Implementing Transition at Bedside in an Academia Setting

Ashley Oatman BSN RN
Monique Rhodes MSN RN
Belle Ann Tungpalan BSN RN
OBJECTIVES

1. Discuss the barriers with implementing transition at bedside in an academia setting.
2. Apply the PDCA model for implementing transition at bedside.
3. Describe the lessons learned, ongoing challenges, and “where do we go from here”.

Our Hospital

Located in the heart of the Texas Medical Center, Ben Taub General Hospital has garnered respect both locally and worldwide as an outstanding acute care facility and an elite Level I Trauma Center. Staffed by physician faculty and residents from Baylor College of Medicine, Ben Taub serves as a teaching facility to the next generation of healthcare providers.

Our hospital has demonstrated a commitment to improving care processes and practices that affect infant feeding outcomes by supporting and budgeting our current breastfeeding clinic. The clinic, established in the fall of 2002, is open five days a week from 8:00 - 4:30 to anyone in the community. Our hospital has also supported outreach and education to all community clinics with regards to breastfeeding support and education.
Our Unit

- 312 deliveries/month; 3744 annually (2012)
- VBAC rate 77.4%
- Baylor resident program (OB, FP)
- Certified Nurse Midwifery
- Nurse make-up
  ** 20+ years experience 49% (L/D) 31% (PP)
  ** 10-15 years experience 21% (L/D) 50% (PP)
Our Patients

Statistics

HCHD Patient Demographics

- Hispanic: 85.4%
- African American: 10.3%
- Caucasian: 1.9%
- Asian: 2.3%
- Other: 0.1%

HCHD Payor Mix

- Medicaid
- CHIP
- No Insurance
- Private Insurance
Timeline

Stakeholder meeting  
Initial pilot team meeting  
Pilot implementation  
Training of all staff  
Unit-wide implementation  
C/S pilot  

September 2011  
November 2011  
December 2011  
February 2012  
April 2012  
December 2012
Common Barriers to Implementation

Routine practices of mother-baby separation in the first hour for examination and cleaning of baby

Perception that routine procedures (such as bathing, warming, observation) have priority over breastfeeding in the first hour of life.

Inconsistent advice and teaching among staff

Limited staff competence in assessing and educating mothers

Limited staff time
Common Barriers cont’d

Perception of staff and/or mothers that sleep quality is improved when mothers and babies are separated.

Perception that routine separation is necessary for bathing, examinations, observation and other medical procedures.
Strategies Used to Overcome Barriers

1. Reviewed recent research on the importance of early feeding on breastfeeding outcomes and sleep and mother-baby contact.

2. Examine the routine procedures that “require” infant to be taken to the nursery. Determine which procedures could be done in mother’s room.

3. Undertake a small scale observational study to trial changing immediate postpartum mother-baby contact and track breastfeeding rates of those pairs.
Nurses’ attitudes and perceptions

- “We’ve always done it this way.” – many experienced nurses (20+ years)
- “That’s gross!”
- “I didn’t breastfeed my babies, and they’re just fine!”
- “This is just too much of a hassle.”
Quality Improvement Process
PDCA Model

Planning
• Investigate the Process (Current/Future Flow)
• Identify the data (Self-Appraisal Tool)

Do
• Design Improvement (Pilot study)

Check
• Improved skin-to-skin and breastfeeding rates
• What’s “working well” and “not so well”

Act
• Full implementation
1. Identify outputs and customers and their expectations.
2. Describe current process.
3. Measure and analyze.
4. Focus on an Improvement opportunity
5. Identify root causes.
6. Generate and choose solutions.
7. Map out the trial run.
8. Implement the trial run.
9. Evaluate the results.
10. Draw conclusions.
11. Standardize the change.
12. Monitor; hold the gains.

PDCA
Aim

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act

Plan

Study

Do

Institute for Healthcare Improvement
Current Flow
Do

Began with pilot team of 2 nurses each from nursery, L&D, and postpartum

- Day shift only to begin with
- Coordinated schedules
- One nursery nurse per shift is assigned to L&D to catch and transition babies. L&D nurses assist as necessary when nursery nurse is too busy.
- Assigned nurses accordingly (L&D nurse assigned to active patients, PP nurse given lighter patient load with no Gyn patients)
PILOT TEAM

Nurses from L&D, nursery, and postpartum, nurse educators, and lactation

- Mapped current process for all parties (L&D, nursery, postpartum, lactation)
- Discussed expected barriers
- Established initial plan for bedside transition process
- Established timeline for change
- Discussed process changes necessary (equipment and supplies, documentation, Epic, pyxis, printers, etc.)
PILOT TEAM EDUCATION
Check

Biweekly meetings of pilot team to discuss process and necessary modifications

Issues addressed:

- Timing of weight
- Timing of bath
- Supplies
- Documentation changes and questions
- Notification of Pedi/Neo team
- Equipment (more warmers on postpartum)
- Glucose checks and how to intervene (learning process with L&D nurses)
- Transportation (with mom in wheelchair vs. crib)
- Staffing
Act

Training sessions held for all nursing staff

Unit-wide implementation began
Current Bedside Transition Process

Patient educated at admission on bedside transition process and skin-to-skin

1 nursery nurse per shift assigned to baby nurse on L&D. (If staffing does not permit, L&D nurse assigned to baby nurse role.) For shifts with scheduled C/S, a second baby nurse is assigned to perform transition in the OR.

Baby nurse attends all deliveries

Infant initially placed on blankets on mom’s chest and dried.

As soon as infant is dried, infant is placed skin-to-skin on mother’s chest, and blankets are replaced.

Within 5 minutes, infant is weighed, measurements taken, and immediately returned skin-to-skin
Current Bedside Transition Process

Bands placed, prints taken, and Q30 minute vital signs performed with infant skin-to-skin
Breastfeeding initiated with assistance of baby nurse when infant shows signs of interest
Medications (eye prophylaxis, vitamin K, and hepatitis B) given at approximately 1 hr of life
Accuchecks performed per protocol
Infant transferred in bassinet with mother
Bath given during first 2 hours on postpartum unit
Outcomes

Increased initiation breastfeeding rates from 8% to 19%

Increased skin-to-skin rates from 0% to 66%

Increased patient satisfaction

Increased communication between departments

Increased camaraderie
Nurses’ Experiences

Biggest impact on nursery nurses

- Change of physical location
- Change of atmosphere
- Change of coworkers
Where Are We Now!!
Where Are We Now!!

Best Fed Beginnings

22 month collaborative with CDC and NICHQ (National Institute for Children’s Healthcare and Quality)

Selected as 1 of 90 hospitals to participate

Focus on improving breastfeeding rates and exclusivity

Reversing the culture of formula
BTGH 2012
Exclusive Breastfeeding Rates (using Baby Friendly USA criteria, including late preterm newborns)
BTGH 2012
Skin to Skin Holding After Delivery

<table>
<thead>
<tr>
<th>Month</th>
<th>Vaginal Birth (%)</th>
<th>Cesarean Birth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>70.6%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Aug</td>
<td>56.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Sept</td>
<td>60.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Oct</td>
<td>35.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Nov</td>
<td>81.0%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Dec</td>
<td>70.6%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>
OPERATIONALIZING IT!!!

Maureen Padilla, DNP, RNC, NEA-C