Ensuring a comparable standard of care for cesarean deliveries

Your facility is having a baby boom. The number of cesarean births is exceeding the obstetrical unit’s capacity. Administrators want the OR to perform the overflow cases. What plans do you make for patient safety and care of both mother and newborn?

The cesarean birth rate has risen by more than 25% in this decade. Cesareans accounted for 31% of births in 2006, the latest figure available from the Centers for Disease Control and Prevention. That places a strain on many obstetrical units and creates a need for closer collaboration with peri-operative services.

A surgical services director faced this situation recently. Her hospital, with 460 beds and 11 ORs, has a large and growing obstetrical volume. In the OB unit, cesarean births were staffed with one circulating nurse. But the director thought 2 RNs were needed: one to circulate for the mother’s surgery and the second to care for the newborn.

She asked what nursing practice standards and guidelines apply, a question other OR directors may also be asking.

A related and larger question: How can you help ensure a comparable standard of care throughout the organization? This is a growing need as invasive procedures expand to GI endoscopy, interventional radiology, the cath lab, and other departments. Joint Commission standard LD.04.03.07 requires that “patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.”

At Yale-New Haven Hospital in New Haven, Connecticut, a collaborative task force has developed policies and procedures that apply across departments (sidebar).

What guidelines apply?

Professional associations have recommendations applicable to cesarean births.

AORN’s staffing guidelines, which apply to any surgical procedure, specify 1 RN per patient per OR in the role of circulating nurse. Other AORN recommended practices also apply, such as counts and maintaining a sterile field. The count recommendations specify a sponge count before closure of a cavity within a cavity, such as the uterus.

The American Academy of Pediatrics (AAP) and the American College of Obstetrics and Gynecology (ACOG) Guidelines for Perinatal Care recommend for circulating for the intrapartum phase is a 1:1 RN-to-patient ratio.

“That means the circulator is responsible for only the role of the circulator until mom and baby reach the recovery area,” says Catherine Ruhl, CNM, MS, associate director for the Association for Women’s Health,
Obstetric, and Neonatal Nurses (AWHONN). The association does not issue standards on staffing ratios.

“Therefore, the role of your circulator can be no different than the role of the circulator in your general OR,” says Ruhl, referring to the requirement for a comparable standard of care. Thus, “One nurse (or scrub tech) must be available to scrub, one nurse must be available to circulate, and one nurse must be available for the infant.”

About 1 in 10 newborns require some assistance with breathing at birth, and about 1% require extensive resuscitative measures, according to the AAP.

Guidelines for neonatal resuscitation from the American Heart Association and the AAP state that at every birth “there should be at least 1 person whose primary responsibility is the newborn.”

This person must be capable of initiating resuscitation, with someone else immediately available to perform a complete resuscitation. With careful assessment, most newborns who will need resuscitation can be identified before birth, the guidelines note.

What experts say

When polled, most members of the OR Manager Advisory Board said that when cesareans are performed in the OR, in addition to the RN circulator, the OB unit sends a nurse and/or a pediatrician to care for the infant.

One advisor, Kathleen Miller, RN, MHSA, CNOR, senior clinical consultant for Catholic Health Initiatives, Denver, says she has addressed this situation a number of times as an OR manager and director.

“In the OR, the circulating nurse as well as the anesthesia provider can only be responsible for one patient. That patient is the mother,” Miller says. “All of the same rules apply to a c-section surgical case that apply to every surgical case—counts, aseptic technique, and so forth.

“The baby is handed off to the OB nurse or pediatrician,” she notes. “The OR nurse must stay focused on the mother and the sterile field. This is a critical time for the surgical case because of bleeding, the count, and other issues.” Expecting the OR staff also to be responsible for the baby is outside their scope of practice and expertise and would present a risk to the hospital, Miller adds.

She recommends that policies be developed to delineate responsibilities of both specialties. The policies should address the range of issues, from simple ones, such as how the bassinette is brought to the OR, to more serious issues, such as what neonatal drugs, emergency equipment, medical gases, etc, must be available.

An expert in perinatal nursing, Kathleen Rice Simpson, RNC, PhD, FAAN, says the decision about whether nurses from the main OR or the OB unit perform the circulating duties depends on the hospital’s volume and the ability to maintain competency.

The common practice is to have a labor RN come to attend to the baby first and if there are problems to send a respiratory therapist, neonatal nurse, neonatal nurse practitioner, or neonatologist. Simpson, a researcher, educator, and author, is perinatal clinical specialist at St John’s Mercy Medical Center in St Louis, which has 8,000 births a year.

Being family friendly

The trend in the OB OR and recovery area is toward being more family friendly for births.
Fathers have been able to attend cesarean births in the OB unit for some time, Simpson notes. The mother sometimes requests another person as well. A teenage mother may want her mother to be present, for example, and such a request is often granted.

At the same time, there is a more rigorous focus on safety. “Being mother and baby friendly does not preclude safety,” Simpson says.

The ACOG statement on surgical patient safety issued in 2006 addresses issues such as prevention of wrong surgery, the need for adequate personnel, and the need to minimize distractions during the surgery.

“We constantly emphasize surgical safety, such as no interruptions during counts,” Simpson says. Time-outs before cesarean births are a way of life, as they are for any invasive procedure. At St John’s, counts are conducted as recommended by AORN, including calling for an x-ray if a discrepant count cannot be resolved.

A director’s solution

In a follow-up e-mail, the director who asked the question about staffing says her concerns are being addressed. She had shared her concerns with the hospital’s physicians and anesthesia group, who discussed them with the medical staff leadership. She says they have now adopted the AORN standards for counts.

For cesarean births in the OR, the staffing plan will include a per diem nurse cross-trained for the OB unit from the postanesthesia care unit (PACU), or the OB unit will send a nurse to care for the baby.

Because this second nurse will be needed for only 30 to 45 minutes, there will not be a big impact on productivity. The OB unit was also considering how to provide a second staff member routinely.

The hospital’s education department will provide education for the OB nurses on counts and other surgical practices, with assistance of veteran perioperative nurses.

Concern about retained items

There’s reason to be concerned about counts during cesarean births. The director says she knows of 2 incidents of retained objects that may be associated with cesareans performed in the past at other hospitals.

In one case, 2 sponges were discovered in a woman’s uterus after she went to another hospital with abdominal pain not long after her cesarean. In the second case, a woman who had a CT scan performed after a fall was found to have 2 size 0-Vicryl suture needles in her abdomen. Her history included previous laparoscopic surgery and 2 cesarean births. Size 0-Vicryl suture needles are used for closing deep layers and could have been left during a cesarean.

Vaginal birth is the most common type of procedure with a retained foreign object, accounting for about one-fourth of such cases, in data from Minnesota’s statewide adverse event reporting system. Hospitals in the state are conducting a Safe Count campaign to prevent retained objects in vaginal deliveries. More information is at www.mnhospitals.org/index/tools-app/tool.385?view=detail.

—Pat Patterson
References


A plan to harmonize practice for OR, labor and birth units

The collaborative effort at Yale-New Haven Hospital to harmonize standards for cesarean births began when a senior nursing VP asked the OR management to consult with the labor & birth (L&B) unit.

“We had collaborated over the years, but we wanted to put a more formal structure in place,” says Ena Williams, RN, MBA, MSM, nursing director for perioperative services. Yale-New Haven’s main campus, with 940 beds, has 37 ORs; the L&B unit has 3 ORs.

Williams began with a 2- to 3-week assessment of L&B. “We looked at the patient populations and recognized they had similar requirements,” she says. “The patients need similar intraoperative management and postoperative care. There are regulatory issues in common, such as the National Patient Safety Goals.”

These are steps the units’ leadership teams took to harmonize practice between the 2 departments. The collaborative model has since been applied to other departments, including interventional radiology, the GI endoscopy unit, and a freestanding ambulatory care facility that joined the system.

Form a leadership team

A multidisciplinary task force was formed to oversee the project. As much as possible, the leaders tried to match representatives from both departments, including physicians, nurses, managers, educators, and support services.
The team set a goal: To ensure that the ORs in L&B maintain similar standards to the ORs in perioperative services “to optimize patient safety, quality, and service excellence.”

**Identify focus areas**

The task force identified 7 focus areas common to the OR and L&B:

- National Patient Safety Goals, such as eliminating wrong surgery, improving handoffs, and medication reconciliation
- Infection control, including flash sterilization
- Environment of care, such as standardizing cleaning protocols, establishing a latex-free environment, and performing daily checks of emergency equipment
- Policies and procedures, including surgical counts, malignant hyperthermia management, and sterilization protocols
- Central sterile supply, including a system for equipment refurbishment and an audit process for surgical kits
- Patient safety, such as blood availability and fire safety
- Staff development, including orientation for L&B RNs to the perioperative department; consistent staffing for cesarean births; and education in high-risk, low-occurrence cases.

**Develop a work plan**

A work plan was devised to address the focus areas, and an L&B manager partnered with Williams to implement the plan.

“The first goal was to standardize practice,” Williams says. The second was to prepare the L&B staff so that if a problem occurred, such as a patient having a cesarean who required a hysterectomy, the L&B staff would be prepared.

Staff from L&B spent time in the OR with the perioperative GYN staff so they could become more familiar with surgeons they might work with in an emergency. OR staff also go to the L&B unit to support the staff and act as a resource when an unexpected situation occurs.

The 2 staffs also worked together to standardize cards for emergency cases. The L&B unit’s emergency cart was redesigned to support situations the unit may experience.

**Harmonize policies and procedures**

Comparable policies were developed for relevant aspects of L&B and perioperative services. These included policies such as counts, management of emergency procedures, and postoperative care. Documentation forms were standardized as much as possible.

A staffing model was developed for cesareans in the OR and L&B. Current practice is to provide an RN circulator plus a nurse for the baby.

“We now have a model where a second circulator is available to support the baby during a c-section so the circulating nurse can stay focused on the surgical procedure,” Williams says.

A uniform count policy includes a procedure for addressing discrepant counts, including x-rays. “When there is a count discrepancy, they follow the same exact standards. Nobody questions it any more,” Williams says.

She explains this is no longer a nursing policy but a hospital policy agreed upon by the medical and the nursing staff.

“You can’t fight this battle on your own,” Williams says. You have to get buy-in from the medical staff.”
**Keep up the collaboration**

To maintain the collaboration, a clinical leader from L&B was identified to become the unit’s “perioperative leader.” She is the go-to person for perioperative aspects of labor and delivery and related staff development and is mentored by the OR’s clinical leader for GYN surgery.

Williams says the position reinforces the bond between OB and the OR. “For us, it’s no longer how you do things versus how we do things. Now there is a standard. The collaborative leadership structure has eliminated lines between departments.”

**Stay prepared for surveys**

Be prepared for questions on a comparable standard of care from the Joint Commission and state surveyors, Williams advises.

“They will go from unit to unit and location to location. They will ask about your policies, so you had better be practicing the same way,” she says.

A collaborative team can also be a good resource for managers on standards and practice. Yale New-Haven’s team continues to meet every 4 months to address questions, practice issues, and policy development.

“We have come a long way,” she says. “It no longer feels like we are working in silos. We are discussing ways to expand this across the health system because many of our surgeons practice in other facilities.”