Implementing a Maternal Newborn Service Excellence Program: Lessons Learned

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infant death syndrome, hyperbilirubinemia, HELLP syndrome, and blood gas interpretation. Each case study included a self-teaching module with an assessment tool. Each month the nursing staff completed the case studies and submitted them to the committee members for evaluation. At the end of the year, data were retrieved to evaluate the nursing staff completion and assess the participation in the case studies. The manager of the Nursing unit had encouraged the staff to complete at least 4 of the 11 case studies that were presented (36%). On average, staff nurses completed six case studies and related a positive learning experience and acquisition of knowledge as a result of the case studies.

As a result of the knowledge attained by the staff nurses, the development of new case studies was continued into 2009. The nursing staff has actively increased their knowledge related to evidence-based practice and nursing research practices while making a commitment to lifelong learning and acknowledging their role as professional nurses.

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Poster Presentation

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Professional Issues

Capacity and *throughput* are two words that are becoming increasingly familiar. Obstetric and newborn care processes are not immune to these challenges. Our 895-bed, Magnet-designated, community teaching hospital currently has more than 3,900 deliveries per year. Factors contributing to daily capacity and throughput challenges include maternal-fetal medicine, referrals, Cesarean birth rate, and increased organic growth of the obstetric service line.

Security and safety for our families was paramount. Quality of care needed to be maintained. Immediate actions to meet the capacity demand were identifying and using an approved area off the Mother/Baby Unit. Holding mothers in Labor & Delivery was happening with increased frequency, which was not optimum. It affected our ability to promote the Family unit. It was crucial to remain aware of patient satisfaction. Although our families were understanding and appreciative of their care, this was not what we wanted to continue. We needed to identify other interventions.

Nursing leadership initiated the first meeting in May 2008. Committee membership included representation from Labor & Delivery, Mother/Baby Unit, Neonatal Intensive Care Unit, Lactation Consultants, and outpatient obstetric and pediatric practices. Discussions were robust. Opportunities for change and improvements for out-patient and in-patient services were identified. We titled our committee Maternal-Newborn Service Excellence. A mission statement was developed and approved in July 2008. The enthusiasm and participation of the committee members continued. The culture of openness, creativity, and transparency during subsequent meetings identified many additional projects and initiatives. All agreed the projects and initiatives needed to be included if we were striving for excellence.

A year later we had more questions than answers. Discussions were held with program management leaders, development specialists, and organizational development consultants. We needed to refocus and restructure the process and went back to the drawing board. The outcome is an overarching Maternal-Newborn Service Excellence Committee with a formal Charter that clearly defines sponsorship, function, leadership, and membership.

The Maternal-Newborn Service Excellence Committee reached a consensus to identify and develop specific workgroups to address the various projects and patient care initiatives identified. Each workgroup will have designated leadership and goals. The workgroups will assess, plan, implement, and evaluate various aspects of obstetric and newborn care. The outcome is for our families to be prepared for their birth, their post delivery stay, and care of mothers and babies upon discharge. Resources will be maximized to meet these outcomes and minimize the challenges, contributing to capacity and throughput.

The restructuring of the Maternal-Newborn Service Excellence Committee and the workgroups was a great learning opportunity. Staying focused, eliminating barriers/challenges, and meeting our patients' and families' diverse needs will have a direct impact on outcomes and patient satisfaction. Proactively managing capacity and throughput while maintaining quality patient care for our obstetric and neonatal families is our "passion for better medicine."

It's Not Rocket Science: Simulation Makes It Safer

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Professional Issues

Poster Presentation

Even a facility delivering 6,000 babies a year has opportunities to improve clinical practice and outcomes. The literature shows us that when emergencies are rehearsed, clinical practice and knowledge improves. However, the literature does not prove how knowledge is measured, only that it is perceived to be improved. Simulation leads to reduction of error, improved communication, and better patient outcomes. In creating "real-life" situations, the staff in this organization saw the benefit of working together to create a safer environment. We took simulation one step further and measured learning pre- and post simulation drills to ensure that actual knowledge was gained.

Mission Control . . . Leading the Norton Health Care Community

Norton Suburban Hospital's Labor and Delivery Unit was chosen as the pilot unit for "high-reliability team training." Several staff members, physicians, and leadership were trained on the concept of Crew Resource Management (CRM), which parallels aviation and healthcare focusing on high-volume, high-risk, and high-stress environments.

Houston We Have a Problem . . . Creating a Culture of Safety

Prior to CRM training, the work environment focused on individual goals and desires of the staff and physicians. The facility has more than 80 obstetricians and 80 pediatricians all with varying practice patterns who need to come together to reach the common goal of patient safety. One of the concepts of CRM is simulation drills that lead to reduction of error, improved communication, and better patient outcomes. Teamwork is crucial, and to reach the goal, the staff and physicians needed to be able to practice clinical patient scenarios in a controlled nonthreatening environment. Suburban added the simulation mannequin Noelle to their team in 2008 for labor and delivery, postpartum, and newborn drills.

We Have Lift Off . . . Conducting Simulation Drills

Simulation drills with Noelle were centered around obstetric emergencies including emergency Cesarean delivery for umbilical cord prolapse, eclamptic seizure, postpartum hemorrhage, shoulder dystocia, maternal and neonatal mock codes. Each drill included a prebriefing and debriefing to ensure that the staff receives immediate feedback.

Lift Off is a Success . . . Evaluating Effectiveness/Lessons Learned

Limited research has yet to create a standardized tool to measure learning effectiveness. In the obstetric simulations conducted at Norton Suburban Hospital, we measure the clinical skills and teamwork used during the drill through checklists and through pre- and post tests. A 10-question quiz was created by the educator and administered prior to the simulation and again at the conclusion of the debriefing. A 20% to 36% increase in knowledge has been demonstrated postsimulation.

One Small Step for Man . . . Sharing the Vision With the Community Served

In an effort to show our commitment to patient safety, the team was featured on the local news during a health briefing. As simulation drills are becoming the community standard, this team felt it important to ensure that the community understood the commitment to quality and safe patient care.