ACOG criteria
  - What does the change impact?
  - Key Change: Facilitate scheduling policies that respect ACOG criteria
  - What do you expect will happen?
    - We will book 2 deliveries on Sat and the doctors won't push for <90 work patients to be booked on Thu and Fri because no weekend slots
- **DATA**
  - Implementation of Change
  - Wide-Scale Tests of Change - designed to predict and prevent failures
  - Hunches, Theories, Ideas
  - Follow-up Tests - a variety of conditions to identify weaknesses
  - Very Small Scale Test - simple and designed to succeed

Repeated use of PDSA cycle

- Changes that result in improvement
- Plan for collection of data - 반드시 모든 정보를 기록하여 (Sept 2012) Review monthly Patient Satisfaction Scores

---

Educational Presentations continued
DO

DO: Test the changes.
Was the cycle carried out as planned? □ Yes □ No

Record data and observations: 2 deliveries scheduled on each of 3 Saturdays, one on 4th Sat. Susie reported less arguments about Friday deliveries being done at 3886

What did you observe that was not part of our plan? 3 Mothers were very happy husbands didn’t have to miss as much work.

STUDY

STUDY: Did the results match your predictions? □ Yes □ No

Compare the result of your test to your previous performance: Easier to convince the MDs to wait to 38 if they have options

What did you learn?

Sharing and Learning Teams Report-Out

- A.O. Fox Hospital
- Cortland Regional Medical Center
- Kings County Hospital Center
- UHSH – Wilson Medical Center

Support with PDSAs

- NYSPFP Project Managers will now be providing support of PDSA cycles and worksheets
- If not participating in NYSPFP, Kristen will be providing you with support

Sharing and Learning Teams Report-Out

- Briefly describe your prediction and what you tested.
- What did you learn (expected and unexpected lessons learned)?
- What do you plan to do next?

PDSA Worksheet #2

- Continue to work on your PDSA cycles and send your second PDSA Worksheet to your NYSPFP Project Manager
- If not participating in NYSPFP, send to NYSPQC@health.state.ny.us
- PDSA Worksheet #2 is due October 30
Example of Measures
Kristen Farina

Reporting
Todd Gerber

Reporting

Reminders
- Health Commerce System (HCS) accounts
- September data is due **October 31**
- FAQ document
- Send additional questions to NYSPQC@health.state.ny.us

Next Steps
Lorraine Ryan and Christa Christakis
Next Steps

Data
- HCS accounts
  - Apply
  - Follow-up with CAMU if necessary
  - Report HCS account ID to DOH
- Data reporting through the HCS
  - September data entry is due October 31

Next Steps

PDSAs
- Continue to share your PDSA cycles and developed project tools by sending to your NYSPFP Project Manager
- If not participating in NYSPFP, send to NYSPQC@health.state.ny.us
- PDSA Worksheet #2 due October 30

Contact

NYSPQC Project Team at DOH
- Phone: (518) 473-9883
- E-mail: NYSPQC@health.state.ny.us

NYSPFP Project Managers
- Contact your hospital’s designated PM

Survey

https://www.surveymonkey.com/s/NH8Z77Y

Next Steps

First Educational Webinar
- Learning From Fetal Loss
- Presented by Pete Cherouny, M.D.
- November 13, 2012 @ 2 p.m. ET

Next Coaching Call
- November 20, 2012 @ 11 a.m. ET
Improvement Strategies: Utilizing Bundles and Protocols

Peter Cherouny, MD
University of Vermont
Division of Maternal-Fetal Medicine

Objectives

1. Introduce and define the concept of the bundles
2. Use the perinatal bundles as examples of reliable design
3. Results

Learning Objectives

At the end of the presentation, the participant:

- Will be able to state what a clinical bundle represents
- Will be able to describe the induction and augmentation bundles
- Will be able to implement bundles in their work setting

Disclosures
Dr. Cherouny has no conflict of interest to disclose.
**Why focus on perinatal care?**

2007
4,317,119 births in US

Birth trauma 6.3-7.3/1000
estimated 50-90% are preventable

---

**What do we want to do?**

Prevent the preventable
Defend the unpreventable

---

**What does that mean for NY?**

New York State
1600-1900/yr
800-950 preventable

---

**What is Idealized Design of Perinatal Care?**

- The development of reliable clinical processes to manage labor and delivery (Perinatal Bundles)
- The use of principles that improve safety (i.e., preventing, detecting, and mitigating errors)
- The establishment of prepared and activated care teams that communicate effectively with each other and with mothers and families

---

**What does that mean for US?**

27,000-32,000 injured babies total
13,500-16,000 preventable

---

**Reasons for the Reliability Gap In Healthcare**

- Communication
  - 84% of sentinel events reported to JCAHO involving fetal/infant adverse events cited communication among care providers as the primary factor

**What is Reliability?**

> “Reliability is failure free operation over time.”

David Garvin
Harvard Business School

---

**The Reliability Design Strategy**

- Prevent initial failure
  - Intent and standardization function
- Identify failure (defects) and mitigate
  - Redundancy function
- Measure and then communicate learning from defects
  - Redesign function

---

**Why Standardize?**

- Contributes to building an infrastructure (who does what, when, where, how and with what)
- Support training and competency testing to sustain the process
- Achieve front line articulation of key processes by staff
- Allows the appropriate application of Evidence Based Medicine consistently
- Feedback about errors and application of learning to design is possible

---

**What is Reliability?**

- Individual Autonomy
- Guidelines as defined by professional standards
- Legal space
- Usual space
- Illegal-normal space
- Very unsafe space

---

**The Clinical Bundle as Standardization**

- Forbidden behavior except under extreme circumstances
- Guidelines as defined by professional standards
- Legal space
- Perceived vulnerability
- Systemic guidelines
- Feedback about errors and application of learning to design is possible
What is a Clinical Bundle

- A group of clinical events that should happen every time a given process occurs
- Individual elements based on solid science
- Emphasis initially on process rather than outcome
- Based on failure modes
- Eventual endpoint is outcome improvement

Assault on Everest Summit

- Summit Bundle
  - Acclimatization at altitude
  - Work together
  - Cannot assist someone on the ascent
  - Fixed turn around time

What is a Clinical Bundle

- Bundle example with your life on the line
- Into Thin Air by Jon Krakauer
  - Assault on Everest, Spring, 1996

Assault on Everest Summit

- Summit Bundle
  - Standard acclimatization techniques
    - # days and at what altitude
  - Work together
  - Cannot assist someone on the ascent
  - Fixed turn around time

Assault on Everest Summit

- Hard and Fast Rules
  - Acclimatization at altitude
  - Work together
  - Cannot assist someone on the ascent
  - Fixed turn around time

Assault on Everest Summit

- Summit Bundle
  - Standard acclimatization techniques
    - # days and at what altitude
  - Practice team work (between and among teams)
  - Cannot assist someone on the ascent
  - Fixed turn around time
Assault on Everest Summit
Summit Bundle

- Standard acclimatization techniques
  - # days and at what altitude
- Practice team work (between and among teams)
- No “short-roping” on the ascent
  - No assisting with climbing on the ascent
- Fixed turn around time

Assault on Everest Summit
Summit Bundle Compliance

- All teams acclimatized but there was no standard
- Teams refused to cooperate on timing through Hilary’s Step (one person rope)
- Some climbers were assisted on the ascent as it was felt they had to summit on this climb
- Turn around time was set but not honored
  - Last summit was about 5 PM

Assault on Everest Summit
Summit Bundle

- Standard acclimatization techniques
  - # days and at what altitude
- Practice team work (between and among teams)
- No “short-roping” on the ascent
  - No assisting with climbing on the ascent
- Turn around time fixed and honored
  - (1 PM for most groups)

Assault on Everest Summit
Result

- Experienced leader; summits at 3PM
- Less experienced leader; assisted two climbers up
- Inexperienced leader; split group up with one climber summiting at 5 PM

Assault on Everest Summit
Result

- Eleven Deaths
- Survivors
  - PTSS
  - Marital problems
  - Work problems

Educational Presentations continued
Assault on Everest Summit
Summit Bundle

- Standard acclimatization techniques
  - # days and at what altitude
- Practice team work (between and among teams)
- No “short-roping” on the ascent
  - No assisting with climbing on the ascent
- Turn around time fixed and honored
  - (1 PM for most groups)

Mindful Practice

- It is not enough to do your best
  you must know what to do
  and then do your best

  - W. Edwards Deming

Quality Care in Obstetrics
Birth Trauma

- Causation
  - Large fetuses
  - Operative vaginal deliveries (esp midpelvic & combined)
  - Vaginal breech delivery
  - Inappropriate use of pitocin
  - Abnormal/excessive traction
  - Inadequate assessment of fetal status

Quality Care in Obstetrics

- Prevention
  - Don’t deliver large fetuses
  - Don’t do Operative vaginal deliveries
  - Don’t do Vaginal breech delivery
  - Don’t use pitocin
  - Don’t pull too hard
  - Interpret fetal status perfectly

Quality Care in Obstetrics

- Pitocin Bundles as standardization of care
  - Developing the Bundles

Quality Care in Obstetrics
Birth Trauma

- Prevention
  - Practice Dermatology
Quality Care in Obstetrics
Birth Trauma and Pitocin

Causation
- Large fetuses
- Operative vaginal deliveries (esp midpelvic & combined)
- Vaginal breech delivery
- Inappropriate use of pitocin (tachysystole)
- Abnormal/excessive traction
- Inadequate assessment of fetal status

Pitocin is involved in over 50% of the situations leading to birth trauma

Prevention of Pitocin Related Trauma
- Identify large babies
- Don’t do midpelvic deliveries when macrosomia is suspected
- Limit vaginal breech delivery
- Identify and respond to tachysystole
- Avoid abnormal/excessive traction
- Interpret fetal monitor by consensus guidelines

Use Pitocin Safely and Effectively
- Know everything about the drug
- Have established protocols and use them

Use Pitocin Safely and Effectively
- Know everything about the drug
- Have established protocols and use them
Quality Care in Obstetrics

**Pitocin Use**

**Requirements for elective labor induction**
- Assessment of gestational age
- Monitoring fetal heart rate for reassurance
- Monitoring uterine contractions for tachysystole
- Pelvic assessment

**Confirmation of Term Gestation**
- Fetal heart tones have been documented for 20 weeks by nonelectronic fetoscope or for 30 weeks by Doppler.
- It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test was performed by a reliable laboratory.
- An ultrasound measurement at less than 20 weeks supports gestational age of 39 weeks or greater.
- Amniocentesis and documentation of fetal maturity

**Assessment of gestational age**
- Confirmation of Term Gestation
- Iatrogenic prematurity is unacceptable and indefensible
Requirements for elective labor induction
- Assessment of gestational age
- Monitoring fetal heart rate for reassurance
- Monitoring uterine contractions for tachysystole
- Pelvic assessment

Monitoring fetal heart rate for reassurance
- Reassuring Fetal Status – use a common language (NICHD)
- Personnel familiar with the effects of uterine stimulants on the fetus
- Physician capable of performing a cesarean delivery should be readily available and responds when asked
Quality Care in Obstetrics

Elective Labor Induction - Requirements

**Requirements for elective labor induction**
- Assessment of gestational age
- Monitoring fetal heart rate for reassurance
- Monitoring uterine contractions for tachysystole
- Pelvic assessment

**What is Tachysystole**
- > 5 contractions in 10 minutes
- Contractions persistently lasting greater than 2 minutes
- < 60 seconds baseline tone between contractions
- Tachysystole associated with fetal compromise not necessary

**Monitoring uterine contractions for tachysystole**
- Personnel familiar with the effects of uterine stimulants
- Monitoring fetal heart rate and uterine contractions is recommended as for any high-risk patient in active labor

**Pelvic assessment**
- Cervical evaluation
  - Bishop's Score
- Fetal presentation and size
- Clinical Pelvimetry
Educational Presentations continued

**Quality Care in Obstetrics**

*Elective Labor Induction - Requirements*

*Requirements for elective labor induction*
- Assessment of gestational age
- Monitoring fetal heart rate for reassurance
- Monitoring uterine contractions for tachysystole
- Pelvic assessment

**Quality Care in Obstetrics**

*Elective Labor Induction - Requirements*

*Elective Labor Induction Bundle*
- Gestational age ≥ 39 weeks
- Monitoring fetal heart rate for reassurance
- Monitoring uterine contractions for tachysystole
- Pelvic assessment

**Quality Care in Obstetrics**

*Elective Labor Induction - Requirements*

*Elective Labor Induction Bundle*
- Assessment of gestational age
- Monitoring fetal heart rate for reassurance
- Monitoring uterine contractions for tachysystole
- Pelvic assessment

**Quality Care in Obstetrics**

*Elective Labor Induction - Requirements*

*Elective Labor Induction Bundle*
- Gestational age ≥ 39 weeks
- Category I EFM
- Monitoring uterine contractions for tachysystole
- Pelvic assessment

**Quality Care in Obstetrics**

*Elective Labor Induction - Requirements*

*Elective Labor Induction Bundle*
- Confirmation of Fetal Maturity
- Monitoring fetal heart rate for reassurance
- Monitoring uterine contractions for tachysystole
- Pelvic assessment

**Quality Care in Obstetrics**

*Elective Labor Induction - Requirements*

*Elective Labor Induction Bundle*
- Gestational age ≥ 39 weeks
- Category I EFM
- Absence of tachysystole with increases in pitocin/Response to tachysystole
- Pelvic assessment
Quality Care in Obstetrics

**Elective Labor Induction**

**Induction Bundle**
- Gestational age ≥ 39 weeks
- Category I EFM
- Absence of tachysystole with increases in pitocin/Response to tachysystole
- Pelvic assessment

**Quality Care in Obstetrics**

**Augmentation Requirements**

**Augmentation Bundle**
- Estimated fetal weight
- Category I and some Category II EFM
- Absence of tachysystole with increases in pitocin/Response to tachysystole
- Pelvic assessment

**Quality Care in Obstetrics**

**Augmentation Requirements**

**Augmentation Bundle**
- Gestational age ≥ 39 weeks
- Category I EFM
- Absence of tachysystole with increases in pitocin/Response to tachysystole
- Pelvic assessment

**Perinatal Care and IHI Perinatal Bundle**

**Results**
- Measure, Measure, Measure

**Quality Care in Obstetrics**

**Augmentation Requirements**

**Augmentation Bundle**
- Estimated fetal weight
- Category I EFM
- Absence of tachysystole with increases in pitocin/Response to tachysystole
- Pelvic assessment

**Seton Hospital Alpha Sites**

**Birth Trauma**

[Graph image showing data distribution]
Quality Care in Obstetrics  
*Preventing Trauma with Vacuum Delivery*

- **Bundle Components**
  - Individual components supported by science
  - Required to be performed for every patient, every time
  - Bundle compliance measured by fulfilling all parts of the bundle
  - Focus on system

---

**Preliminary considerations**
- Consider alternative management
- High chance of success
- Exit strategy prepared
- Prepared patient
  - Informed consent
  - Resuscitation team available

---

**Vacuum Bundle**
- Alternative labor strategies considered
- Prepared patient
  - Informed consent discussed and documented
  - High probability of success
    - EFW, fetal position and station known
  - Maximum application time and number of pop-offs predetermined
- Exit strategy available
  - Cesarean and resuscitation team available

---

**Technical considerations**
- Fetal parameters known and considered
  - EFW, Station, Position
- Application time and pop-offs limited
- Torque in direct line of birth canal
  - No rocking movements
Gestational Age Reliability Project

Objectives and Goals
- Evaluate the accuracy of gestational dating by historic and ultrasound measures
- Recognize the limitations of menstrual dating
- Use available data to develop tools to assess the accuracy of gestational dating at your institution

Gestational Age Assessment
- Accurate assessment of gestational age
  - Allows better assessment of fetal outcome by one week blocks
  - Induction protocols
    - < 39 weeks
    - ≥ 41 weeks
- Risk/benefit balance is used in the assessment of need for delivery
- The “risk” part for the fetus/neonate for delivery is generally driven by the gestational age

Gestational Age Assessment
- Accurate assessment of gestational age is core to what we do
  - Periviable counseling
    - Days makes a difference
  - Preterm labor management
    - To treat or not to treat

Gestational Age Assessment
- Ask 5 people...
Gestational age

- Gestational age assessment at your institution – is it reliable?
- How do you know it is reliable?
- What makes it reliable?

Gestational age assessment – is it reliable?

- Do you have a standard for determining and "correcting" gestational/menstrual dating?
- Is there consistent use of the gestational dating once it is established?
- Is there frustration among patients and providers over dating criteria?
- Are you assuming added risk for patients and babies based on an unreliable assessment of gestational age?

The Data

- Based on ovulation dates 1st and 2nd trimester US
  - CRL has error of around 2.1 days
  - BPD error 2.8 days
  - BPD and FL error 2.2 days
  - FL alone 3.1 days


The Data

- 208 singleton IVF pregnancies
  - CRL vs IVF dates 0.9 day different EGA
  - BPD vs IVF dates 2.1 day different EGA


The Data

- Meta-analysis – Cochrane’s database
  - Relative risk for post dates with ultrasound dating is 0.49
  - Induction for any reason RR=0.78
  - Induction for postdates pregnancy RR=0.61
  - No increase in preterm deliveries

Ultrasound for fetal assessment in early pregnancy (Review) ii
Copyright © 2010 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.
What is Reliability?

• “Reliability is failure free operation over time.”
  David Garvin
  Harvard Business School

• “When applied to clinical processes consider the viewpoint of the patient by invoking the all or none measure.”
  IHI Innovation Team

DISCUSSION

• Select a process for improvement.
  Assessment of gestational age

• Are there steps in the process where…
  – if you asked each individual assigning gestational age, would there be differences?
  – this is documented in the medical record?

Design Strategy for Reliability

• Prevent Initial Failure using intent and standardization

• Identify failure and mitigate
  – Redundancy function

• Redesign from failure modes (identify critical failures and then redesign)

Why Standardize?

• Contributes to building an infrastructure (who does what, when, where, how and with what)
• Supports training and competency testing to sustain the process
• Achieve front line articulation of key processes by staff
• Allows the appropriate application of evidence-based medicine consistently
• Feedback about defects and application of learning to design is possible

Gestational age assessment

Suggested gestational dating paradigm:

-First day of LMP should be
  • 1) accurately known and documented
  • 2) in a patient with regular menstrual cycles (28 +4d)
  • 3) in a patient who has not recently come off hormonal contraception.

Suggested gestational dating paradigm:

• If all conditions are met
  – Gestational dating should be considered confirmed by an ultrasound
    ➢ if a first trimester ultrasound CRL is within 4 days of the menstrual dating or
    ➢ If a second trimester BPD is within 6 days
  – After 20 weeks, a significant difference in ultrasound and menstrual dating should be viewed as a gestational range
Gestational age assessment

**Suggested gestational dating paradigm:**

- **If all conditions are met**
  - Gestational dating should be established by ultrasound, preferably between 6 and 10 weeks, by crown rump length measurements that are recorded for review as needed (Yolk sac or gestational sac measurement is not acceptable for accurate dating).
  - No matter how the menstrual dates correlate with the ultrasound dating, ultrasound dating should be used.

- **If all conditions are not met**
  - Gestational dating should be established by ultrasound, preferably between 6 and 10 weeks, by crown rump length measurements that are recorded for review as needed (Yolk sac or gestational sac measurement is not acceptable for accurate dating).
  - No matter how the menstrual dates correlate with the ultrasound dating, ultrasound dating should be used.

---

**Questions/ Educational Presentations continued**
Learning from Fetal Loss

Peter Cherouny, M. D.
Emeritus Professor, Obstetrics, Gynecology and Reproductive Sciences
University of Vermont College of Medicine

Fetal Demise (aka stillbirth)
Objectives

• At the end of the presentation, the participant will:
  – Recognize the relationship of fetal death across the range of gestational age
  – Understand the relationship between fetal death neonatal risk at different gestational ages
  – Employ the recommended work up for fetal death in clinical cases

Fetal Demise

• Incidence – 6.23 or approx 1/160
• Number – 4.3 million deliveries per year
  – 25,000 stillbirths/year
• Definition
  – Apgars 0/0; no signs of life
  – 20 weeks or greater or 350 gms or greater
• Note: Patient groups prefer stillbirth to fetal death

Fetal Demise by gestational age groups

Fetal Demise with decreasing elective early term deliveries

Fetal Death Risk

• Perinatal Mortality rate
  – Fetal MR + Neonatal MR
• Fetal MR represents 58% of the PMR
• FMR 6.23 in 2003

Fetal Death Risk

• FMR 6.23
  - 80.3% of Fetal Mortality occurs prior to term
    • FMR at term is 1.2


Fetal Death Risk

• NY State FMR 4.51 after 24 weeks
  - 80.3% of Fetal Mortality occurs prior to term
    • FMR at term is 0.9


Fetal Death Risk

- Baseline FMR 1.2

- False negative rate of antepartum fetal testing is 0.6-1.9/1000

- In general, a tested high-risk population has about one-half the fetal death rate as an untested low-risk population

Specific Diagnoses and Fetal Death Risk

– Diabetes
  • 2-3 fold increased risk of perinatal mortality
  • Congenital malformations, respiratory distress syndrome (RDS), and extreme prematurity account for most perinatal deaths in contemporary diabetic pregnancies

– Growth Restriction
  • Marked increased risk of perinatal mortality
  • 60+% of increased perinatal risk is related to fetal death
  • Nonanomalous fetal death related to placental issues which are testable
  • Unclear if delivery is the best option


Specific Diagnoses and Fetal Death Risk

– Chronic Hypertension in Pregnancy
  • 3 fold increased risk of perinatal mortality
    – Unclear benefit of antihypertensive therapy
    – Fetal risk increased in pregnancies with superimposed preeclampsia (85% of increased fetal risk) and growth restricted fetuses (15%)

– Components of Evaluation
  • Fetal Assessment
  • Placental Assessment
  • Maternal Assessment


Specific Diagnoses and Fetal Death Risk

– Twins
  • Unclear if increased perinatal mortality when compared to singletons by gestational age
  • General consensus that fetal risk lowest at approximately 38 weeks

– Fetal and Placental Evaluation
  • Fetal Autopsy
  • Fetal Karyotype
  • Placenta, Cord, Membrane Assessment
    – Gross and microscopic


The Evaluation of Fetal Demise
The Evaluation of Fetal Demise

– Alternatives to Autopsy
  • Limited external examination
  • Imaging studies – MRI, US
– Fetal Karyotype
  • Amniocentesis appears to be the best option
  • Placental membrane or fetal sampling has a lower yield
– Placenta, Cord, Membrane Assessment
  • Examination by a perinatal pathologist

Fetal Demise - conclusion

– Fetal death is an appropriate balancing measure
– Collaborative Fetal Demise numbers do not currently differentiate by gestational age
– Fetal demise risk at term is lower or equivalent to neonatal mortality and Cerebral Palsy risk
– Appropriate evaluation is necessary to assess fetal demise causation and to appropriately define preventability

The Evaluation of Fetal Demise

– Maternal Assessment
  • Detailed history
  • Laboratory assessment
    – Include Parvovirus B19 IgG & IgM, K-B test, Thyroid (TSH), Toxocosis (blood and serum) and Glucose screening as appropriate
    – Thrombophilia assessment in select cases
  • Developing Technology
    – Genomic hybridization

NYSDOH Key Drivers

1. Awareness of risks/expected benefit of late preterm an early term delivery by patients and consumers
2. Dating criteria: optimal estimation of gestational age
3. Hospital and physician practice policies that facilitate ACOG criteria
4. Awareness of risks/expected benefit of late preterm and early term delivery by clinician
5. Culture of safety and improvement

The Evaluation of Fetal Demise

– Recommended Quality Measurement
  • Number of patients where autopsy is performed and offered
  • Number a patients where the placenta was evaluated
  • Number of patients where proper maternal assessment was performed

Late Preterm Deliveries & Early Term Deliveries


NYSDOH OB Expert Work Group Webinar - July 12, 2010

59
Coaching Call, September 16, 2014

Welcome and Introductions
Lorraine Ryan

Agenda

<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>SPEAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00 a.m.</td>
<td>Welcome and Introductions</td>
<td>Lorraine Ryan</td>
</tr>
<tr>
<td>11:00 – 11:10 a.m.</td>
<td>Progress to Date</td>
<td>Kristen Lawless</td>
</tr>
<tr>
<td></td>
<td>OB Toolkit</td>
<td></td>
</tr>
<tr>
<td>11:10 – 11:55 a.m.</td>
<td>Sustaining the Gains</td>
<td>Pat Heinrich, RN, MSN, Pete Chernou, MD</td>
</tr>
<tr>
<td>11:55 – 12:00 p.m.</td>
<td>Next Steps</td>
<td>Loretta Willis</td>
</tr>
</tbody>
</table>
Common reasons for medically unindicated deliveries

- Breech
- Decreased fetal movement
- Polyhydramnios
- Repeat C-section
- Twins (Not Moni-Di or 38 weeks)
- Vaginal bleeding

Scheduled Delivery Reminders

- Cases in spontaneous active labor should **not** be included in monthly data collection/ submission
- Ensure you are checking the appropriate maternal or fetal reason when available as opposed to checking “other”
  - Example: “Placental Abruption” is listed under #20, “Maternal reasons”, this indication was incorrectly listed by facilities in the “other” category

Scheduled Delivery Data Completeness

<table>
<thead>
<tr>
<th>Month</th>
<th>Hospitals Submitting</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2013</td>
<td>94.8% (92/97)</td>
</tr>
<tr>
<td>November 2013</td>
<td>94.8% (92/97)</td>
</tr>
<tr>
<td>December 2013</td>
<td>92.8% (90/97)</td>
</tr>
<tr>
<td>January 2014</td>
<td>95.9% (93/97)</td>
</tr>
<tr>
<td>February 2014</td>
<td>94.3% (92/97)</td>
</tr>
<tr>
<td>March 2014</td>
<td>94.3% (92/97)</td>
</tr>
<tr>
<td>April 2014</td>
<td>92.8% (90/97)</td>
</tr>
<tr>
<td>May 2014</td>
<td>90.7% (88/97)</td>
</tr>
<tr>
<td>June 2014</td>
<td>67.6% (85/97)</td>
</tr>
<tr>
<td>July 2014</td>
<td>72.2% (70/97)</td>
</tr>
</tbody>
</table>

Maternal Hemorrhage/Hypertension Data Completeness

- 74 facilities have signed a letter of commitment with NYSPFP to participate in the maternal hemorrhage/hypertension portion of the project

<table>
<thead>
<tr>
<th>Month</th>
<th>Hospitals Submitting</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2014</td>
<td>60.6% (45/74)</td>
</tr>
<tr>
<td>May 2014</td>
<td>58.1% (43/74)</td>
</tr>
<tr>
<td>June 2014</td>
<td>59.5% (44/74)</td>
</tr>
<tr>
<td>July 2014</td>
<td>44.6% (33/74)</td>
</tr>
</tbody>
</table>
Data Submission

- Due COB Wednesday, September 24, 2014:
  - August 2014 data for scheduled deliveries, stillbirths, PC-01, hemorrhage, and pre-eclampsia
  - Please try to complete outstanding data collection/submission as soon as possible
  - Send questions to NYSPQC@health.state.ny.us or call 518/473-9883
OB Toolkit

- Compiled policies, forms, tools, etc. from participating hospital teams for inclusion
- Tools were reviewed by Dr. Cherouney
- Teams edited as appropriate

- If your team did not submit any items for the toolkit, but would like Dr. Cherouney to review materials, email to: NYSPQC@health.ny.gov

Sustainability

“There will come a time when you think you are finished. That will be the beginning.”
Louis L’Amour

OB Toolkit

- Toolkit also contains presentation slides, data and QI tools
- Electronic version of toolkit will be available on NYSPQC website
- All hospital teams will receive hard copy of the toolkit

This, too, could happen to you?

Or not...
Educational Presentations continued

Challenge...

Holding Gains During Testing
- Test the changes under a wide range of conditions
- Consider change ideas (concepts) that lead to more reliable design
- Standardize process (create formal process)
- Use reminders and differentiations
- Provide information on why the change is being made and how it will affect people. Ask for input
- Celebrate early successes

Change is Hard

Requires more than persistence

Holding Gains During Implementation
- Supportive Management Structure
- Structures to “ Foolproof ” Change
- Robust, Transparent Feedback Systems
- Shared Sense of the Systems to Be Improved
- Culture of Improvement and a Deeply Engaged Staff
- Formal Capacity-Building Programs

* Source: Improvement leader’s guide to sustainability and spread. NHS Modernisation Agency, Ipswich, England; Ancient House Printing Group; 2002

Importance of Sustainability Strategies Throughout Phases of Work

Supportive Management Structure
- Leaders have created accountability systems
- Leaders have effectively communicated measurable improvement aims and the importance of sustaining performance
- Leaders celebrate successful attainment of improvement targets along the way
**Structures to Foolproof Change**

- Successful processes, protocols and guidelines have been documented and designed into training materials.
- Tools such as checklists and pre-packaged kits have been developed for staff to use in various interventions.
- Wherever possible, technology is used to support sustained implementation of the intervention.

Make the new way unavoidable--make it hard to do the wrong thing!

---

**Culture of Improvement & Deeply Engaged Staff**

- Everyone is clear on major performance improvement activity and can explain their role in it.
- Staff view quality improvement as part of their job.
- Leaders write job descriptions to reflect improvement responsibilities.
- Leaders of improvement develop forums for stakeholders to express concerns and share ideas about the improvement process.

Is there a gap in perception between leadership and front-line staff about the importance of quality improvement?

---

**Robust, Transparent Feedback Systems**

- The hospital has in place a measurement system that regularly generates data on performance.
- The hospital publicly displays improvement data on all improvement interventions.

Do you make the information visible to all of the key team members that provide the care? Are you transparent?

---

**Formal Capacity Building Programs**

- Leaders of improvement activity closely consider the composition and skill base of the participating teams and work to enhance their confidence and core competencies.
- Every stakeholder in the organization is introduced to the content of any new improvement intervention and provided ongoing training in quality improvement methods (e.g., The Model for Improvement, Plan-Do-Study-Act cycles).

---

**Shared Sense of Systems to Improve**

- All stakeholders in making improvement (executive leaders, managers, frontline providers of care) share an understanding of the processes and systems that they are seeking to improve, and are clear on their contribution to the sought-after improvement.

---

**The “Human Side” of Holding the Gains**

- Continue to celebrate successes.
- Thank people for their work.
- Keep listening to your patients.
How Are You Doing at Holding Your Gains?

- As a team, review the sustainability checklist making any notes regarding strategies and ideas for improvement.
- Use your results to focus you work to sustain your improvement.

Sustainability

Doing things right with consistency. Being the example.

Remember the Reflections

- How are we perceived, not how we perceive ourselves

Leadership

Management is doing things right. Leadership is doing the right things.

Peter Drucker, management consultant and writer

The Challenge to Lead and Sustain

- We are convinced we are doing the right thing
- We look at all the reasons (papers, research) that agree with us
- We find fault in the reasons (papers, research) that disagree with us
- We are always confident
- We are occasionally correct
Intuition vs Data

Rules for professionals

Rule 1: The confidence one has in one's intuitions is not a reliable guide to their validity.

Rule 2: Intuition cannot be trusted in the absence of stable regularities in the environment.

Rule 3: A lack of definitions is a strong sign of an irregular environment.


Data

Why does this matter?
Simple, non-weighted algorithms consistently outperform professional intuition.


Intuition vs Data

Rules for professionals

Just because everyone agrees with you, it doesn’t make you right. The facts (science) of the matter dictate correctness.


Sustainability requires Data

Data driven care

- With which we are comfortable:
  - Apgar score
  - Group B strep prophylaxis
  - Ultrasound measurements

- Not so much:
  - Oxytocin bundles
  - Direct quantitation of blood loss
  - Determination (defining) of active labor
  - Standardized means of treating severe hypertension

Sustainability requires Data

Data driven care improves outcomes

- It can be measured
- It can be shared and discussed
- It can be reliably applied
- The importance lies in choosing the right data to measure

Sustainability

Data driven care

Measure
Share
Change
Next Steps

- Coaching Call
  - Tuesday, October 21, 2014, 11 AM – 12 PM

- Data Submission:
  - Due COB Wednesday, September 24, 2014 for:
    - August 2014 data for scheduled deliveries, stillbirths, PC-01, hemorrhage, and pre-eclampsia

Survey

https://www.surveymonkey.com/s/XSQTMDP

Contact

NYSPQC Project Team at DOH
  - Phone: (518) 473-9883
  - Email: NYSPQC@health.ny.gov

NYSPFP Project Managers
  - Contact your hospital’s designated project manager
Data & Quality Improvement Tools

Data and quality improvement tools are important components of the NYSPQC/NYSPFP model. The tools provided in the following section allow data to be consistently collected across hospitals. Data was used to track progress and execute quality improvement activities.

The data collection tools were developed for this project with the help of the NYSPQC Obstetrical Expert Work Group. These tools have been vetted and updated throughout the project, and modified as facilities expressed the need for changes.

The NYSPQC/NYSPFP Obstetrical Improvement Project uses the Institute for Healthcare Improvement’s Breakthrough Series (BTS), a learning model that has been modified to meet the requirements and unique needs of this topic and context. Additionally, the project uses the Model for Improvement, a change model developed by the Associates in Process Improvement. Both the BTS and Model for Improvement have demonstrated effectiveness in this and previous NYSDOH projects. By using these models, the NYSPQC/NYSPFP Obstetrical Improvement Project assists participating teams with embedding strategies to measure and address disparities in care and outcomes throughout the process. A BTS Collaborative is a vehicle for identifying, testing, and spreading changes that are effective for improving care and outcomes for defined populations. The quality improvement tools in this section are key tools used by participating facilities to achieve desired goals.

Additional data collection and quality improvement tools can be found on the NYSPQC website: www.nyspqc.org.

<table>
<thead>
<tr>
<th>Data Collection Tools</th>
<th>70</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Scheduled Delivery Form</td>
<td></td>
</tr>
<tr>
<td>• Stillbirth Aggregate Data Log</td>
<td></td>
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<tr>
<td>• Stillbirth Individual Event Log</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Improvement Tools</th>
<th>73</th>
</tr>
</thead>
<tbody>
<tr>
<td>• AIM Statement Worksheet</td>
<td></td>
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<tr>
<td>• PDSA Tutorial</td>
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<tr>
<td>• PDSA Worksheet</td>
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<td>• OB Key Driver Diagram</td>
<td></td>
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<tr>
<td>• Proposed Drivers, Changes, and Tools</td>
<td></td>
</tr>
</tbody>
</table>
### New York State Perinatal Quality Collaborative – Scheduled Delivery Form

Scheduled is defined as all inductions and cesarean sections prior to onset of labor between 36 0/7 and 38 6/7 weeks gestational age

#### A. Patient Demographics

1. Permanent Facility Identifier (PFI):  
2. Facility Name:  
3. Sequence Number:  
4. Admit Date (Month and Year): mm/yyyy  
5. Maternal Age: years

**Medical Record Number:**

<table>
<thead>
<tr>
<th>Delivery Type</th>
<th>Vaginal</th>
<th>Operative</th>
<th>Cesarean</th>
<th>Primary</th>
<th>Repeat</th>
<th>Induced Labor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Vaginal:</td>
<td>Spontaneous</td>
<td>Operative</td>
<td>Operative</td>
<td>Primary</td>
<td>Repeat</td>
<td>Induced Labor</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Cesarean:</td>
<td>Primary</td>
<td>Repeat</td>
<td>Primary</td>
<td>Repeat</td>
<td>Repeat</td>
<td>Induced Labor</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

9. Induced Labor:  
10. Patient ethnicity: Hispanic  
11. Patient race: White  
12. Primary Insurer: Medicaid

#### B. Clinical Data

13. Final Gestational Age at Delivery: ______ weeks ______ days

14. Was gestational age documented in the chart? Yes  
15. Was gestational age of less than 39 weeks confirmed by one of the following?  
   - First or second trimester ultrasound < 20 weeks Yes  
   - Fetal heart tones documented for 30 weeks by Doppler ultrasonography Yes  
   - 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test result Yes

16. Was fetal lung maturity documented by amniocentesis? Yes  
17. For inductions, was the Bishop Score of cervical status 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother? Score ≥8 primigravida, ≥6 multigravida Determined, did not meet criteria Not measured or cannot be calculated

Patient Counseling (18a and 18c are only required for RPCs participating in the OB Prenatal Education Project)

18a. Was there documentation in the medical record that the maternal and fetal risks and benefits of scheduled delivery between 36 0/7 and 38 6/7 weeks were discussed with the mother? Yes  
18b. Was there documentation in the medical record of the mother’s preferred language? If yes, please specify the language. Yes, ___________  
18c. Was patient education provided in the mother’s preferred language? Yes  

Reason for Scheduled Delivery  
19. Was there documentation in the medical or prenatal record of the primary reason for scheduled delivery? Yes  

Which of the following was the PRIMARY reason documented in the medical records for a scheduled delivery between 36 0/7 and 38 6/7 weeks gestation? (Reasons can be maternal, fetal, psychosocial)  

***SELECT ONLY ONE (AND SPECIFY BELOW AS NEEDED)***

### Maternal Reasons for Scheduled Delivery

- Premature rupture of membranes  
- Prepregnancy hypertension  
- Hematological condition (specify in #23 below)  
- Prolonged rupture of membranes  
- Gestational diabetes  
- Active genital herpes infection  
- Chorioamnionitis  
- Diabetes (Type I/II)  
- Prior myomectomy  
- Placental abruption  
- Liver disease (specify in #23 below)  
- Placenta previa/Vasa previa  
- Heart disease (specify in #23 below)  
- Placental hypertensive  
- Renal disease (specify in #23 below)  
- Gestational hypertension  
- Pulmonary disease (specify in #23 below)  
- Preeclampsia/Eclampsia  
- HIV  
- Placenta Accreta  
- Other (specify in #23 below)
**New York State Perinatal Quality Collaborative – Scheduled Delivery Form**

Scheduled is defined as all inductions and cesarean sections prior to onset of labor between 36 0/7 and 38 6/7 weeks gestational age

### 21. Fetal Reasons for Scheduled Delivery

**SELECT ONLY ONE IF NO MATERNAL REASON SPECIFIED**

- Oligohydramnios
- Intrauterine growth restriction (< 5th percentile for gestational age)
- Fetal demise
- Macroamnios – Sono EFW > 5,000 gms
- Abnormal fetal testing (by NST, BPP, or continuous wave Doppler)
- Mono-Di Twins
- Major fetal anomaly
- Alloimmunization/fetal hydrops
- Other (specify in #23 below)

### 22. Psychosocial Reasons for Scheduled Delivery

**SELECT ONLY ONE IF NO MATERNAL OR FETAL REASON SPECIFIED**

- Psychosocial stress (e.g., domestic violence, no social support, working long hrs. upright)
- Patient request – “Elective”
- Convenience of patient/doctor (includes scheduling difficulties)
- Other (specify in #23 below)

### 23. Specify (narrative as directed above)

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

### 24a. When ‘Other’ is selected as the Maternal or Fetal reason, was the reason for scheduled delivery reviewed by a designated reviewer or panel?

- Yes
- No
- Review Pending

**Results of scheduled delivery review from Q24a:**

### 24b. Medically indicated based on review?

- Yes
- No

### 24c. If the answer to question 24a is “Yes”, please explain decision based on review

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

### C. Data collection, entry and verification

30. Initials of individual completing this form: ____________________________

31. Initials of obstetrician: ____________________________

### D. Optional Data Collection (for site use only)

31. Optional Field for Data Collection(#1)

32. Optional Field for Data Collection(#2)

33. Optional Field for Data Collection(#3)

34. Optional Field for Data Collection(#4)

35. Optional Field for Data Collection(#5)
### Stillbirth Aggregate Data Log

**Count of Total Stillbirths, Live Births and Deliveries Each Month**

<table>
<thead>
<tr>
<th>PFI</th>
<th>Facility Name</th>
<th>Admit Year (yyy)</th>
<th>Admit Month (1-12)</th>
<th>Total Stillbirths</th>
<th>Total Live Births</th>
<th>Total Deliveries</th>
<th>Total Stillbirths</th>
<th>Total Live Births</th>
<th>Total All Deliveries</th>
<th>Total All Scheduled Deliveries</th>
<th>Confirm when Zero Scheduled Deliveries</th>
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<tbody>
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</table>

### Stillbirth Individual Event Log

**Listing for each Stillbirth**

<table>
<thead>
<tr>
<th>PFI</th>
<th>Sequence Number</th>
<th>Year (yyy)</th>
<th>Month (1-12)</th>
<th>Gestational Age (wks/days)</th>
<th>weight at delivery (&gt;350g)</th>
<th>Known or Possible Diagnosis</th>
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</table>

Data Collection Forms – New York State Perinatal Quality Collaborative Revised Date: 10/12/2012 Printed: 12/7/2012
**AIM Statement (aka SMAART objective) Worksheet:**

1. AIM Statement (include your draft AIM Statement and edit as you work through the criteria in #2 below).

2. Review the AIM Statement again for the components of a SMAART objective (Specific, Measureable, Actionable, Achievable, Realistic and Timely).

   • **SPECIFIC** – Is the statement precise about what you hope to achieve?

   • **MEASURABLE** – Are the objectives measureable? Will you know if the change resulted in improvement?

   • **ACTIONABLE** – Are “who,” “what,” “when,” and “where” defined?

   • **ACHIEVABLE** – Is this doable in the time you have? Are you attempting too much? Could you do more?

   • **REALISTIC** – Do you have the necessary resources (people, time, support)?

   • **TIMELY** – Do you identify the timeline? When will you accomplish each part?
NYSPQC PDSA Tutorial

1. Gather ideas about what changes will lead to improvement
You need to understand some basic information about what are the existing challenges to improving care to reduce elective deliveries before 39 weeks. For example, are the challenges you are facing related to role clarification, delegation, staff education, lack of leadership support, or tools and prompts? Consider who could offer insight into the particular area and ideas for improving it.

This is a “thinking” step that will help to explore the reasons why areas of practice have become less than optimal. Understanding barriers that prevent change will help you plan initiatives that anticipate and overcome barriers.

PDSA cycles are small tests designed to help you make progress toward a goal. Small tests do not necessarily mean small changes; rather, small tests represent small steps needed to achieve significant improvement.

2. Plan the PDSA Cycle
It is important to develop a detailed plan for your PDSA so that you know exactly what needs to occur in your DO phase (who will do it, which patients it will involve, and how you will track your progress). When planning, ask yourself the following questions:

- What are we testing?
- Who are we testing the change on?
- When are we testing?
- Where are we testing?
- Who will implement the cycle?
- What is our measurement plan?
Don’t forget to make a prediction.
Anticipating the impact of your cycle will help you to focus on
• Planning
• Areas for improvement
• Clarifying measures
• Being creative

When predicting, ask yourself, “What do you expect to happen?” Making a prediction will assist in anticipating what might come next and whether or not the cycle was a success or failure. If it was a failure, it is important to take the time to understand why (Study).

Don’t forget to include measurement plan.
Integrate the study part of the PDSA into the daily routine as much as possible. What you measure to show if your PDSA resulted in an improvement may or may not be the same as the measures you use for the Collaborative reports. Usually the study part of the PDSA cycle can be an observation, or asking one of the team members their impression of how the test of change went. Build on existing systems when re-designing. What examples of success within your office can you learn from?

Example:
Goal: Increase smoking assessment and appropriate counseling to patients.
   What is being tested: OB office is running a PDSA on handing out the March of Dimes Brain Card
   Prediction: New tool will help build consumer buy-in for full term deliveries
   When/Where/Who: Nurse offers card to Mom at first prenatal visit and explains the importance of going to 39 weeks.
   Measurement: Nurse will report how mother’s responded to the new tool.

3. Conduct the Cycle (DO)
Carry out the cycle, collect data and begin analysis. Don’t forget to seek opinions about changes tested in this cycle.

Example:
Nurses gave the card to 4 new patients last week and reported patient response. All patients were interested and responded well to the message.

4. Analyze the Results (STUDY)
Studying the results allows you to answer the questions:
• Was this change an improvement?

• If yes, do we need more information before implementing the change with others in the practice (e.g., Test again on different days with different staff)?

• If not, what have we learned from this test? What could we do differently next time to make it an improvement over the current system? What additional information do we need to achieve an improvement?
• Share your results: Plot data of key measures each week and display for others in the office to see. Seek input from everyone in your office.

5. Decide What to Do Next (ACT)
Identify what changes are to be made in the current cycle, from this, identify your next cycle. “The science in PDSA is in the act of reflection, learning from what one did. Those who want improvement to occur need to reserve specific times to ask, ‘What did we learn, and how can we build on it?’”

Learning: Feasible strategy for practice, but additional education and prompts are needed to ensure consistent and ongoing and counseling occur.

Potential Next Cycles: After we reach a point that the patients have been getting the brain cards reach the time to schedule their deliveries we will measure if the use of these cards resulted in fewer requests by patents for an early elective delivery.

PDSA Cycle

<table>
<thead>
<tr>
<th>Plan</th>
<th>Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What are we testing?</td>
<td>• What was actually tested?</td>
</tr>
<tr>
<td>• Who are we testing the change on?</td>
<td>• What happened?</td>
</tr>
<tr>
<td>• When are we testing?</td>
<td>• Observations</td>
</tr>
<tr>
<td>• Where are we testing?</td>
<td>• Problems</td>
</tr>
<tr>
<td>• Who will implement the cycle?</td>
<td></td>
</tr>
<tr>
<td>• What is our measurement plan?</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Act</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What changes should we make before the next test cycle?</td>
<td>• Was this change an improvement?</td>
</tr>
<tr>
<td>• What will the next test cycle be?</td>
<td>• If yes, do we need more information before implementing the change with others in the practice (e.g., Test again on different days with different staff)?</td>
</tr>
<tr>
<td>• Are we ready to implement the change?</td>
<td>• If not, what have we learned from this test? What could we do differently next time to make it an improvement over the current system? What additional information do we need to achieve an improvement?</td>
</tr>
</tbody>
</table>

• Share your results: Plot data of key measures each week and display for others in the office to see. Seek input from everyone in your office.
PDSA Worksheet

PDSA WORKSHEET

Full facility name: ___________________________ Date of test: ____________ Test Completion Date: ____________

Overall organization/project AIM: ___________________________

What is the objective of the test?

PLAN:

Briefly describe the test:

How will you know that the change is an improvement?

What driver does the change impact?

What do you predict will happen?

List the tasks necessary to complete this test (what) | Person responsible (who) | When | Where
---|---|---|---
1. |
2. |
3. |
4. |
5. |
6. |

Plan for collection of data:

DO: Test the changes.

Was the cycle carried out as planned?  □ Yes  □ No

Record data and observations.

What did you observe that was not part of our plan?

STUDY:

Did the results match your predictions?  □ Yes  □ No

Compare the result of your test to your previous performance:

What did you learn?

ACT: Decide to Abandon, Adapt, Adopt

Abandon: Discard this change idea and try a different one.

Adapt: Improve the change and continue testing plan. Describe what you will change in your next PDSA:

Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

If you plan to adopt, what plans do you have for your next 2 - 3 PDSA cycles for follow-up tests and implementation:
**OB Key Driver Diagram**

**Goals**: Reduce the number of scheduled deliveries performed without an appropriate medical indication between 36 0/7 and 38 6/7 weeks gestation.

**PROJECT AIM**: Within 18 months, we aim to improve maternal and newborn outcomes, and improve capability within New York State for ongoing quality improvement/ transformation of healthcare by applying evidence-based healthcare system change interventions in New York State birthing hospitals. The obstetrical intervention is: *Reducing the number of scheduled deliveries performed without appropriate medical indication between 36 0/7 and 38 6/7 weeks gestation.*

**PRIMARY DRIVERS**

- **Awareness of expected risks & benefits of late preterm/early term delivery by a clinician**

- **Dating criteria: optimal estimation of gestational age using ACOG Criteria**

- **Hospital and physician practice policies prevent delivery < 39 weeks without medical indication**

- **Foster a culture of safety and improvement**

**NYSPQC OB Improvement Project Key Driver Diagram**

- Inform consumers of risk/benefits of deliveries < 39 wks
- Communicate to patient/clinic/hospital ultrasound results
- Promote need for early dating to practitioners and consumers
- Public awareness campaign

- Promote need for early dating to practitioners and consumers
- Document criteria used to establish EDC
- Appropriate use of fetal maturity testing
- Empower nurses/schedulers to require dating criteria Identify a specific contact for authorization dispute re: dating
- Provide patient with hard copy results of ultrasound

- Empower nurses/schedulers to require dating criteria
- Document rationale and risk/benefit for scheduled deliveries at 36 0/7 to 38 6/7 weeks gestation
- Document discussion with patient about the above
- Both patient and MD to sign consent statement for scheduled delivery between 36 0/7 to 38 6/7 weeks
- Physician awareness campaign: what are the reason(s) for scheduled delivery?
- Maximize access to delivery and OR for optimal scheduling
- Facilitate scheduling policies that respect ACOG criteria

- Prenatal caregivers receive feedback from postnatal caregivers about neonatal outcomes of scheduled deliveries
- Ensure complete and accurate handoffs OB/OB and OB/ Peds
- Document discussion with patient about risk/benefits of late preterm/early term delivery
- Promote need for early dating to practitioners and consumers

- Continuous monitoring of data & discussion of this effort in staff/division meetings
- Project outcomes posted on units and we assess develop ways to include staff and physician input about communications and handoffs
- Connect with organizational initiatives on safety and use existing approaches as possible
- Empower nurses/schedulers to require dating criteria

**Rev. July 2012**
### Proposed Drivers, Changes and Tools

**NYSPQC OB Learning Session 1**  
*Proposed Drivers, Changes and Tools*  
July 24 and July 26, 2012

<table>
<thead>
<tr>
<th>Driver</th>
<th>Changes</th>
<th>Tools</th>
</tr>
</thead>
</table>
| **Increase awareness of expected risks and benefits of late preterm/early term delivery by patients, consumers and clinicians** | By Patients and Consumers  
- Inform consumers of risk/benefits of deliveries < 39 weeks  
- Communicate to patient/clinic/hospital ultrasound results  
- Promote need for early dating to practitioners and consumers  
- Public awareness campaign | • Educational brochures (culturally appropriate for target population) two examples from OPQC and CA Grow Before You Show  
• Patient consent for delivery <39 weeks  
• US results - copy to patient  
| | By Clinician  
- Prenatal caregivers receive feedback from postnatal caregivers about neonatal outcomes of scheduled deliveries  
- Ensure complete and accurate handoffs OB/OB and OB/Peds  
- Document discussion with patient about risk/benefits of late preterm/early term delivery  
- Promote need for early dating to practitioners and consumers | • Multidisciplinary rounds – for education and review of case studies  
• Policies and procedures  
• Patient consent for delivery <39 weeks  
• OPQC Daily Delivery Sheet |
| **Optimal estimation of gestational age using ACOG criteria for dating** | • Continuous monitoring of data & discussion of this effort in staff and division meetings.  
• Project outcomes posted on units and websites.  
• Develop ways to include staff and physician input about communications and handoffs  
• Connect with organizational initiatives on safety and use existing approaches as possible  
• Empower nurses /schedulers to require dating criteria | • Media/public awareness campaign to encourage early prenatal care  
• http://www.gobeforeyoushow.com/  
  ○ Education Brochures (culturally appropriate for target population)  
  ○ 800#  
• Policies and procedures – scheduling and dating criteria  
• Tools to remind/prompt providers  
• Leadership  
  ○ Peer review  
  ○ No tolerance policies |

Revised 7.2012
<table>
<thead>
<tr>
<th>Driver</th>
<th>Changes</th>
<th>Tools</th>
</tr>
</thead>
</table>
| Institute hospital and physician practice policies that prevent delivery <39 wk without medical indication | • Empower nurses /schedulers to require dating criteria  
• Document rationale and risk/benefit for scheduled deliveries at 36.0 to 38.6 weeks gestation  
• Document discussion with patient about the above  
• Both patient and MD sign consent statement for scheduled delivery 36.0 - 38.6 wks  
• Physician awareness campaign: what are the reason(s) for scheduled delivery?  
• Maximize access to Delivery and OR for optimal scheduling  
• Facilitate scheduling policies that respect ACOG criteria                                                                 | • Policies and procedures  
  o Scheduling and dating criteria  
  o Expectations for documentation  
• Patient consent for delivery <39 weeks  
• Leadership  
  o Peer review  
  o No tolerance policies                                                                                                                                                       |
| Foster a culture of safety and improvement                             | • Continuous monitoring of data & discussion of this effort in staff/division meetings.  
• Project outcomes posted on units and websites.  
• Develop ways to include staff and physician input about communications and handoffs  
• Connect with organizational initiatives on safety and use existing approaches as possible  
• Empower nurses /schedulers to require dating criteria                                                                                                                          | • ARHQ Hospital Survey on Patient Safety Culture available from  
• TeamSTEPPS™ Training and tools  
  https://teamstep.ahrq.gov/  
• Storyboards  
• Multidisciplinary rounds and case reviews                                                                                                                                            |
Participants of the NYSPQC/NYSPFP Obstetrical Improvement Project created and submitted the following resources, which were developed in an effort to reduce scheduled deliveries without a medical indication between 36 0/7 and 38 6/7 weeks gestation. These documents may be used to guide facilities in developing their own tools, or updating existing materials.

Participants of the NYSPQC/NYSPFP Obstetrical Improvement Project created and submitted the following resources, which were developed in an effort to reduce scheduled deliveries without a medical indication between 36 0/7 and 38 6/7 weeks gestation. These documents may be used to guide facilities in developing their own policies, tools and forms, or updating existing materials. The sample hospital policies, tools and forms provided in this toolkit are not intended to provide medical advice and should not be relied upon as such, nor should the information be used as a substitute for clinical or medical judgment.

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<td>• Flyer &lt;39 Weeks: Labor and Delivery Staff</td>
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<td>• Scheduled Delivery Form</td>
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</tbody>
</table>
SUBJECT: Elective Delivery prior to 39 weeks gestation

POLICY: The Birthplace follows ACOG recommendations for elective induction or cesarean section to be no earlier than 39 completed weeks of singleton gestations as documented by one of these parameters:

- Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater.
- Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography.
- It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result.

Elective delivery is defined as those in which medical or Obstetric indication(s) are not present.

PROCEDURE:

I. Booking process

1. All requests for scheduled delivery will include the medical indication, and the EDC.

2. The booking request, scheduled delivery note, and prenatal record will be reviewed by a member of the clinical review team, which consists of nursing unit leadership (NM/ANM/CNS or designee) to determine if the indication(s) meet those approved by the WHQIT.

   2. Upon approval by the clinical review team member, the surgical scheduler is permitted to schedule a delivery.

   3. If the indication does not meet criteria as approved, the clinical review team member will refer the request to the department chair or designee for consideration.

   4. If necessary, the requesting attending will further discuss the request with the department chair prior to approval.

II. There will be no after hours (7 am -3:30 pm) elective deliveries scheduled.

ASSOCIATED REFERENCES:

ACOG Practice Bulletin # 97 Fetal Lung Maturity, 9/08, p.2; # 107 Induction of Labor, 8/09 p.4, Committee Opinion # 394 Cesarean Delivery on Maternal Request, 12/07, p. 1

### Birthplace Admission/OR Scheduling Form

**AMC: THE BIRTHPLACE ADMISSION/OR SCHEDULING FORM (FAX 262-0183)**

**ORDERING DR:**

**REQUESTED OR DATE:**

**TIME:**

**SURGEON:**

<table>
<thead>
<tr>
<th>PATIENT DEMOGRAPHICS</th>
</tr>
</thead>
</table>
| **PATIENT:**
| LAST NAME:_____________________________|
| FIRST NAME:___________________________|
| **DOB:**  ___________  SS# ___________  MR# __________________|
| **ADDRESS:**__________________________|
| **CITY:**_________________  **STATE:**   ___  **ZIP:**________|
| **HOME PHONE #** ( ) ______________|
| **MARITAL STATUS:**  S  M  W  D  **RACE:**________   **WORK PHONE #:** ( ) _____________|
| **EMPLOYER**_______________________  **OCCUPATION** __________________|

<table>
<thead>
<tr>
<th>INSURANCE</th>
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<tbody>
<tr>
<td><strong>PRIMARY INSURANCE:</strong>_____________________</td>
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<tr>
<td><strong>SECONDARY INSURANCE:</strong>____________________</td>
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<tr>
<td><strong>POLICY #</strong>_________________  <strong>POLICY #:</strong>__________________</td>
</tr>
<tr>
<td><strong>SUBSCRIBER NAME:</strong>_______________________</td>
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<td><strong>SUBSCRIBER NAME:</strong>_______________________</td>
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<tr>
<td><strong>RELATIONSHIP TO PT:</strong> SELF/ SPOUSE/ PARENT  <strong>RELATIONSHIP TO PT:</strong> SELF/ SPOUSE/ PARENT</td>
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<tr>
<td><strong>AUTHORIZATION #:</strong>_______________________</td>
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<td><strong>AUTHORIZATION #:</strong>_______________________</td>
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<thead>
<tr>
<th>ADMISSION /SURGICAL INFORMATION</th>
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<tbody>
<tr>
<td><strong>IS PT AN INPATIENT:</strong> YES     NO  <strong>IF YES ROOM #</strong>______________________</td>
</tr>
<tr>
<td><strong>EDD:</strong>_________________  <strong>LMP:</strong>_________________  <strong>IS THIS A MULTIPLE PREGNANCY:</strong> YES      NO</td>
</tr>
<tr>
<td><strong>DIAGNOSIS/PRIMARY INDICATION FOR DELIVERY:</strong>____________________________________</td>
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<tr>
<td><strong>OTHER /SECONDARY DIAGNOSIS:</strong>_______________________________  <strong>ICD 9:</strong>__________________</td>
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<tr>
<td><strong>PROCEDURE :</strong>_______________________  <strong>CPT CODE:</strong>__________________</td>
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<tr>
<td><strong>MEDICAID STERILIZATION CONSENT:</strong> YES / NO  <strong>DATE SIGNED:</strong>__________________</td>
</tr>
<tr>
<td><strong>DOES PATIENT HAVE A LATEX ALLERGY :</strong> YES     NO  <strong>Wt:</strong>____  <strong>Ht:</strong>____</td>
</tr>
<tr>
<td><strong>COMORBIDITIES:</strong> Please indicate by circling condition the presence of any of the following</td>
</tr>
<tr>
<td>CHRONIC HTN  DIABETES—INSULIN: YES     NO  CARDIAC DX (Specify__________)</td>
</tr>
<tr>
<td>ENDOCRINE DX (Specify__________)  RENAL DX (Specify__________)</td>
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<tr>
<td>RESPIRATORY DX (Specify__________)  HISTORY OF BACK SURGERY</td>
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<tr>
<td>HEMATOLOGIC DX (Specify__________)</td>
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<thead>
<tr>
<th>CONFIRMATION</th>
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<tbody>
<tr>
<td><strong>PATIENT CONTACT NUMBER:</strong>______________________  <strong>May Leave Message:</strong> YES / NO</td>
</tr>
<tr>
<td><strong>CLINICAL APPROVAL:</strong>  Date:_________________  Time:________  <strong>Initials:</strong>__________________</td>
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<tr>
<td><strong>BYPASS PAT APPROVAL:</strong>  Date:_________________  Time:________  <strong>Initials:</strong>__________________</td>
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<tr>
<td><strong>PAT REQUIRED:</strong>  Date:_________________  Time:________  <strong>Initials:</strong>__________________</td>
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<td><strong>MD NOTIFIED:</strong>  Date:_________________  Time:________  <strong>Initials:</strong>__________________</td>
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<tr>
<td><strong>LETTER SENT:</strong>  Date:_________________  Time:________  <strong>Initials:</strong>__________________</td>
</tr>
</tbody>
</table>

REVISED: 11/21/2012
OTHER: ___________________________________________________________________________

SPECIAL INSTRUMENTS NEEDED _______________________________________________________________________

PATIENT’S PHONE NUMBER (to call with booking confirmation info): ________________________

IS IT OK TO LEAVE MESSAGE: YES  NO

Revised: 11/21/2012
Induction/Scheduled Cesarean Delivery Note

Obstetrics/Gynecology: Induction/Scheduled Cesarean Delivery Note

For inductions ONLY: Bishop score ________ total (Check factors that are present at start of induction):

<table>
<thead>
<tr>
<th>Cervix/Factors</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>Dilatation</td>
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<td>Closed</td>
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<td>1-2</td>
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<td>3-4</td>
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<td>Greater than 5</td>
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<td>Effacement</td>
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<td>0-30%</td>
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<td>40-50%</td>
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<td>60-70%</td>
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<td>Greater than 80%</td>
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<tr>
<td>Station</td>
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<td>+3</td>
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<td>+2</td>
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<td>+1/0</td>
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<td>+1/+2</td>
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<tr>
<td>Cervical Position</td>
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<td>Posterior</td>
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<td>Mid-Position</td>
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<tr>
<td>Anterior</td>
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</tbody>
</table>

Presentation: ________ Estimated Fetal Weight: ________ g

Pelvis is clinically adequate for vaginal delivery:   □ yes   □ No → induction contraindicated

For all deliveries:

**Primary Indication for delivery**

- Post term (gestational age greater than 41 weeks)
- Pre-eclampsia
- Diabetes (type I or type II) Insulin   YES NO
- Fetal testing:  □ Oligohydramnios
  - Amniotic fluid index cm;
  - Biophysical profile /10
  - Non-reactive fetal non stress test
- Chronic or Gestational Hypertension
- Other ________________________________
- Cardiac (______________________________)
- Endocrine (___________________________)
- Respiratory (_________________________)
- Renal (______________________________)
- Hematologic (________________________)
- Previous cesarean section, declines or TOLAC ineligible
- Non-cephalic presentation

**Secondary indications/diagnoses**

- Post term (gestational age greater than 41 weeks)
- Pre-eclampsia
- Diabetes (type I or type II) Insulin   YES NO
- Fetal testing:  □ Oligohydramnios
  - Amniotic fluid index cm;
  - Biophysical profile /10
  - Non-reactive fetal non stress test
- Chronic or Gestational Hypertension
- Other ________________________________
- Cardiac (______________________________)
- Endocrine (___________________________)
- Respiratory (_________________________)
- Renal (______________________________)
- Hematologic (________________________)
- Previous cesarean section, declines or TOLAC ineligible
- Non-cephalic presentation

The patient was made aware of the risks, benefits, alternative, and possible side effects/complications for both mother and fetus/newborn(s) to induction/augmentation of labor.

**Signature of credentialed practitioner**

Date ______/_______/_______ Time: ____________ h  Print name________________________________

Clinical team member review and approval:

Signature: ____________________________ Date: _/__/__ Time: ___
OBSTETRICS PHYSICIAN EDUCATION
“Going the Full Forty”

The A. O. Fox Hospital Obstetrics Service is in full support of “Going the Full Forty”. More specifically, we are committed to improving the maternal and newborn outcomes by reducing the number of scheduled deliveries performed without medical indication between 36 0/7 – 38 6/7 weeks gestation.

In an effort to reach, and maintain, this goal, we are participating with the Partnership for Patients – New York State Perinatal Quality Collaborative.

As a member of our obstetric team, we anticipate your full support of our efforts. The information below is provided to educate you on the expectations of our program:

- **Medical Necessity** – Acceptable medical indications may include maternal or fetal issues and must be documented in the medical record. Please see the reverse side for acceptable indications.

- **Documentation** – In the event that a patient presents meeting the indications above, you must clearly document the appropriate indication in the medical record.

- **Patient Education** - All patients at 35 weeks gestation are counseled on the importance of going the full 40 utilizing information obtained from the March of Dimes – “Going the Full Forty”

- **Monitoring** – We collect, analyze and submit data to the New York State Perinatal Quality Collaborative on a monthly basis. We are pleased to report that we have only had one (1) scheduled delivery without acceptable medical indications since September 2012. Please help us to continue this trend!

If you have questions relating to this information or identify opportunities for improvement during your affiliation with our hospital, please contact one of the Perinatal Quality Collaborative Team members listed below:

- Lynne Shanks, Nursing Director, Obstetrics, Ext. 5105
- Dorraine Young, Quality Management Services Coordinator, Ext. 5061
- Bryan S. Evanczyk, M.D. – Physician Champion/Medical Director, Ext. 5627/5374
- Marie Matthews, RN – Staff Nurse/Lactation Counselor, Ext. 5730
ACCEPTABLE MEDICAL INDICATIONS
FOR LATE PRE-TERM OR EARLY-TERM DELIVERIES
(per ACOG guidelines)

- Preeclampsia, eclampsia, gestational hypertension, or complicated chronic hypertension
- Oligohydramnios
- Prior classical cesarean delivery or prior myomectomy
- Placenta previa or placenta accreta
- Multiple gestations
- Fetal growth restriction
- Pregestational diabetes with vascular disease
- Pregestational or gestational diabetes—poorly controlled
- Placental abruption
- Chorioamnionitis
- Premature rupture of membranes
- Cholestasis of pregnancy
- Alloimmunization of pregnancy with known or suspected fetal effects
- Fetal congenital malformations

The closer the fetus gets to 40 weeks gestation the more fully developed the fetus will be. The important development of the brain, lungs and eyes occurs in the last few weeks of pregnancy.

If your patient’s pregnancy is healthy, wait for labor to begin on its own.
BELLEVUE WOMAN’S CENTER
CESAREAN SECTION/LABOR INDUCTION PATIENT SCHEDULING FORM

Last Name: ___________________________ First Name: ___________________________
Address: ___________________________ DOB: ___________________________
City: ___________________________ State: ___________________________
Primary Phone: ___________________________ Alternate Phone: ___________________________
Insurance: ___________________________ ID#: ___________________________ Grp# ___________________________
OB Provider: ___________________________ OB Provider Phone: ___________________________ FAX: ___________________________
Desired Induction Date: ___________________________ Scheduled Date: ___________________________
Desired Cesarean Section Date: ___________________________ Scheduled Date: ___________________________

PROCEDURES:
☒ C/S ☐ C/S with BTL ☒ Routine Induction (Oxytocin) ☒ Cervical Ripening + IOL

Special Concerns: (i.e., allergies, medical problems, special needs): ___________________________

PELVIC ASSESSMENT: (Required for Inductions):

Bishop Score (see below): ___________________________

<table>
<thead>
<tr>
<th>Bishop Scoring System</th>
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<tbody>
<tr>
<td>Score</td>
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</tr>
<tr>
<td>0</td>
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<tr>
<td>1</td>
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<td>2</td>
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</tbody>
</table>

* Station reflects a -3 to +3 scale.

Modified from Bishop EH. Pelvic scoring for elective induction. Obstet Gynecol 1964: 24: 266-8

COUNSELING:
☒ Risks/Benefits/Alternatives of delivery discussed with patient

DATED:
Gravida _____ Para _____ LMP ___________ EDD ___________ (please indicate on next line)
EDD Based on: ☐ US < 20 weeks; ☐ Doppler FHT+ for 30 weeks; ☐ +hCG for 36 weeks
Gestational Age at Date of Induction or C/S: weeks _________ days _______
☒ Other dating criteria ___________________________ (details)
By ACOG Guidelines, women should be 39 wks or greater before initiating an elective (no medical indication) delivery. ACOG also states that a mature fetal lung test in the absence of clinical indication is not considered an indication for delivery.

**INDICATIONS:**
- Schedule ≥ 41+0 wks
- Elective Induction ≥ 39 wks
- Schedule C/S ≥ 39 wks
  - Prior C/S (x__________)
  - Patient Choice
- Patient Choice/Social
- Macrosomia
- Distance
- Other:

**Obstetric and Medical Conditions (OK if < 39 weeks)**
- Abruption
- Previa
- Preeclampsia/Eclampsia
- Fetal Demise (current)
- Antiphospholipid Syndrome
- Non-reassuring fetal status
- Fetal anomalies
- Twins ≥ 38 wks w/o complications
- Liver disease (e.g. cholestatsis of preg.)
- Diabetes (Type I or II)
- Polyhydramnios
- Herpes Gestationis
- Prior Myomectomy
- Other:

**SCHEDULING OFFICE USE**
- PAT Scheduled by ______________ on ______________ (date)
- Induction Scheduled by ______________ on ______________ (date)
- C/S Scheduled by ______________ on ______________ (date)
- C/S-Induction Approved by ______________
- C/S-Induction Not Approved by ______________
- Confirmation faxed to office ______________ by _______ (initials)
- Referred to OB Hospitalist ______________ (date) by _______ (initials)

Revised: 7/23, 7/24/13, 7/29/13, 7/30/13, 7/31/13
CALCULATION OF ESTIMATED DATE OF DELIVERY – EDD

It has become increasingly important to establish and confirm the correct and precise EDD in all pregnancies. The following guidelines are strongly recommended to be used by all members of the perinatal team.

- The initial step in arriving at an EDD is to use Naegele’s rule. This involves using the patient’s Last Normal Menstrual Period (LNMP). By adding 7 days to the date of the first day of the LNMP and counting back 3 months, the EDD is determined. The use of “Pregnancy Wheels” for this purpose is to be discouraged because of as much as 5 days variation between different wheels. – Williams Obstetrics – 23rd Edition, 2010

- An OB dating ultrasound before 20 weeks gestation is recommended to confirm the EDD calculated from the LNMP. “Ultrasound may be considered to confirm menstrual dates if there is a gestational age agreement within 1 week by crown-rump measurements obtained in first trimester or within 10 days by an average of multiple fetal biometric measurements obtained in the second trimester (up to 20 weeks of gestation)”. – ACOG Practice Bulletin, #101, February 2009.

- In general, Ultrasound-established dates should take preference over menstrual dates when the discrepancy is greater than 7 days in the first trimester and/or greater than 10 days in the second trimester.

- If the LNMP is unknown, uncertain, or if the measurements from the less than 20 weeks dating sonogram are beyond the above noted ranges, the EDD can be confidently established by simply using the EDD projected from the first dating sono at less than 20 weeks gestation.

- If there is no dating sono less than 20 weeks it is not possible to have a “confirmed” EDD. In such cases clinical judgment needs to be based solely on the LNMP or later ultrasound findings, with an awareness that the EDD and, therefore, gestational age has not been confirmed and, therefore, is only probable.

December 10, 2010
Committee on Perinatal Safety
# CVPH Labor & Delivery Scheduling and Procedures 2011

**Procedures and Forms**

**CVPH Medical Center**
Labor and Delivery Scheduling and Procedures

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## Procedure Scheduling Book

**Inductions**

<table>
<thead>
<tr>
<th>TIME:</th>
<th>INDUCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT. NAME:</td>
<td>PHONE #:</td>
</tr>
<tr>
<td>G</td>
<td>P</td>
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<tr>
<td>OBSTETRICIAN:</td>
<td>INDICATION:</td>
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<tr>
<td>PEDIATRIC grp:</td>
<td>EDC:</td>
</tr>
<tr>
<td>Fetal/Maternal Risk Factors:</td>
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**Scheduling Time**

**PROCEDURE COMPLETED BY:**

**Inductions**

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<thead>
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<th>TIME:</th>
<th>INDUCTIONS</th>
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<tbody>
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<td>EDC:</td>
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<td>Fetal/Maternal Risk Factors:</td>
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**Scheduling Time**

**PROCEDURE COMPLETED BY:**

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**C/Sections**

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<th>C/SECTIONS</th>
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<tbody>
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<tr>
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<td>INDICATION:</td>
</tr>
<tr>
<td>PEDIATRIC grp:</td>
<td>EDC:</td>
</tr>
<tr>
<td>1ST ASSIST:</td>
<td></td>
</tr>
<tr>
<td>PEDIATRIC grp:</td>
<td>NOTIFIED: Y N SCHED. WITH OR: Y N</td>
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<td>Fetal/Maternal Risk Factors:</td>
<td></td>
</tr>
</tbody>
</table>

**Scheduling Time**

**PROCEDURE COMPLETED BY:**

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**Other Procedures/Treatments**

<table>
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<tr>
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<th>INDUCTIONS</th>
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<tbody>
<tr>
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<tr>
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<td>EDC:</td>
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<tr>
<td>Fetal/Maternal Risk Factors:</td>
<td></td>
</tr>
</tbody>
</table>

**Scheduling Time**

**PROCEDURE COMPLETED BY:**

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**Day shift responsible for obtaining the prenatal records - evening shift will be responsible for assembling the chart Please write all comments on back**

---

**Legend**

- **Y** Yes
- **N** No
- **E** Induction Time
- **C** C/Section Time
**Elective Labor Induction & Cesarean Section Scheduling Form**

**Good Samaritan Hospital Medical Center**

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chorioamnionitis</td>
<td>≥41 weeks gestation/Post term pregnancy</td>
</tr>
<tr>
<td>Preeclampsia/HELLP</td>
<td>IUGR – reassuring testing</td>
</tr>
<tr>
<td>Abruptio placenta</td>
<td>Fetal demise</td>
</tr>
<tr>
<td>Bleeding D/T marginal placenta previa</td>
<td>Maternal HIV</td>
</tr>
<tr>
<td>Non-reassuring fetal testing</td>
<td></td>
</tr>
<tr>
<td>PROM</td>
<td></td>
</tr>
<tr>
<td>Fetal hydrops/isoinmunization</td>
<td></td>
</tr>
<tr>
<td>Oligohydramnios (AFI &lt;5 or GLP&lt;2)</td>
<td></td>
</tr>
<tr>
<td>Blood group sensitization</td>
<td></td>
</tr>
<tr>
<td>Fetal compromise (severe IUGR)</td>
<td></td>
</tr>
<tr>
<td>Fetal anomaly</td>
<td></td>
</tr>
<tr>
<td>Maternal medical conditions</td>
<td></td>
</tr>
<tr>
<td>Gestational hypertension</td>
<td></td>
</tr>
<tr>
<td>Multifetal gestation</td>
<td></td>
</tr>
</tbody>
</table>

**Reasons for Scheduled Delivery:** Check all appropriate indications below

- Level 1
- Level 2
- Level 3
- Level 4

**Confirmation of gestational age:**

EDC determined by: Check all that apply
- Ultrasound obtained at <20 weeks on ___________ @ ___________ weeks confirms gestational age
- Known date of conception on ___________ associated with infertility treatment

*Provide explanation if scheduling Level 3 or 4 at <39 weeks

**Note:** A mature fetal lung maturity profile is not an indication for delivery under 39 weeks in the absence of another maternal or fetal indication for delivery under 39 weeks.

*PLEASE FAX FORM TO LABOR & DELIVERY AT (631) 376-3605*

**Procedure scheduling determination:**
- Level 1 or Level 2 indication scheduled as requested
- Medically indicated procedure necessitates delivery prior to 39 weeks gestation
- Level 3 or Level 4 procedure scheduled as requested
- Gestational age ≥39 weeks on scheduled procedure date per ACOG recommendation
- Level 3 or Level 4 procedure scheduling request requires further review
- Gestational age <39 weeks on scheduled date of procedure
- Gestational age or fetal maturity not determined using established criteria

**Completed by:** ____________________________ Time: __________
Kaleida Health
Obstetrical Induction Scheduling Form

KALEIDA HEALTH
OBSTETRICAL INDUCTION SCHEDULING FORM
FAX TO: LDU: 568-3012 (MFS) ---or--- 878-7974 (CHOB)

***Inductions will be scheduled ONLY within 7 days of the requested induction date***

Instructions: (1) Complete portions A thru D and sign form. (2) Fax completed copy of form to LDU. (3) Then call LDU Charge Nurse to confirm a date & time for the requested induction.

Patient Name:___________________________________ Phone #   ______-____________
Age:_____  Gravida:____  Para:_________   EDC (LMP)_________ EDC (U/S)_________

A. Requested Induction date: ____/____/____       Requested Admission Date: ____/____/____
Gest. age (date of induction): _____wks ____days   Requested Admission Time: _____:_____ 

B. Calculate Bishop Score: Pelvic Exam (Dilatation/Effacement/Station):

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilatation (cm)</td>
<td>closed</td>
<td>1-2</td>
<td>3-4</td>
<td>≥ 5</td>
</tr>
<tr>
<td>Effacement (%)</td>
<td>0-30</td>
<td>40-50</td>
<td>60-70</td>
<td>≥80</td>
</tr>
<tr>
<td>Station</td>
<td>-3</td>
<td>-2</td>
<td>-1</td>
<td>+1,+2</td>
</tr>
<tr>
<td>Consistency</td>
<td>Firm</td>
<td>Medium</td>
<td>soft</td>
<td></td>
</tr>
<tr>
<td>Position of cervix</td>
<td>Posterior</td>
<td>Mid-position</td>
<td>Anterior</td>
<td></td>
</tr>
<tr>
<td>Total Score:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. Indicate Planned Intervention (please check (✓) box): [ ] Cervidil, [ ] Foley Bulb, [ ] Pitocin

D. Identify Medical Indication for Labor Induction (Please check (✓) all that are appropriate):
[ ] Postdates (>41wks)
[ ] Pregnancy-Induced hypertension (submit supportive data i.e. B/P, proteinuria, CBC, LFT, 24 hour urine TP/CrCl)
[ ] Premature rupture of membranes
[ ] Chorioamnionitis
[ ] Oligohydramnios (AFI ≤ 5 cm.) (Submit U/S Report)
[ ] Suspected fetal jeopardy (i.e. IUGR): Please list indication:
[ ] Maternal medical condition (i.e. Insulin Dependant Diabetes): Please list indication:
[ ] Fetal demise

If induction does not meet the above INDICATION CRITERIA provide justification below:
____________________________________________________________________________________
____________________________________________________________________________________
Every attempt will be made to accommodate your request. Please instruct your patient to arrive at the confirmed arrival time to ensure a timely admission and induction process.

Attending Physician/CNM
Print name: ___________________________ Signature: ___________________________ Date: __________

LDU Charge Nurse Documentation of confirmed Induction Date/Admission Date & Time:
LDU Charge RN
Print name: ___________________________ Induction date: __________ Admission date: __________

Indications for the induction of labor other than the above listed medical indications are referred for review and approval by the hospital site GYN/OB Chief of Service:

GYN/OB
Chief of Service
Print name: Dennis Weppner, MD Signature: ___________________________ Date: __________

Outcome: Mode of delivery: _________ APGAR Score: ___/___ Date of Delivery: ___/___/___

MYDOC/FORMS/PITMD.DOC
## Obstetrical Oxytocin Administration Orders

### A. INDICATION FOR OXYTOCIN ADMINISTRATION FOR INDUCTION/AUGMENTATION OF LABOR

- □ Absence of labor after Cervidil®/Indwelling balloon catheter removal
- □ Presence of uterine hypo-contractility in laboring patient
- □ Elective (39 completed weeks gestation or a mature lung profile)
- □ Postdates (41 weeks or greater)
- □ Chorioamnionitis
- □ Fetal demise
- □ Gestational hypertension
- □ Preeclampsia, Eclampsia
- □ Premature rupture of membranes
- □ Logistic factors (rapid labor risk, significant distance from hospital)
- □ Suspected fetal jeopardy (i.e., intrauterine growth restriction, oligohydramnios):
- □ Maternal medical condition (i.e., insulin dependent diabetes, thrombophilia, etc.):

### B. EVALUATION OF MATERNAL/FETAL STATUS

- Evaluating physician: ____________________________
- Estimated date of confinement by last menstrual period: ________________
- Estimated date of confinement by sonogram: ________________
- Pelvic exam: _______________________________________
- Presentation: ______________________________________
- Reassuring fetal status: □ Yes □ No
- Pelvis adequate: □ Yes □ No
- Discussion with patient of indication for induction/augmentation of labor, method, and risk: □ Yes □ No
- Plan of management acceptable to the woman: □ Yes □ No

### C. OXYTOCIN ORDER

- Start Date: ________ Start Time: ____________
- Oxytocin 15 units/250 mL Lactated Ringers (60 milliunits/mL) 1 milliunit/minute (1 mL/hour)
- □ Initiate Oxytocin Induction Protocol (MAT 50):
  - Initiation of oxytocin 1 milliunit/minute, then increase increments by _______ milliunits/minute (1 or 2 milliunits/minute) every _______ minutes (30 to 60 minutes; maximum dosage of 20 milliunits/minute)

### Torb

- Date: ____________ Time: ____________
- Signature: ____________________________

### Orders Noted by RN

- Date: ____________ Time: ____________
- Signature: ____________________________

---

**ALLERGIES:** REFER TO ALLERGY PROFILE/POWERCHART

**FAX TO:** Labor & Delivery - (716) 568-3012 (MFS) / (716) 878-7974 (WCHOB)

(✓) Check, circle and/or fill in all orders to be implemented as appropriate.
Title: Oxytocin for Induction Augmentation of Labor

Owner: Women and Infants’ Standards Committee

Keywords: Induction; Augmentation; Pitocin; Oxytocin

Policy Reference:

I. Statement of Purpose

Oxytocin is a commonly used drug used to induce or augment labor. Individual patients vary in sensitivity and response to oxytocin. This policy defines the responsibility of the qualified members of the obstetrical team in the implementation of oxytocin for induction or augmentation of labor.

II. Standards of Practice/Standard Operating Procedures

A. The use of oxytocin for induction or augmentation of labor will be conducted on the Labor and Delivery Unit. The attending physician and/or a qualified member of the obstetric team who functions under the direct supervision of the responsible physician must examine the patient, including vaginal exam before the oxytocin infusion is initiated. The obstetric team on the Labor and Delivery Unit functions under the direct supervision of the responsible physician.

B. The attending in-house physician must be immediately available during the initiation of the induction/augmentation and for at least 20 minutes to determine that the drug is well tolerated by the patient and fetus.

C. During the entire time of the infusion of the oxytocin agent, the Attending physician, or another physician who has assumed responsibility for the patient’s care, shall be available within 10 minutes to manage any complications that may arise.

D. The Obstetrical Cervical Ripening Order (KH01266) and/or Obstetrical Oxytocin Administration Order (KH01267) must be completed.

E. Personnel who are familiar with the effects of oxytocin and who are able to identify both maternal and fetal complications should be in attendance during administration of the agent.

F. The RN who cares for the patient during the oxytocin infusion must demonstrate competence in fetal heart rate pattern assessment and interventions in response to changes in fetal heart rate patterns. The RN must also demonstrate competence in the administration of oxytocin via infusion pump, and recognize the possible side effects of the medication.

G. Criteria for Use of Oxytocin:

1. Medical indications for the induction of labor may include, but are not limited to the following:
   a. Pregnancy induced hypertension
   b. Premature rupture of membranes
   c. Chorioamnionitis
   d. Suspected fetal jeopardy
   e. Maternal medical conditions
   f. Fetal demise
   g. Post term pregnancy
   h. Logistic factors

Page 1 of 7
Title: Oxytocin for Induction Augmentation of Labor  

**Keypoint:** When labor is induced for Logistic factors (i.e. nonmedical indication) the pregnant women should be at least 39 completed weeks of gestation or fetal lung maturity should be established to avoid the risk of iatrogenic prematurity

i. Abruptio Placenta
j. Preeclampsia, eclampsia

2. Obstetric Conditions that are not contraindications to oxytocin but require special attention:
   a. A trial of labor after a previous cesarean birth or history of a prior uterine scar
   b. Breech presentation
   c. Maternal heart disease
   d. Polyhydramnios
   e. Presenting part above the pelvic inlet
   f. Severe hypertension
   g. Abnormal FHR patterns not requiring emergent birth
   h. Multiple pregnancy
   i. Invasive cervical cancer

3. Elective induction of labor:
The “Obstetrical Induction Scheduling Form” must be completed and sent to the Labor and Delivery Unit prior to the day of scheduled induction. Induction of labor, where no medical indication exists and for indications other than the above listed criteria, is subject to review and approval by the hospital site OB/GYN Chief of services (or his/her designee)

4. Augmentation of labor:
Augmentation of labor refers to the stimulation of uterine contractions when spontaneous contractions have failed to result in progressive cervical dilatation or descent of the fetus. Before augmentation is to be started an assessment of the maternal pelvis and cervix and fetal position, station and well-being should be performed.

5. Contraindications to oxytocin include but are not limited to:
   a. Complete placenta previa
   b. Vasa previa
   c. Prior classical uterine incision
   d. Pelvic structural deformities
   e. Active genital herpes infection
   f. Transverse fetal lie
   g. Prolapsed umbilical cord
   i. HIV positive patients with high viral load

H. Supportive Data:
Oxytocin may be used to induce labor when the benefits to either the mother or the fetus outweigh those of continuing the pregnancy. Oxytocin is used for augmentation and enhancement of inadequate uterine contractions. The goal of induction or augmentation of labor is to produce adequate uterine activity for cervical dilation and vaginal delivery, while avoiding uterine tachysystole and fetal compromise.
I. Content:
   1. Assessment/Data Collection:
      a. Prior to initiation of oxytocin infusion:
         1) The attending physician and/or a qualified member of the obstetric team who functions under the direct supervision of the responsible physician must examine the patient, including a vaginal exam.
         2) The Oxytocin Order Form must be completed which includes evaluation of the following:
            a) Indication for induction/augmentation
            b) Responsible physician who will be available within 10 minutes
            c) Evaluation of maternal/fetal status
            d) Discussion with patient of indication for induction/augmentation and risk
            e) Plan of management is acceptable to women
            f) Medication order
         3) Apply fetal monitor and tocodynamometer to determine baseline fetal heart rate and contraction pattern if present, for a minimum of 20 minutes to verify reassuring fetal status.
         4) Obtain baseline maternal vital signs
      b. During oxytocin infusion:
         1) Monitor vital sign as follows:
            a) Assess and document maternal vital signs at regular intervals as clinical condition warrants.
            b) Assess and document maternal temperature every 4 hours if membranes are intact or every 2 hours if membranes are ruptured.
         2) Assess and document intake and output.
         3) Assess fetal heart rate and uterine activity every 15 minutes during the first stage of labor and every 5 minutes during the 2nd stage of labor.
            **Keypoint:** Patient must be on continuous fetal monitoring during administration of oxytocin.
            **Keypoint:** When external fetal heart rate monitoring is used to record data permanently, periodic documentation can be used to summarize fetal status. The fetal heart rate should be assessed and documented before each dose increase of oxytocin.
   2. Care and Management:
      a. Start an IV infusion (primary line) using 1000ml Lactated Ringers.
         **Keypoint:** IV solutions may vary depending upon the patient’s medical condition, i.e. diabetes.
      b. Set up a secondary line of oxytocin on infusion pump and connect to primary line port (clave) or stopcock closest to angiocath insertion site.
         **Keypoint:** Oxytocin concentration (0.6 units per 10 ml) yields an administration ratio of 1 milliunit/minute=1 milliliter/hour.
      c. Initiate infusion as ordered.
1) **Induction/Augmentation Protocol:**
   a) Initiation of oxytocin should not exceed 1 to 2 milliunits/minute.
   b) Increments: Increase by 1 milliunit/minute to 2 milliunits/minute every 30 to 60 minutes.
   c) Maximum dosage of 20 milliunits/minute.
   **Keypoint:** Titrate dose to the maternal-fetal response to labor.

d. Oxytocin is increased per protocol until uterine activity is adequate as evidenced by the following:
   1) Moderate to strong palpable contractions with frequency at 2-3 minutes.
   2) Regular contractions duration of 40-60 seconds, not to exceed 90 seconds. A 60 (sixty) second interval between contractions should be observed between moderate to strong contractions.
   **Keypoint:** When an intrauterine pressure catheter (IUPC) is inserted, an adequate contraction pattern is defined as one that generates at least 200 Montevideo units (per 10 minute window) over a period of 2 hours.
   3) Progressive cervical dilatation and descent.
   **Keypoint:** A cervical dilatation of 1cm/hr in the active phase indicates that labor is progressing sufficiently, and thus oxytocin administration is adequate.

e. The nurse may not exceed protocol increments but may titrate infusion rate by limiting increments according to maternal/fetal response. Once the desired frequency of contractions has been established and labor has progressed to 5-6 centimeters dilatation, oxytocin may be reduced or discontinued depending on clinical judgment.

f. An order is required to advance oxytocin infusion rate beyond 20 milliunits per minute (20ml/hr). Maximum dose is 30 milliunits per minute. (30ml/hr).

g. Tachysystole is the most concerning side effect of oxytocin. It is defined as more than 5 contractions in 10 minutes averaged over a 30 minute window, and may or may not include nonreassuring fetal heart rate measurements.
   **Keypoint:** Long periods of tachysystole can lead to progressive deterioration in fetal status and subsequent nonreassuring fetal heart rate patterns. Thus interventions for tachysystole should not be delayed until there is evidence of nonreassuring fetal status.

1) **Clinical Protocol for Oxytocin-Induced Uterine Tachysystole:**
   a) With reassuring fetal heart rate:
      1. Maternal repositioning (left or right lateral position)
      2. IV fluid bolus of at least 500ml of lactated Ringers solution
      3. If uterine activity has not returned to normal after 10-15 minutes, decrease oxytocin rate by at least half; if uterine activity has not returned to normal after 10-15 more minutes, discontinue oxytocin until uterine activity is no more than 5 contractions in 10 minutes.

   b) With nonreassuring fetal heart rate:
      1. Discontinue oxytocin
(2) Maternal repositioning (left or right lateral position)
(3) IV fluid bolus of at least 500 ml of Lactated Ringers solution
(4) Oxygen 10 liters/minute via tight facemask
(5) If no response consider 0.25 mg terbutaline, subcutaneously.

**Keypoint:** If oxytocin has been discontinued for 20-30 minutes, the FHR is reassuring and contraction frequency, intensity and duration are normal, resume oxytocin at no more than half the rate that caused the tachysystole and gradually increase the rate as appropriate based on maternal-fetal status. If oxytocin is discontinued for more than 30-40 minutes, resume oxytocin at initial dose ordered.

3. **Safety:**
   a. The private attending physician shall order initiation of the infusion of the oxytocin agent. The qualified health care team, under the direction of the attending physician, will remain with the patient for a period of at least 20 minutes to ensure that the drug is well tolerated and has caused no adverse reaction.
   b. During the entire time of the infusion of the oxytocin agent, the private attending, or the in-house attending shall be immediately available in the event a complication may arise.
   c. If a registered nurse is not available to evaluate the effects of the oxytocin infusion at least every 15 minutes, the infusion should be discontinued until that level of nursing care is available (AAP & ACOG, 2007). The attending physician or midwife will be notified.
   d. Oxytocin should be discontinued with notification of the attending physician and/or responsible physician of the following:
      1) Tachysystole with nonreassuring fetal heart pattern
      2) Suspected water intoxication
      3) Suspected uterine rupture

4. **Infection Control:**
   Maintain Standard Precautions

5. **Complications and Reportable Incidents:**
   a. Oxytocin infusion may be complicated by:
      1) Tachysystole
      2) Impaired fetal oxygenation
      3) Maternal hypertension or hypotension
      4) Ruptured Uterus
      5) Precipitous labor
      6) Postpartum hemorrhage
      7) Uterine atony
      8) Pulmonary edema
      9) Water intoxication
   b. The private attending physician will be contacted if there are any identified maternal or fetal concerns regarding the induction. In the event that the private attending is not immediately available, the in-house
attending will be contacted to provide immediate assessment and initiate management as clinically indicated.

c. The obstetric team member covering the labor unit and the charge nurse for the labor unit are notified of alterations in maternal/fetal status.

6. Emergency Management:
   a. In the presence of a nonreassuring fetal heart rate pattern, discontinue oxytocin and initiate intrauterine resuscitative measures. (MAT.100-Intrauterine Resuscitation).
   b. Administer terbutaline if ordered.
   **Keypoint**: Notify attending physician and/or chief resident to evaluate patient following administration of terbutaline.
   c. Have operative personnel aware if interventions do not improve fetal status and cesarean section is necessary.
   d. Notify neonatal team.

7. Patient/Family Education:
   a. The indication for the induction/augmentation
   b. The desired effect, including contraction pattern and cervical progression of labor.
   c. Possible adverse effects to mother and fetus
   d. Indications for cesarean section.

III. Approved by - (Include date)

   Women Standards Committee: 9/05, 10/08
   Women Services Standards Committee: 1/16/12
   Women and Infant’s Services Quality Council: 10/08, 1/24/12, 11/19/12
   Infection Control: 9/05, 5/09, 12/22/11
   Department of OB/GYN: 10/05, 10/08, 1/24/12
   Kaleida Nurse Pharmacy: 11/05, 1/09
   Kaleida Nurse Policy Council: 11/05, 2/14/12
   Kaleida Nurse Executive Council: 12/05, 6/09, 9/7/12

IV. References

   Obstetrical Cervical Ripening Order (KH01266)
   Obstetrical Oxytocin Administration Order (KH01267)
   Electronic Medical Record (EMR)


   Mosby’s Nursing Skills Speciality “High Risk Obstetric Nursing” Oxytocin Maternal /Newborn


Kaleida Health developed these policies, procedures and standards of practice in conjunction with administrative and clinical departments. These documents were designed to aid the qualified health care team, hospital administration and staff in making clinical and non-clinical decisions about our patients’ care and the environment and services we provide for our patients. These policies, procedures and standards of practice should not be construed as dictating exclusive courses of treatment and/or procedures. No one should view these documents and their bibliographic references as a final authority on patient care. Variations of these standards of practice, in practice may be warranted based on individual patient characteristics and unique clinical and non-clinical circumstances. Please contact Standard Register regarding any associated forms.
MAIMONIDES MEDICAL CENTER

CODE: PROF-OBS-GYN-30(Revised)
DATE: December 19, 2013
ORIGINALLY ISSUED: December 15, 2011

SUBJECT: ESCALATION POLICY—OBSTETRICAL UNIT

I. POLICY

The intent of this policy is to provide for a uniform response when an obstetrical patient or her fetus experiences a sudden and acute status change. It will also serve for extraordinary operational issues in Labor and Delivery. It is to provide guidance to the RN, PA, CNM or Junior Resident in recognizing when to directly call the Chief Resident or the Attending of Record. The policy facilitates rapid intervention and effective communication among care providers.

II. PROCEDURE

A. The Chief Resident and/or Attending will be called and will respond by coming immediately to the bedside. Examples of when to immediately call the Chief resident and/or Attending include but are not limited to:

1. All Category III fetal heart tracing
2. Concerning or non-resolving Category II tracing
3. Maternal Respiratory Compromise
4. Acute change in level of Maternal Consciousness
5. Concern about the patient’s plan of care/management plan
6. Issues related to excess obstetrical volume
7. Concerning vital signs that signal patient compromise.

B. Examples of when to immediately call the Attending of the Day include but are not limited to:

1. Unavailability of OR when case warrants it
2. If the patient has a private Attending that is not in-house at the time, the Attending of the Day will assume responsibility for the care until the private Attending has been notified by the Chief Resident or designee and is available to care for the patient.
C. All efforts should be made to communicate effectively during obstetrical situations requiring rapid intervention by the obstetrical team.

1. SBAR language should be used by team members until the situation is resolved. This technique consists of concisely describing the situation, the background, assessment and the recommended plan of care.

2. Closed-loop communication should be used to ensure that vital information has been received and understood.

3. If a provider that is called cannot respond immediately, they must provide a name/contact for the next appropriate person to contact.

D. Should any member of the obstetrical team be concerned, or disagree with the plan of care, they may seek clarification immediately by stating clearly to the team leader (i.e. Attending and/or Charge RN), “I need clarity.”

1. A concern about management or care can be stated using the CUS tool (I’m concerned, uncomfortable, this is a safety issue). If the person being questioned is not responding, the challenger must address the concern (Two Challenge Rule) prior to proceeding. If there is no response, the concern must be escalated further.

2. If there is a question about the management by the covering attending, another in house attending/MFM covering/Director of Obstetrics should be called to reevaluate.

3. Ideally, if the situation allows, conversations regarding clinical conflict should take place away from the patient. If this occurs at the patient’s bedside, the conversation should occur in a manner that does not unduly alarm the patient or a family member.

E. If the patient’s or the fetus’ condition worsens, despite the intervention of the Chief Resident and Obstetrical Attending, the OB Emergency Response Team, the Rapid Response Team, or the Hospital Code 3 Team should be activated, as and when appropriate.

III. RESPONSIBILITY

A. The person who initiates the Escalation should clearly state their concern and remain at the bedside to assist in the response, unless reassigned by the Chief Resident, Attending responding or Charge RN.
B. Any RN utilizing the Escalation Policy to alert a Chief Resident and/or Attending, should also escalate up the nursing chain of command to alert the Charge RN, Team Leader, Assistant Nurse Manager, Nurse Manager/Supervisor designee, and/or AVP. This ensures team communication and an opportunity for mutual support.

C. The Charge Nurse, the Attending of the Day, and the Voluntary Attending may further escalate the situation to either the Maternal Fetal Medicine Attending covering the service, the Nursing Director for Women’s Health Services, the Director of Obstetrics, and/or the Chairman.

D. Documentation: Following resolution of the clinical situation, the person who initiated the escalation, as well as the Chief Resident or Attending that responded, must document the event and the response that ensued in the medical record.

IV. CONTROLS

Any issues arising from this policy shall be brought to the attention of the Chairman of Obstetrics and Gynecology or his/her designee.

Pamela S. Brier
President

PB:SM:cg

INDEX: Escalation Policy – Obstetrical Unit
ORIGINATING DEPARTMENT: OB/GYN
Disclosure to patients scheduled to deliver between 37 weeks and 38 weeks + 6 days.

The patient understands that her fetus is considered “early term.” Early term means gestational age between 37 weeks and 38 weeks and 6 days. Babies born in this gestational age range may experience some difficulty with breathing on their own and may be slower feeders. These babies may also be at higher risk to develop some jaundice and may face a longer hospital stay. They might need admission to NICU. However she also understands that there is a specific maternal/fetal indication which warrants delivery at this time.

PeriBirth Electronic Medical Record:

Early Term Disclosure Note with decision support added (once (CAM W7)):
1. When the Gestational Age is between 37 and 38 + 6 weeks and there is any of the following:
   - Labor Induction is decided
   - Cesarean Section is decided
   - Labor Induction or Cesarean Section is selected on:
     - the Procedures card of the Chief Complaint OR
     - the Plan of Care cards
   - The delivery date is entered in the delivery report
2. Unload the requirement after delivery is done.
Patient Safety Alert

To ALL Labor and Delivery staff:
Maimonides is part of a statewide initiative to decrease elective deliveries <39 weeks in order to reduce unnecessary prematurity.

In Effect Now:
Women are not to be admitted for induction or elective cesarean section at less than 39 weeks unless a maternal/fetal indication is specified.

Examples of medically indicated delivery at < 39 wks include:
- Fetal demise
- Premature rupture of membranes
- Gestational hypertension, preeclampsia, eclampsia, chronic hypertension
- Maternal conditions: (e.g.) diabetes, renal disease, chronic pulmonary disease
- Fetal Compromise: (e.g.) IUGR, isoimmunization, oligohydramnios
- Placental abruption, placental previa, unspecified antenatal hemorrhage
- Fetal distress, abnormal fetal heart rate
- Fetal malformation, chromosomal abnormality, or suspected fetal injury

If a patient presents to triage for elective induction or cesarean at <39wks without a specific indication:

1. Call provider: inquire about indication & confirmation of dates
2. If no indication, as per ACOG/TJC: refer to Service Attending
3. If situation still unresolved: MOG Attending will refer to MFM
4. If patient must be rescheduled: inform patient of >39wk benefits:
   - Increased brain development between 36 and 39 weeks
   - Less NICU admissions
   - Improved breathing and feeding in newborns

Questions?
Contact Charge Nurse or Attending (x1744). Or speak to a member of the MMC/NYSONQC Committee: Dr. Ron Berka, Heather Raphael, PA, Team Leader: Rosa Peralta, RN, Rani Shankar, CNM, Dr. Sandra McCalla, Perinatal Safety Officer: Lora Dibner-Garcia, RN (x7542).
Dept. of Obstetrics & Gynecology

**718-283-8218** Call to reserve slot  
**718-635-7309** Fax form within 48 hours of phone booking

**Patient’s name:** ______________________________ **Patient’s phone #:** ____________________________

**Provider’s name:** ______________________________ **Provider’s/Office contact #:** ____________________________

**Desired date/Time:** ____________  
**Indication:** ________________________________________________________

**Age:** _______ G _____ P _____ _____ _____  
**Please fax a copy of first ultrasound report**

**EDC:** __________ is based on (please check all that apply):

- □ A. LMP _______ (specify date)  
- □ B. Early sonogram (up to 15 weeks)  
- □ C. 2nd Trimester sono (consistent with LMP)  
- □ D. 3rd Trimester sono (>23 weeks)

**Twins/Multiple gestation:** □ Yes □ No  
**History of PPH:** □ Yes □ No

**LUS/large myomas:** □ Yes □ No  
**Known coagulopathy:** □ Yes □ No

**Interventional Radiology consult:** □ Yes □ No  
**Anesthesia consult:** □ Yes □ No

**# Prior cesarean sections:**  
**Placenta previa:** □ Yes □ No

**If GA <39 weeks: Amniocentesis done for fetal lung maturity testing?** □ No □ Yes **Date:** ____________________________

**BMI >40:** □ Yes □ No

**Medical issues (circle all that apply):**
- cardiac / pulmonary / musculoskeletal / other:

**Objections to blood transfusions:** □ Yes □ No  
**Reason if known:** ____________________________

*Patients at high risk for hemorrhage will be contacted about Pre Admission Testing.*  
**A mature fetal lung maturity profile is not an indication for delivery under 39 weeks in the absence of another maternal or fetal indication for delivery under 39 weeks.**

**Thank you. Provider’s office will be contacted within 3 business days to confirm.**

---

**For internal use only:**  
**Fax rec’d Date:** ____________________________  
**Time:** ____________________________ **By:** ____________________________

**At admission patient will be _____ weeks _____ days. MFM review needed? Y / N  
**Case Approved? Y / N**

**MFM Assessment:** ____________________________

**MFM Signature:** ____________________________

**Pre Admit Consultation needed? Y / N**  
**Pre Admit Testing Scheduled? Y / N  
**Scheduled By:** ____________________________

**Confirmed w/ Dr. Office Date:** ____________________________  
**Time:** ____________________________ **Via:** ____________________________ **By:** ____________________________

---

Pre-Admission Form Updated 06-04-14
Pre-Procedure Booking Form Compliance

Unit: Labor and Delivery  
Topic: Pre-Procedure Booking Form Compliance  
Month ___________________ Year: ________

<table>
<thead>
<tr>
<th>Last Name</th>
<th>Provider</th>
<th>C/S booked</th>
<th>≥ 39 at day of procedure</th>
<th>Less than 39 at day of procedure</th>
<th>Booking form faxed</th>
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</table>
PRENATAL RECORD FAX TRANSMISSION

To (Recipient): ______________________________          Date: __________________

Recipient’s Fax Number: ___________________________          # Pages sent: ______________

From (Sender): _______________________________________________________

Best contact information of sender (email or telephone #): _____________________________

Documents to follow for (Patient Name): ________________________________

Patient date of birth: ______________

Documents sent:

□ ACOG prenatal record          □ First ultrasound report
□ Type and screen              □ Hgb electrophoresis
□ HIV                         □ Hepatitis B surface antigen
□ RPR                         □ Rubella
□ GCT                         □ GTT
□ CBC

□ Other labs, if relevant (specify): _____________________________________________

__________________________________________________________________

For office use only:

Confirmation of receipt of prenatal records: □ Yes          □ No

Signature: ____________________________          Print name: ____________________________

Date: ____________________________

Document Updated: 07-12-13
# New York Methodist Hospital
## Labor & Delivery Cesarean Section Surgical Booking Information Form

**PLEASE FAX COMPLETED FORM to (718) 780-3211 or 5119**

## LABOR & DELIVERY CESAREAN SECTION
### SURGICAL BOOKING INFORMATION FORM

### (Page 1 of 2)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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</thead>
<tbody>
<tr>
<td>RESIDENT NAME:</td>
<td>____________________</td>
</tr>
<tr>
<td>BEEPER NUMBER:</td>
<td>____________________</td>
</tr>
<tr>
<td>OBSTETRICIAN NAME:</td>
<td>____________________</td>
</tr>
<tr>
<td>Contact Telephone #:</td>
<td>____________________</td>
</tr>
<tr>
<td>Patient M.R. # (if applicable):</td>
<td>____________________</td>
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<tr>
<td>Contact Person's Name:</td>
<td>____________________</td>
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<tr>
<td>Patient’s Full Name:</td>
<td>____________________</td>
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<td>(Last Name)</td>
<td>(First Name)</td>
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<td>Address:</td>
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<td>Work #: (       )</td>
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<td>Insurance Pre-Authorization #:</td>
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<tr>
<td>Date/Time of Procedure:</td>
<td>(Day &amp; Date)</td>
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<tr>
<td>Surgical Procedure Planned:</td>
<td>□ REPEAT C-SECTION</td>
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<tr>
<td>Admitting Diagnosis:</td>
<td>□ PRIOR C-SECTION</td>
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<tr>
<td>Co-Morbid Diagnoses:</td>
<td>□ TWINS</td>
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<tr>
<td>OTHER DIAGNOSES (NO ABBREVIATIONS)</td>
<td>____________________________________________</td>
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<tr>
<td>Type of Anesthesia:</td>
<td>□ Per Anesthesia Service</td>
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<tr>
<td>DOSA (Day of Surgery Admittance)</td>
<td>□ PSAT (Prior Surgical Admittance): Date to be admitted: / /</td>
</tr>
<tr>
<td>Medical Doctor’s Name/Telephone #:</td>
<td>____________________</td>
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<tr>
<td>PREOPERATIVE TESTING REQUESTED: (Please check appropriate box)</td>
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<td>□ PT/PTT</td>
<td>□ CBC</td>
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<td>□ URINE ANALYSIS</td>
<td>□ TYPE &amp; SCREEN</td>
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</table>

*ALL above information has been verified by OR Scheduler with Obstetrician and/or Representative:

<table>
<thead>
<tr>
<th>OR Scheduler Signature</th>
<th>Date/Time</th>
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</table>

Pre-Surgical Testing Date: / / Schedule By: __________________________
**Hospital Policies, Tools & Forms continued**

PLEASE FAX COMPLETED FORM to (718) 780-3211 or 5119

LABOR & DELIVERY CESAREAN SECTION
SURGICAL BOOKING INFORMATION FORM
Page 2 of 2

PATIENT FIRST NAME ______________________   LAST NAME __________________________

ATTENDING PHYSICIAN __________________________

REQUESTED DATE OF CESAREAN SECTION:   _____/_____/_____

REQUESTED TIME   ____:____ AM/PM

G___  P___  GESTATIONAL AGE AT TIME OF C-SECTION :  ____ WEEKS

“FINAL EDC” (AS DETERMINED BY LMP AND SONO)    ____/___/___

PLACENTAL LOCATION (CIRCLE) :   FUNDAL  |  LOW LYING |  ANTERIOR  |  POSTERIOR

<table>
<thead>
<tr>
<th>Obstetrical Indications</th>
<th>Maternal Indications</th>
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<tbody>
<tr>
<td>Prior CS at 39 weeks or greater</td>
<td>Diabetes Mellitus</td>
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<tr>
<td>Number of Prior Sections</td>
<td>Preeclampsia/Eclampsia</td>
</tr>
<tr>
<td>Prior Classical C/Section</td>
<td>Chronic Hypertension</td>
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<tr>
<td>Breech Presentation at 39 weeks or greater</td>
<td>Renal Disease</td>
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<tr>
<td>Complete Placenta Praevia</td>
<td>Chronic Pulmonary Disease</td>
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<tr>
<td>Cesarean Section on Maternal Request*</td>
<td>Previous myomectomy (involving endometrium)</td>
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<td>* Requires MFM Consult on chart</td>
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<tr>
<td>Twin Gestation, non vertex presentation</td>
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<tr>
<td>Severe Fetal Growth Restriction (IUGR)*</td>
<td>Isoimmunization</td>
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<tr>
<td>*requires sonogram report on chart</td>
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<tr>
<td>Other</td>
<td>HIV infection</td>
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</table>

Indications Reviewed: YES      NO

Labs Reviewed          YES      NO

Comments _________________________________________________________

Reviewed by: _____________________ DATE:  ____/____/____
**INDUCTION OF LABOR ADMISSION FORM**

**PATIENT NAME ___________________  PHYSICIAN __________________**

“FINAL EDC” _____/_____/____  GESTATIONAL AGE: _____ WEEKS

**CLINICAL EFW _______  ULTRASOUND EFW (if done) ________**

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<tr>
<th>Obstetrical Conditions</th>
<th>Maternal Medical Conditions</th>
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<td>Postterm Pregnancy (41 0/7 Weeks Or Greater)</td>
<td>Diabetes Mellitus GDMA 1 _____ GDMA2 _____ Insulin Dependent ________</td>
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<td>Chorioamnionitis</td>
<td>Preeclampsia/Eclampsia</td>
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<td>Fetal Demise</td>
<td>Chronic Hypertension</td>
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<td>Non Reassuring Antepartum Testing</td>
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<td>Oligohydramnios (AFI of ≤ 5.0 cm)</td>
<td>Chronic Pulmonary Disease</td>
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<tr>
<td>History of Precipitous Labor</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** All elective (non medical) inductions must be 39 weeks and have a Bishop score of 5 or more

**Bishop Scoring System** (Circle all that apply)

<table>
<thead>
<tr>
<th>Score</th>
<th>Dilation (cm)</th>
<th>Effacement (%)</th>
<th>Station</th>
<th>Cervical Consistency</th>
<th>Position of Cervix</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Closed</td>
<td>0-30</td>
<td>-3</td>
<td>Firm</td>
<td>Posterior</td>
</tr>
<tr>
<td>1</td>
<td>1-2</td>
<td>40-50</td>
<td>-2</td>
<td>Medium</td>
<td>Midposition</td>
</tr>
<tr>
<td>2</td>
<td>3-4</td>
<td>60-70</td>
<td>-1.0</td>
<td>Soft</td>
<td>Anterior</td>
</tr>
<tr>
<td>3</td>
<td>5-6</td>
<td>80</td>
<td>+1,+2</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

**Attending Physician Score:**

I (or my designee) have explained the risks, benefits and possible complications to my patient, who agrees with my plan of care.

**Attending Physician Signature ______________________ Date _____________**

Please fax at time of scheduling the induction to Labor and Delivery (718-780-3508)

**Resident Bishop Score:**

Dilation _____ Station _____ Effacement _____ Position _____ Consistency _____

Total Score: __________

**Resident Signature ______________________ Date _____________ Time: ____________
NYU Langone Medical Center
Updated Scheduling Procedure for OB Patients

Making a reservation is easy, just fax it!

- Requests may be made once the patient has reached the gestational age of 30 weeks
- Requests will only be accepted via fax
- Requests will be reviewed at 1pm Mon-Fri
- ICD-9 codes must be provided with each reservation for c-section; cerclage placement or tubal ligation requests
- Procedures will be confirmed within one business day via email.
  (646) 754-9614

**Please…do not call the floor for planned procedures**

It’s urgent! What should I do?

- Emergent procedures that need to be done that day
  - Call the unit and speak with nursing leadership (charge nurse, ANM) or the safety officer.

Available Times on the Schedule

<table>
<thead>
<tr>
<th>M</th>
<th>T</th>
<th>W</th>
<th>Th</th>
<th>F</th>
<th>S</th>
<th>Su</th>
</tr>
</thead>
<tbody>
<tr>
<td>8a</td>
<td>8a</td>
<td>9a</td>
<td>8a</td>
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<td>9a</td>
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<td>10</td>
<td>11</td>
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<td>10</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>12</td>
<td>12</td>
<td>1p</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A few changes in the model…

- Elective Inductions are not being scheduled prior to 40 weeks
- Elective deliveries <41 weeks with a poor bishop score may be asked to be delayed to a later date
- Indication for delivery **must** be provided
- The more information completed on the form the easier it is to make the reservation.
Thank you! We appreciate your support and flexibility
Procedure Reservation Form Instructions

1. Send completed Procedure Scheduling Request Form via fax by 1pm each day Monday – Friday.
2. Requests received after 1 pm may not be processed until the following business day.
   a. The fax number is (646) 754-9614
3. Wait for confirmation via email within one business day.
4. Requests for next day procedures will be confirmed by 3:00 pm of day requested via email.
5. Provide internal contact for questions and email for confirmation.

Tips for scheduling procedures
1. Requests will only be processed after the patient has reached the gestational age of 30 weeks
2. Deliveries less than forty weeks without a medical indication will not be honored
3. Elective deliveries less than 41 weeks with a poor bishop score may be asked to be delayed to a later date
4. Once the process is in place, please send requests via fax.
5. Scheduling questions may be referred to obsecregistration@nyumc.org
Procedure Reservation Form: Fax to (646) 754-9614

Today’s Date ____________________________

Requesting Physician ____________________________

Patient Name ____________________________ DOB ___________ G ___ P ___________

EDC ___________ ☐ Confirmed by Early Ultrasound ☐ Other ___________

Medical Record (if in EPIC) ____________________________

Requested Procedure Date ____________________________

Method of Delivery: ☐ Cesarean Delivery ☐ Primary ☐ Repeat ☐ Repeat C/S Preferred Time ____________________________

☐ Induction ☐ Needs Cervical Ripening ☐ GBS Status ____________________________

Date fetal presentation U/S ___________ EFW ___________ Bishop Score ____________________________

Reason for Delivery prior to 39 weeks

☐ Chorioamnionitis
☐ Preeclampsia/HELLP
☐ Abruptio placenta
☐ Previa
☐ Poor fetal testing (describe results below)
☐ PROM
☐ Fetal hydrops/isoimmunization
☐ Blood group sensitization
☐ IUGR (indicate percentile below)
☐ IUGR with poor testing
☐ Fetal Anomaly
☐ Maternal medical conditions (please indicate below)
☐ Gestational hypertension
☐ Multifetal gestation (Twins ≥ 38 weeks)
☐ Hx of Classical C/S
☐ Oligohydraminos (AFI <5 at term)
☐ Prior myomectomy

Other Indications for Delivery:

Clinical Data/Consults/Referrals:

Other Reasons for Delivery

At this time we are not scheduling elective inductions prior to 40 weeks

☐ > 40 weeks gestation
☐ Repeat C/S
☐ Maternal HIV
☐ Fetal Demise
☐ Malpresentation
☐ Unstable lie
☐ Gestational diabetes

Must Provide ICD-9 code for C/section; cerclage placement or tubal ligation. Without the code the case cannot be scheduled.

OB Internal Office Number ____________________________ Patient Contact Number ____________________________
Obstetrical Pre-Admission Form for Elective Induction

Patient’s Name: ________________________________  Patient’s Phone: _____________________________

Provider’s Name: ________________________________  Patient’s Date of Birth: ___

Providers Best Contact Number (please provide cell#) ________________________________

Preferred Date/Time of Admission (select by order of preference):
1. Date _______ Time: __________
2. Date _______ Time: __________
3. Date _______ Time: __________

Indication: _________________________________________________________________

If < 41 weeks 0 days, approved by (name of MFM) ________________________________

Patient’s LMP: _______________  Patients EDC: _______________

EDC determined by:

☐ An ultrasound measurement at less than 20 weeks of gestation
   Date of first prenatal ultrasound: ________________________________

☐ Fetal heart tones documented as present for 30 weeks by Doppler
   Date of first Doppler: ________________________________

☐ 36 weeks since a positive serum or urine HCG pregnancy test result
   Date of positive pregnancy test: ________________________________

☐ Other: (Please indicate how gestational age was calculated and why one of the above methods could not be used)

___________________________________________________________

For internal use only:
At admission patient will be _________ weeks _________ days

Please FAX this form to: 212-523-8066
Obstetrical Pre-Admission Form for Elective C-Section

Patient's Name: ___________________________ Patient's Phone: ________

Provider's Name: ___________________________ Patient's Date of Birth: ________

Providers Best Contact Number (please provide cell#) ___________________________

Preferred Date/Time of Admission: 1. Date ________ Time: ________

2. Date ________ Time: ________

3. Date ________ Time: ________

Indication: ___________________________

If < 39 weeks 0 days, approved by (name of MFM) ___________________________

Pre-admission Essential Information: G ______ P ________

3rd Trimester Hematocrit value: ________ LIJS/large myomas □ Yes □ No

# Prior C-sections: ________ Known coagulopathy: □ Yes □ No

BMI ≥ 40: □ Yes □ No Objections to blood transfusions: □ Yes □ No

Patient's LMP: ________ Patients EDC: ________

EDC determined by:

□ An ultrasound measurement at less than 20 weeks of gestation
  Date of first prenatal ultrasound: ________

□ Fetal heart tones documented as present for 30 weeks by Doppler
  Date of first Doppler: ________

□ 36 weeks since a positive serum or urine HCG pregnancy test result
  Date of positive pregnancy test ________

□ Other: (Please indicate how gestational age was calculated and why one of the above methods could not be used)

________________________

For internal use only:
At admission patient will be ________ weeks ________ days

Please FAX this form to: 212-523-8066
PURPOSE
The purpose of this policy is to allow for the safe delivery of obstetric care and the efficient utilization of organizational resources. It is also intended to eliminate non-medically indicated elective deliveries prior to 39 weeks.

POLICY STATEMENTS
St Peter’s Hospital follows American Congress of Obstetricians and Gynecologists (ACOG) recommendations for elective inductions or cesarean sections (C/S). Elective delivery is defined as those in which medical indications are not present. Non-medically indicated cesarean sections or inductions of labor prior to 39 weeks completed gestation may not be scheduled without approval of Maternal-Fetal Medicine or the Chief of Obstetrics.

SCOPE OF AUTHORITY / COMPETENCY
Information Associate (IA), Scheduler, Scheduling Associate, Registered Nurse (RN), OR/PAT Scheduling Secretary

**DEFINITIONS**

Medical and obstetric indications for cesarean section or induction of labor can be classified into maternal and fetal reasons for delivery. The necessity to deliver the patient prior to 39 completed weeks gestation must take into account the severity of the condition, ACOG recommended guidelines for early scheduled delivery, and the risks and benefits to the mother AND the fetus/newborn.

A scheduled delivery is considered as any delivery occurring by cesarean section or induction of labor PRIOR to the onset of spontaneous labor.

Gestational age at the time the patient will present for the scheduled cesarean or induction of labor must be used when scheduling the procedure.

Those indications that **DO NOT** require approval from the OB/GYN department chair or Maternal-Fetal Medicine to deliver **prior to 39 weeks gestation** are listed below. (*Note: The presence of a condition or diagnosis in the list does not imply that all pregnancies with such condition must be delivered prior to 39 completed weeks gestation.)*:

**Maternal Medical or Obstetric Conditions**
- Placental abruption
- Placenta previa / Vasa previa
- Placenta accreta - provider must notify Labor & Delivery Manager and/or Perinatal CNE/CNS and OB/Gyn Department Chair
- Prior myomectomy
- Prior vertical or “T” uterine incision scar from prior cesarean section
- Preeclampsia
- Gestational hypertension
- Chronic hypertension (diagnosed prior to pregnancy)
- Gestational Diabetes, with or without insulin therapy
- Diabetes, Type I or II (diagnosed prior to pregnancy)
- PROM – Premature (before labor) Rupture of Membranes
- Prolonged Rupture of Membranes (12 hours or more)
- Chorioamnionitis
- Active genital herpes infection
- HIV
- History of poor pregnancy outcome (i.e. prior fetal demise) - must be specified at time of booking and documented in patient record
- Liver disease (i.e. cholestasis of pregnancy) - provider must specify at time of booking
- Hematologic condition (i.e. history of PE/DVT, anticoagulant therapy, hemophilia) - must be specified at time of booking and documented in patient record
- Heart disease - must be specified at time of booking and documented in patient record
- Pulmonary disease (chronic) - must be specified at time of booking and documented in patient record
- Renal disease (chronic) - must be specified at time of booking and documented in patient record

**Other maternal/obstetric indications may be booked with pre-approval from the OB/GYN department chair or Maternal-Fetal Medicine - indication and approval must be documented by the attending provider in patient record at time of booking**
Fetal Conditions
- Oligohydramnios (AFI less than or equal to 4cm³) - must be specified at time of booking and documented in patient record
- IUGR – Intrauterine Growth Restriction (ultrasound measurements consistent with less than 5th percentile for GA) – must be specified at time of booking and documented in patient record
- Macrosomia (ultrasound measurements revealing estimated fetal weight [EFW] greater than 5000g) – must be specified at time of booking and documented in patient record
- Abnormal fetal testing (by non-stress test [NST], biophysical profile [BPP], or continuous wave Doppler) – must be specified at time of booking and documented in patient record
- Fetal demise (current pregnancy)
- Alloimmunization/ fetal hydrops (i.e. Rh sensitization)
- Major fetal anomaly – provider must specify at time of booking and notify Neonatology group
- Twin gestation with complications (i.e. twin to twin transfusion syndrome, discordant growth, etc.) – must be specified at time of booking and documented in patient record
- Monochorionic-Diamnionic Twins without complications
- Dichorionic-Diamnionic Twins without complications ONLY at 38 weeks or greater
- Other fetal/newborn indications may be booked with pre-approval from the OB/GYN department chair or Maternal-Fetal Medicine - indication and approval must be documented by the attending provider in patient record at time of booking

Scheduled deliveries greater than or equal to 39 weeks gestation may be booked for any of the above listed conditions or diagnoses, or for the following additional indications without approval from the OB/GYN department chair or Maternal-Fetal Medicine:

Scheduled Cesarean Section (C/S)
- Prior cesarean section, no trial of labor
- Breech presentation
- Other malpresentation
- Patient requests

Elective Induction
- Patient requests
- Psychosocial stress (i.e. domestic violence, no social support, etc.)
- Convenience of patient/ doctor (includes scheduling difficulties, past due date, etc.)

Post Dates Induction
- Post-dates inductions may only be selected at greater than or equal to 41 weeks gestation (i.e. patient scheduled for 40 weeks +2 days GA is past due and shall be scheduled for an elective induction if no medical, obstetrical, or fetal indication exists)

PROCEDURE
Confirmation of Gestational Age and Patient Counseling for Scheduled Delivery less than 39 weeks:
1. Gestational Age must be confirmed by one of the following:
   a. First or 2nd trimester ultrasound less than 20 weeks gestation
   b. Fetal heart tones have been documented for 30 weeks by Doppler.
   c. It has been 36 weeks since a positive serum or urine human chorionic gonadotropin (HCG) pregnancy test was performed by a reliable laboratory.
Title: Labor & Delivery Scheduling – Induction, Cesarean Section & Other Surgical Procedures

Effective Date: 

Page 4 of 6

2. Amniocentesis for fetal lung maturity (FLM) may be indicated in certain circumstances prior to scheduled delivery less than 39 weeks; however, positive maturity by FLM alone is not an indication for scheduled delivery less than 39 weeks in the absence of a medical/obstetric or fetal/newborn indication for delivery.

3. **Patient counseling:** The mother undergoing any scheduled delivery (induction or cesarean section) prior to 39 completed weeks gestation shall have reviewed with her provider the maternal and fetal/newborn risks and benefits of scheduled delivery. This discussion will be documented either in the prenatal care record, history and physical, or progress notes.

4. Recommended information regarding patient counseling for scheduled delivery: [ACOG FAQ #181: Elective Delivery Before 39 Weeks](#)

**Scheduling of Induction/Dilation and Curretage:**

1. Provider or designee will call the Labor and Delivery (L&D) day Information Associate (IA) (525-1381) between the hours of 7am and 7pm, or in her absence, the Labor and Delivery Team Leader (525-8358).

2. Provider/designee will give indication for procedure and gestational age at the day of scheduled admission for induction/surgery.

3. Booking sheet for D&C procedures is initiated by the Information Associate and is to be faxed to the PAT department to book the OR. PAT department is called and notified of incoming fax prior to booking sheet being faxed so that no other procedures may be booked in that OR in the meantime.

4. L&D will accommodate no more than 3 scheduled inductions on any weekday and no more than 2 scheduled inductions on a weekend day. Scheduled inductions include induction of labor by any method.

5. L&D will accommodate no more than 4 scheduled surgeries on any weekday and no more than 2 scheduled cesarean sections on a weekend day.

6. Inductions MUST have a **complete and updated** prenatal record, History and Physical (H&P) and orders faxed to the Right Fax #944-2624 at the time of scheduling.

**Scheduling of Cesarean Section completed in the Pre Admission Testing Department**

1. MD offices will fax a Cesarean section booking sheet and [Cesarean Section Pre-operative Physician/Provider Order Sheet (MD-228)](#) to OR scheduling/PAT to request scheduling the elective case. If case booking occurs less than 30 days from procedure, a completed History and Physical will be faxed as well. The ACOG form will be faxed to the Pre Encounter Unit (PEU) in labor and delivery.

2. The MD office will receive a receipt of the request and verification of availability or denial via fax from OR scheduling/PAT within 24 to 48 hours of receiving request. This is related to scheduling limits of maximum of 4 cases per day in the OB OR.

3. A PAT appointment will be made to complete the prenatal labs and other required diagnostics 48 hours prior to procedure.

4. The patient will have a Pre Anesthesia Interview completed by a PAT RN a minimum of 5 days prior to the schedule date and is given the time to report to the hospital for the PAT appointment during this interview.

5. The MD offices will be contacted by PAT at 48 prior to procedure and will be notified of any missing needed forms/requirements or of resolutions to any abnormal lab results in order to avoid cancellation the day of scheduled case.

6. At 24 hours, or by 9AM prior to day of procedure, the physician/provider offices will be called and notified of any missing items. If the chart is not complete by 10AM on this day, the case may be canceled and physician/provider may reschedule once the missing required items are received. The rescheduled date and time may not be the original date and time requested.
Cancellation:

1. Each day the IA, L&D Team Leader or C3 will review the next day’s schedule for inductions and surgeries. If there are procedures scheduled and no updated prenatal record, H&P or orders obtained, a call will be made to the office to day the updated prenatal record by 12 noon that day. (Calls will be made on Fridays for inductions scheduled for Sat, Sun or Mon)

2. When the necessary paperwork is not faxed to L&D by 12 noon the day prior to the scheduled procedure, the patient and physician/provider will be called to let them know that the scheduled time for her procedure has been delayed or cancelled because the paper work has not been faxed to L&D and that as soon as the physician/provider’s office faxes that information (#944-2624), she will be called in for her procedure.

3. The L&D night shift Team Leader or C3 will assess the available resources for the upcoming day shift.

4. When resources are not available due to staffing shortage or high acuity/census, scheduled procedures will be evaluated and prioritized related to their indication and delayed as needed (after consultation with the L&D Operations Manager/Supervisor and/or Chief of Obstetrics). Medically indicated scheduled procedures, including post-dates induction of labor at 41 weeks or more, will take precedence over scheduled procedures without a medical indication (i.e. repeat cesarean over 39 weeks, induction of labor over 39 weeks for patient convenience, etc.).

5. Patients will be notified of the postponement as soon as possible.

6. Providers will be notified by 0800.

7. When a request for a medically indicated procedure is made and the maximum number of scheduled procedures has been met, the L&D Team Leader will refer the provider to the L&D Operations Manager/Supervisor who will determine if additional staffing is available and can be authorized to accommodate the procedure.

8. If it is discovered that a non-medically indicated procedure less than 39 weeks has been scheduled (no recommendation from Maternal-Fetal Medicine or approval from OB/Gyn Department Chair for early delivery), the L&D Operations Manager, Team Leader, C3, or designee will notify the office as soon as possible to cancel and reschedule the procedure for 39 weeks gestation or more.

Admission:

1. Inductions will be admitted on the scheduled day/time only if prenatal record, H&P and orders are received prior to admission.

2. The MD/CNM will examine the patient on admission and/or prior to the initiation of cervical ripening agent and/or oxytocin, and document fetal presentation and Bishop’s score in the medical record.

3. Initiation of cervical ripening agent and/or oxytocin will begin only bundle criteria are met (see below):

Bundle Criteria for Elective Induction:

1. Gestational age greater than or equal to 39 weeks.
2. Normal fetal status (Category I fetal heart rate pattern) prior to the initiation of cervical ripening agent and/or oxytocin.
3. Bishop score documented prior to initiation cervical ripening agent and/or oxytocin. (Recommendation is for Bishop Score greater than or equal to 6 for multigravida or greater than or equal to 8 for primigravida).

REFERENCES

Title: Labor & Delivery Scheduling – Induction, Cesarean Section & Other Surgical Procedures

Effective Date:


<table>
<thead>
<tr>
<th>Approving Official:</th>
<th>CNO; CMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Sponsor:</strong></td>
<td>Operation Managers, Labor and Delivery, Post-Partum and Full Term Nursery</td>
</tr>
<tr>
<td><strong>Reviewed By:</strong></td>
<td>Director of Women’s and Children’s Services; Chief of OB/Gyn; Chief of Anesthesia; Perinatal Policy Workgroup; SPH Policy Council</td>
</tr>
<tr>
<td><strong>Search Terms:</strong></td>
<td>Labor and Delivery, scheduling, L &amp; D, induction, cesarean, surgical procedures, perinatal, pregnant patients, pregnancy, intrapartum</td>
</tr>
</tbody>
</table>

**Effective Date:**

| Original Date: | 10/11 |
| Reviewed/Revised Date: | 12/12; 2/6/14; |

*Reviewed, No Revisions
**Revised without Full Review

| Replaces: | Labor and Delivery Scheduling – Induction, Cesarean Section and Other Surgical Procedures, 2/6/14 |
# Scheduling Form for Inductions and Cesarean Sections

**St Peter's Hospital**

**SCHEDULING FORM**

For Inductions and Cesarean Sections

<table>
<thead>
<tr>
<th>Patient:</th>
<th>DOB:</th>
<th>G/P:</th>
<th>EDD:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Telephone Number:</td>
<td>GA on desired Admit Date:</td>
<td>+</td>
<td>/7 weeks</td>
</tr>
</tbody>
</table>

**Type of Delivery:**

- [ ] Induction
- [ ] Cesarean Section
- Desired Admit Date/Time:

**OB Attending:**

- Office Telephone Number: Requested by:

**Please indicate how gestational age was confirmed: (Please select ONLY one)**

- [ ] Ultrasound measurement at less than 20 weeks that confirmed or established EDD
- [ ] Positive laboratory hCG (urine or blood) at least 36 weeks ago
- [ ] Fetal Heart Tones identified by Doppler for at least 30 weeks

**Pts. with unconfirmed dates and no medical/obstetrical indication may be tentatively scheduled if greater than 39 weeks at admission, pending results amniocentesis for fetal lung maturity.**

**Was fetal lung maturity proven by amniocentesis?**

- [ ] Yes
- [ ] No

**INDICATION FOR SCHEDULED DELIVERY**

### MATERNAL AND FETAL REASONS (OK IF LESS THAN 39 WEEKS)

- [ ] Abruptio placenta
- [ ] Twins with complications
- [ ] Prior myomectomy
- [ ] Oligohydramnios (AFI 4 or less)
- [ ] Placenta accreta
- [ ] Di-Di Twins without complications (38 wks or more)
- [ ] Macrosomia (Sono EFW over 5000g)
- [ ] Abnormal fetal testing (by NST, BPP or continuous wave Doppler):

### SCHEDULED CESAREAN SECTION

(Need to deliver under 39 weeks dependent on severity of condition)

- [ ] Prior Cesarean Section, no TOL*
- [ ] Breech presentation*
- [ ] Active genital herpes infection
- [ ] Macrosomia (Sono EFW over 5000g)
- [ ] Patient requests*
- [ ] Patient requests*
- [ ] Convenience of patient/doctor (includes scheduling difficulties)*
- [ ] Other*: ____________________________

### ELECTIVE INDUCTION

(OVER OR EQUAL TO 39 WEEKS)

- [ ] Patient requests*
- [ ] Psychosocial stress (i.e. domestic violence, no social support, etc.)*
- [ ] Convenience of patient/doctor (includes scheduling difficulties)*
- [ ] Other*: ____________________________

### POST DATES INDUCTION

- [ ] 41 weeks or greater

*If Indication selected and under 39 weeks, requires OB Chief or Perinatology approval. (Send documented discussion with OB Chief or perinatal consult report with History & Physical)*

**Description/Details:**

**BISHOP SCORE:**

<table>
<thead>
<tr>
<th>Score</th>
<th>Dilatation</th>
<th>Effacement</th>
<th>Station</th>
<th>Consistency</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Closed</td>
<td>0 to 30%</td>
<td>-3</td>
<td>Firm</td>
<td>Posterior</td>
</tr>
<tr>
<td>1</td>
<td>1 to 2</td>
<td>40 to 50%</td>
<td>-2</td>
<td>Medium</td>
<td>Midposition</td>
</tr>
<tr>
<td>2</td>
<td>3 to 4</td>
<td>60 to 70%</td>
<td>-1, 0</td>
<td>Soft</td>
<td>Anterior</td>
</tr>
<tr>
<td>3</td>
<td>5 to 6</td>
<td>80%</td>
<td>+1, +2</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>

**Signature:**

**Date:**

**Time:**

**DO NOT WRITE BELOW THIS LINE – SCHEDULING OFFICE/HOSPITAL USE ONLY**

- [ ] Not Scheduled
- [ ] Scheduled, By:
- [ ] Referred to Department Chair
- [ ] Yes
- [ ] No

**Prenatal record received?**

- [ ] Yes
- [ ] No

**Scheduler Signature:**

**Date:**

**Time:**

MR #: NSG-080

Orig: 06/11, Rev: 12/13

Page 1 of 1

* PN0010 *
## Guidelines for Using New Scheduling Form for Inductions and Cesarean Deliveries:

**LIP offices** to complete new scheduling form. Fax complete form to scheduling office (444 1831).

Or scheduling office may be called and information given to scheduler over the phone (444 1880).

**For urgent patients (off hours and < 24hrs before procedure):**

Call L&D (444 2248) and speak to charge RN who will take information over the phone, or fax completed scheduling form to L&D (444-6044).

If patient does not meet listed indications for delivery < 39 completed weeks, LIP must call MFM physician on call for that day, for a consultation.

MFM on call reviews patient history directly with attending LIP. If MFM agrees to scheduling for induction or c delivery < 39 weeks, LIP to call scheduler or L&D charge nurse (off hours), after consultation completed.

Patient is scheduled or not based on decision of MFM. Information is entered into electronic system by scheduler and on scheduling form.

Patient meets criteria for scheduling induction or c delivery ≥ 39 weeks or medical indication if < 39 weeks.

Patient is scheduled. Information is entered into electronic system by scheduler and form filed in scheduling binder.

If scheduling done with L&D (off hours and < 24 hours), charge RN files form in scheduling binder.
Labor and Delivery Scheduling Form

MRN# __________________
Name ____________________________________________ DOB______________________
Maiden name/Previous name________________________ SS# ________________________
Primary Phone ______________________ Alternate Phones________________________________
Insurance _______________________________ Auth/referral #___________________
OB Provider _______________________OB Provider Phone ________________Fax_______________
ICD 9 _________________ CPT __________________

PROCEDURES:

Latex Allergy? ☐ Yes ☐ No  Cell Saver needed? ☐ Yes ☐ No
☐ Amniocentesis  ☐ D&C
☐ Cerclage  ☐ D&E
☐ Cerclage Removal  ☐ Termination of pregnancy (cytotec or prostin)
☐ Contraction Stress Test
☐ Intrauterine Fetal Transfusion
☐ Maternal Transfusion
☐ Version

Requested Date/Time of Procedure: _____________________________

Inductions or Cesarean Deliveries  *require completion of page 2*

☐ C/D  ☐ C/D with BTL  ☐ Routine Induction (Oxytocin)  ☐ Cervidil Induction

Requested Date/Time of Procedure: _____________________________

☐ Cervidil - Requested Date/Time of Admission_______________

Pre-op Services for C/D Labs:

☐ Please contact patient to arrange appt for labwork within 72 hrs of procedure.
☐ Please do not contact patient. Labwork has already been arranged

SCHEDULING OFFICE USE

Proc Sched_______ OR Sched_________ PAT sched__________ Admit Sched___________

Procedure NOT scheduled: ☐
## Scheduling Form for Inductions and Cesarean Deliveries

**Patient Name** ____________________________  **MRN** __________________

### Dating:
- **Gravida** _______ **Para** _______  **LMP** _______  **EDD** _______

Gestational Age at Date of Induction or C/D: **weeks** _______ **days** _______

- **EDD Based on:**
  - US <20 weeks;
  - Doppler FHT+ for 30 weeks;
  - hCG for 36 weeks

- **Other dating criteria:** __________________________________________________

**By ACOG Guidelines, women should be 39 wks or greater before initiating an elective (no indication) delivery. ACOG also states that a mature fetal lung test in the absence of clinical indication is not considered an indication for delivery.**

### Indications:

- **Scheduled > 41+0 wks**
  
<table>
<thead>
<tr>
<th>Scheduled C/D &gt; 39 wks</th>
<th>Elective Induction &gt; 39 wks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior C/S (x____)</td>
<td>Patient Choice/Social</td>
</tr>
<tr>
<td>Breech presentation</td>
<td>Macrosomia</td>
</tr>
<tr>
<td>Other malpresentation</td>
<td>Distance</td>
</tr>
<tr>
<td>Patient choice</td>
<td>Other:________</td>
</tr>
<tr>
<td>Other:_______</td>
<td></td>
</tr>
</tbody>
</table>

- **Obstetric and Medical Conditions (OK if <39 weeks)**
  
  | Abruptio | Other: Requires Perinatology Consult Information Below |
  | Previa | |
  | Preecclampsia | |
  | Gestational HTN | |
  | GDM with insulin | |
  | PROM | |
  | Fetal Demise (current) | |
  | Fetal Demise (prior) | |
  | Oligohydramnios | |
  | IUGR | |
  | Non-reassuring fetal status | |
  | Isoimmunization | |
  | Fetal malformation | |
  | Multiples w/ complications | |
  | Twins > 38 wks w/o complications | |
  | Heart disease | |
  | Liver disease (e.g. cholestasis of preg.) | |
  | Chronic HTN | |
  | Diabetes (Type I or II) | |
  | Renal disease | |
  | Coagulopathy/Thrombophilia | |
  | Pulmonary disease | |
  | HIV infection | |
  | Prior classical C/D | |
  | Prior myomectomy | |

**Indication Detail__________________________________**

**PROM**

**Name of MFM and date approved**

**Additional Information (if any)________________________________**

---

X ____________  X ________________________

Person providing information  Signature of person completing form

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Rev 2-21-11
**Stony Brook-Guidelines for non-urgent patients scheduled through the Central Scheduling Office at:** Fax 444-1831 Phone 444-1880

For faxed bookings

- If patient falls within acceptable guidelines for scheduling delivery, LIP offices completes and faxes new scheduling form to scheduling office 444-1831.
- If patient does not meet listed indications for delivery <39 completed weeks, LIP must call MFM physician on call for that day for a consultation. MFM on call reviews patient history directly with attending LIP. IF MFM agrees to scheduling for induction or C/D <39 weeks, information is documented on scheduling form and faxed to 444-1831. The completed booking will be processed upon delivery. The forms will be held for pick-up by an L&D representative.

For bookings over phone

- If patient falls within acceptable guidelines for scheduling delivery or the approval has been obtained from the MFM for patients not meeting the listed indications for delivery <39 completed weeks, the booking will be scheduled and the page 2 of the form completed and held for pick-up by L&D representative.
- If Patient does not meet listed indications for delivery <39 completed weeks, booking will not be accepted. LIP will be directed to call MFM physician on call for a consultation. MFM on call reviews patient history directly with attending LIP. IF MFM agrees to scheduling for induction or C/D <39 weeks, LIP will call the scheduling office and the booking will be completed by phone. The schedulers will enter the required documentation on the page 2 of the scheduling form which will be held for pick-up by an L&D representative.

**Guidelines for urgent patients scheduled through Labor and Delivery (off hours and < 24 hrs before procedure) at:** Fax 444 6044 Phone 444 2248

Call L&D (444-2248) and speak to charge RN/clinician who will take information over the phone, or fax completed scheduling form to L&D (444-6044).

- Patient meets criteria for scheduling induction or C/D ≥ 39 weeks or medical indication if < 39 weeks. If information taken over phone, charge RN will complete scheduling form and place in scheduling binder.
- If Patient does not meet listed indications for delivery <39 completed weeks, booking will not be accepted. LIP will be directed to call MFM physician on call for a consultation. MFM on call reviews patient history directly with attending LIP. IF MFM agrees to scheduling for induction or C/D <39 weeks, LIP will call L&D charge RN and the booking will be completed by phone. The RN will enter the required documentation on the scheduling form which will be placed in the scheduling binder.
Patient Safety Checklist—Induction of Labor

Date: __________________     Patient: _______________________  DOB: ______________   MR#: _______________

Physician or certified nurse-midwife: _____________________________   Last Menstrual Period: __________________

Gravida / Para: ______________________________________   GBS results: __________________________________

Estimated Date of Delivery: ___________________    Estimated Gestational Age at Delivery: ______________________

Proposed Date of Induction: ___________________________________________

<table>
<thead>
<tr>
<th>High Priority</th>
<th>Low Priority or Elective</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Nonreassuring fetal testing</td>
<td>□ Pregnancy of 39-41 weeks with a favorable Score (&gt;8 in nulliparas or &gt;5 multiparas)</td>
</tr>
<tr>
<td>□ Oligohydramnios (&lt;5cm amniotic fluid index)</td>
<td>□ History of fast labor</td>
</tr>
<tr>
<td>□ Intrauterine growth restriction (&lt;10th percentile)</td>
<td>□ Residence a significant distance from the hospital</td>
</tr>
<tr>
<td>□ Medical complication of pregnancy</td>
<td>□ Documented morbidities that would improve with delivery, such as worsening heartburn, inability to sleep, severe dependent edema, superficial varicostities.</td>
</tr>
<tr>
<td>(indicate)</td>
<td></td>
</tr>
</tbody>
</table>

EFW: □ LGA □ SGA □ AGA

Fetal dating - Low Priority / elective only

□ It has been 36 weeks since a positive serum or urine (HCG) test was performed by reliable laboratory.
□ An Ultrasound measurement of the crown-rump length, obtained 6-12 weeks, supports a gestation age of 39 weeks or more
□ An Ultrasound scan, obtained at 13-20 weeks confirms a gestational age of >39 weeks determined by LMP
□ An amniotic fluid assessment confirms fetal lung maturity-Type of test and result:
_________________________________________________________________________________________

Bishop Score (see below): __________________________

<table>
<thead>
<tr>
<th>SCORE</th>
<th>FACTOR</th>
<th>Dilation (cm)</th>
<th>Position of Cervix</th>
<th>Effacement (%)</th>
<th>Station *</th>
<th>Cervical Consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>Closed</td>
<td>Posterior</td>
<td>0 - 30</td>
<td>-3</td>
<td>Firm</td>
</tr>
<tr>
<td>1</td>
<td>1 - 2</td>
<td>Midposition</td>
<td>40 - 50</td>
<td>-2</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3 - 4</td>
<td>Anterior</td>
<td>60 - 70</td>
<td>-1.0</td>
<td>Soft</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>5 - 6</td>
<td></td>
<td>80</td>
<td>+1, +2</td>
<td>- - -</td>
<td></td>
</tr>
</tbody>
</table>

*station reflects a -3 to +3 scale. Modified from Bishop EH. Pelvic scoring for elective induction. Obst Gynecol 1964:24:266-8

□ Patient counseled about maternal / fetal risks and benefits of induction of labor with
□ Pitocin □ Cytotec □ Cervidil □ VBAC

Provider Signature: ______________________________________   Date: _____________   Time: _________

□ Orders received □ Hard copy Hepatitis B / HIV
□ Oxytocin □ Copy of updated prenatal
□ Cervical ripening

Approved ______________________________________   Date: _____________   Time: _________

or

Hard Stop Signature ____________________/__________________________   Date: _____________   Time: _________

Dept. Chair Signature ____________________________________________   Date: _____________   Time: _________

ini 07.13

Prenatal Care Record
## Patient Safety Checklist—Scheduling Planned Cesarean Delivery

### Prenatal Care Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient</th>
<th>DOB</th>
<th>MR#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physician or certified nurse-midwife:**

**Last menstrual period:**

<table>
<thead>
<tr>
<th>Gravida/Para</th>
<th>GBS results</th>
<th>Estimated date of delivery</th>
<th>Estimated gestational age (at admission)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Proposed cesarean delivery date:**

<table>
<thead>
<tr>
<th>Indication (choose one):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Medically indicated: Diagnosis: __________________________</td>
</tr>
<tr>
<td>☐ Repeat cesarean delivery (choose one):</td>
</tr>
<tr>
<td>☐ Trial of labor not appropriate: Reason: ____________________</td>
</tr>
<tr>
<td>☐ Trial of labor offered</td>
</tr>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No: Reason: ____________________</td>
</tr>
<tr>
<td>☐ Patient counseled about risks and benefits of cesarean delivery versus trial of labor and vaginal delivery</td>
</tr>
<tr>
<td>☐ Repeat cesarean delivery for logistical reasons: Circumstances: ____________________</td>
</tr>
<tr>
<td>☐ Elective primary cesarean delivery at maternal request:</td>
</tr>
<tr>
<td>☐ Gestational age of 39 0/7 weeks or greater confirmed by either of the following criteria:</td>
</tr>
<tr>
<td>☐ Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater.</td>
</tr>
<tr>
<td>☐ Fetal heart tones have been documented as present for 30 weeks of gestation by Doppler ultrasonography.</td>
</tr>
</tbody>
</table>

**If this is an elective cesarean delivery and gestational age is 39 0/7 weeks or less, reason for variance:**

| ☐ Pt counseled about maternal / fetal risks & benefits of cesarean delivery by: |
| Provider Signature: ____________________ | Date: __________ | Time: __________ |

**Preoperative and pertinent prenatal laboratory test results (eg, group B streptococci or Hep B) available**

**Special concerns (eg, allergies, medical problems, and special needs):**

**Pertinent comorbid risk factors (maternal and fetal):**

**To be completed by reviewer:**

| ☐ Approved cesarean delivery for gestational age equal to or greater than 39 0/7 weeks by the aforementioned dating criteria |
| ☐ Approved cesarean delivery before 39 0/7 weeks of gestation (medical indication) |
| ☐ HARD STOP - gestational age, indication, consent, or other issues prevent initiating planned cesarean delivery without further information or consultation with department chair. |

| ☐ Orders received |
| ☐ Copy of updated Prenatal |
| ☐ Hard copy Hepatitis B/HIV |
| ☐ Copy of tubal consent if applicable |

| Approved ____________________ | Date: __________ | Time: __________ |
| or |
| Hard Stop Signature ____________________ | Date: __________ | Time: __________ |
| Dept. Chair Signature ____________________ | Date: __________ | Time: __________ |
SCHEDULED CESAREAN DELIVERY FORM
Fax along with Surgical Admission Form (SMH975MR) to 473-9453

Patient Name _____________________________ MR# or Date of Birth __________
OB Provider _____________________________ G/P __________

Cesarean Type: □ Primary Cesarean  □ Repeat

Cesarean Desired Date/Time ______________________
Date Scheduling Form Submitted __________________

DATING
LMP __________  EDC __________

Gestational Age at Date of Cesarean (weeks+days) ______________
EDC established/confirmed by: _________________________________

By ACOG Guidelines, deliveries without indications are not to be scheduled before 39 weeks. 
Uncomplicated repeat or breech are not considered indications.

☐ Fetal Lung Maturity Test (if applicable): Result __________ Date __________

Cesarean Indication(s): Uncomplicated repeat or breech must be ≥39 weeks unless mature FLM

Note: A mature fetal lung maturity profile is not an indication for delivery under 39 weeks in the absence of another maternal or fetal indication for delivery under 39 weeks

☐ Patient counseled about risks and benefits of scheduled delivery and agrees (required by NSYDOH)

Signature of OB Provider _____________________________
SCHEDULED INDUCTION FORM
Call Triage at 275-3131 and then fax this form to 756-7786

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>MR# or Date of Birth</th>
<th>OB Provider</th>
<th>G/P</th>
</tr>
</thead>
</table>
| Desired Date/Time | Date Scheduling Form Submitted | DATING: LMP EDC Gestational Age at Date of Induction (weeks+days) | EDC established/confirmed by:

Per ACOG Guidelines, deliveries without indications are not to be scheduled before 39 weeks.

- [ ] Fetal Lung Maturity Test (if applicable): Result __________ Date __________

INDICATIONS FOR DELIVERY

| Obstetric/Medical Indication(s) | (the need to deliver <39 weeks is dependent on severity of condition) |
- | - |

Elective Induction Reason (≥39 weeks unless mature FLM)

Note: A mature fetal lung maturity profile is not an indication for delivery under 39 weeks in the absence of another maternal or fetal indication for delivery under 39 weeks

CERVICAL EXAM

<table>
<thead>
<tr>
<th>Exam Date</th>
<th>To Calculate Bishop Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilatation _______ (closed, 1: 1-2, 2: 3-4, 3: 5-6)</td>
<td></td>
</tr>
<tr>
<td>Effacement _______ (0: 0-30, 1: 40-50, 2: 60-70, 3: &gt;80)</td>
<td></td>
</tr>
<tr>
<td>Station _______ (0: -3, 1: -2, 2: 0-1, 3: &gt;0)</td>
<td></td>
</tr>
<tr>
<td>Consistency _______ (0: firm, 1: medium, 2: soft)</td>
<td></td>
</tr>
<tr>
<td>Position _______ (0: post, 1: mid, 2: ant)</td>
<td></td>
</tr>
</tbody>
</table>

Bishop Score __________

<table>
<thead>
<tr>
<th>TYPE OF INDUCTION</th>
<th>Date/Time Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misoprostol</td>
<td>_______ am/pm</td>
</tr>
<tr>
<td>Cervidil</td>
<td>_______ am/pm</td>
</tr>
<tr>
<td>Foley</td>
<td>_______ am/pm</td>
</tr>
<tr>
<td>Pitocin</td>
<td>_______ am/pm</td>
</tr>
<tr>
<td>AROM</td>
<td>_______ am/pm</td>
</tr>
<tr>
<td>For Fetal Demise</td>
<td>_______ am/pm</td>
</tr>
</tbody>
</table>

Induction Location

- [ ] Birth Center
- [ ] Labor & Delivery

Induction Orders

- [ ] Pitocin—start at 1 milliunit (mu) and increase by [ ] 1 milliunit [ ] 2 milliunits q30min
- [ ] Pitocin—start at 2 milliunits (mu) and increase by [ ] 1 milliunit [ ] 2 milliunits q30min

- [ ] Patient counseled about risks and benefits of scheduled delivery and agrees (required by NSYDOH)

Signature of OB Provider ________________________________
Westchester Medical Center
Cesarean Section/Induction of Labor: Scheduling Criteria Form

FORM REQUIRED FOR ALL ELECTIVE CESAREAN/INDUCTION OF LABOR

Procedure Scheduling Determination: All deliveries prior to 39 0/7 weeks required REVIEW

Date: _____________

Requesting Physician: _____________________

Patient’s Name __________________________ Age: ________   G________ P ______________

Medical Record # ________________________   Requested Procedure Date ________  □ AM □ PM

Method of Delivery Planned:

☐ Cesarean delivery: ☐ Primary or ☐ Repeat

☐ Induction:   Fetal presentation ___________ EFW________  gms   Bishop Score ______

Reasons for Scheduled Delivery: Check all appropriate indications below

Maternal Reasons
☐ Premature rupture of membranes
☐ Prolonged rupture of membranes
☐ Chorioamnionitis
☐ Placental abruption
☐ Placenta previa/vase previa
☐ Gestational hypertension
☐ Preeclampsia/Eclampsia
☐ Placenta Accreta
☐ Pregnancy hypertension
☐ Gestational diabetes
☐ Diabetes Mellitus
☐ Maternal Conditions
  ☐ Heart disease
  ☐ Liver disease
  ☐ Cholestasis of pregnancy

☐ Renal disease
☐ Pulmonary disease
☐ Hematological conditions
☐ Herpes gestationis
☐ Maternal malignancies
☐ Active genital herpes infection
☐ Antiphospholipid Syndrome
☐ Rare maternal trauma
☐ Prior myomectomy
☐ Prior vertical or “T” incision C-section
☐ History of poor pregnancy outcome
☐ History of fast labor (<3 hrs.) and distant from hospital

☐ HIV

Fetal Reasons
☐ Oligohydramnios
☐ Polyhydramnios
☐ Macrosomia (sono EFW >5,000gms)
☐ Major anomaly
☐ Intrauterine growth restriction
☐ Abnormal fetal testing
☐ Alloimmunization/fetal hydrops
☐ Fetal demise
☐ Multiple gestation
☐ Psychosocial Reasons
☐ Psychological reasons
☐ Prior c/section: Declines VBAC
☐ Other indication

Clinical indications (with supporting data) ________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

1
Confirmation of gestational age:

EDC ___________ determined by: _______________ Check all that apply

☐ Ultrasound obtained at < 20 weeks on ______ @ ___ weeks confirms gestational age
☐ Known date of conception on
☐ 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test results
☐ Amniocentesis performed ☐ Yes ☐ No Results:______________

Bishop Score (For labor induction): (circle each element of the exam below)

<table>
<thead>
<tr>
<th>Score</th>
<th>Dilation(cm)</th>
<th>Effacement (%)</th>
<th>Station*(-3 to +3)</th>
<th>Consistency</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Closed</td>
<td>0-30</td>
<td>-3</td>
<td>Firm</td>
<td>Posterior</td>
</tr>
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<td>1</td>
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<td>-1, 0</td>
<td>Soft</td>
<td>Anterior</td>
</tr>
<tr>
<td>3</td>
<td>≥5</td>
<td>≥80</td>
<td>+1, +2</td>
<td>------------</td>
<td>----------</td>
</tr>
</tbody>
</table>

*Station reflects a -3 to +3 scale-modified from Bishop EH Pelvic Scoring for Elective Induction, Obstet Gynecol 1964, 24(267)
Please state -5 to +5 for all other purposes.

Total Score: _______________

Counseling on the maternal and fetal/newborn risks and benefits of scheduled delivery at 36 0/7 – 38 6/7 weeks completed? ☐ Yes ☐ No

Provider Name: ___________________________ Provider Signature:_______________________

Approved____________________________ Declined_______________________________________

Director, Maternal Fetal Medicine (or designate):_______________________________________________

OR

Chair, OBGYN (or designate)________________________________________________________________

Date: ____/____/____

NOT REQUIRING REVIEW: Please fax completed document to 914-493-1007

FOR REVIEW: Please fax completed document to 914-493-2279
Scheduled Delivery Form

**SCHEDULED DELIVERY FORM**

Date/Time ______________

Gestational Age (wks/days) ______________

**Method of Scheduled Delivery:**

- Cesarean delivery: □ Primary or □ Repeat
- Induction: □ Fetal presentation ______________ □ EFW __________ gms □ Bishop Score __________

**Induction Agent:** □ Dinoprostone (Cervidil) □ Oxytocin (Pitocin) □ Other: __________________

**Indications for Scheduled Delivery:** Check all appropriate indications below

- □ Abruptio Placentae
- □ Severe Preeclampsia / HELLP
- □ Non-reassuring Fetal Testing
- □ Chorioamnionitis
- □ Gestational Hypertension
- □ Intrauterine Growth Restriction (10%)
- □ PROM
- □ Fetal Demise
- □ Oligohydramnios (AFI < 5cm)
- □ Multifetal gestation
- □ Placenta/Vasa Previa
- □ Maternal HIV
- □ Maturity L/S Ratio or PG present

**Elective Deliveries at ≥ 39 completed weeks** □ Other: __________________

Elective Deliveries < 39 weeks require a Maternal Fetal Medicine consult

**Confirmation of gestational age:**

EDC ___________ determined by: Check all that apply

- □ Ultrasound obtained at < 20 weeks on __________ (date)@_________ weeks confirms gestational age
- □ Known date of conception on ___________ (date) associated with infertility treatment
- □ Documentation on prenatal record that gestational age consistent with first trimester sonogram
- □ Amniocentesis performed on _________________ Results: __________________

**Counseling:**

□ Risk/Benefits/Alternatives of delivery discussed

Provider Signature: ____________________________________________________________  Physician/CNM/PA/NP

Print Name: _____________________________  Contact Number _______________________

**Bishop Score:** This chart is provided for your convenience to assist in calculating the Bishop Score. The final score should be entered on the front of this form where indicated. Vaginal exams should have been performed at least within the last 7 days.

<table>
<thead>
<tr>
<th>Score</th>
<th>Dilation (cm)</th>
<th>Effacement (%)</th>
<th>Station (-3 to +3)</th>
<th>Cervical Consistency</th>
<th>Cervical Position</th>
</tr>
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<tbody>
<tr>
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<td>Anterior</td>
</tr>
<tr>
<td>3</td>
<td>&gt;or=5</td>
<td>&gt;or=80</td>
<td>+1, +2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
References

Bishop’s Score


Gestational Age


Pediatric Attendance at Cesarean Sections


Preterm Births: Clinical Outcomes


Prevention of Preterm Births


Timing of Births


Miscellaneous


Web Links

• American Congress of Obstetricians and Gynecologists (ACOG)
  www.acog.org

• California Perinatal Quality Care Collaborative
  www.cpqcc.org

• Centers for Disease Control and Prevention Perinatal Quality Collaborative Resources
  http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PQC.htm

• Institute for Healthcare Improvement
  www.ihi.org

• March of Dimes
  www.marchofdimes.com

• National Institute for Children’s Healthcare Quality (NICHQ)
  www.nichq.org

• New York State Department of Health (NYSDOH) Health Commerce System (HCS)
  https://commerce.health.state.ny.us/public/hcs_login.html

• NYS Partnership for Patients (NYSPFP)
  www.nyspfp.org

• New York State Perinatal Quality Collaborative (NYSPQC)
  www.nyspqc.org

• Ohio Perinatal Quality Collaborative
  www.opqc.net