

Implementing Best Practices in Intrapartum Care

*What Can We Learn From Others'
Successes & Failures?*

First, Some Background About Midwifery & Nursing Care in Canada

- Nurses, as hospital employees, care for women during labour.
- Midwives are independent practitioners who offer choice of place of birth
- The majority of women are attended by physicians (usually obstetricians) and nurses in hospital labour wards

Second, Why Focus on Caesarean Rates When Discussing Best Practices?

- WHO recommends CS rates of 10-15%
- CS rates are far too high in many developed countries (32% in the USA, 27% in Canada)
- Best Practices can ↓ CS rate

Successes & Failures 1: The Evidence from Cochrane Reviews

- Continuous Labour Support
- Midwifery-Led Care
- Alternative Birth Settings
- Knowledge Translation Strategies

Continuous Labour Support

22 trials, n = 15,288

Support provided by hospital employee (nurse or midwife) or non-employee (doula, friend)

-  Caesarean, instrumental vaginal birth, intrapartum analgesia, baby with low 5-minute Apgar Score
- Slightly shorter labour

Subgroup Analyses

Strongest benefits in settings where:

- Companions not permitted
- Epidural analgesia not routinely available
- Continuous electronic fetal monitoring not routine
- Provider was neither a staff member nor family member or friend

Midwife-led Continuity Models vs Other Models of Care

15 trials; n=17,674

- Fewer fetal/neonatal deaths
- Modest increase in spontaneous vaginal birth, but no significant effect on Caesarean birth.

Alternative Birth Settings

10 trials; n=11,795

- Most trials were of separate units within hospitals. 1 was of a bedroom-like birth room within a labour ward, and 1 was a small pilot trial of a specially designed labour room
- All alternative settings had policies based on a philosophy of birth as a fundamentally normal experience.

Caesarean: RR= 0.88, 95% CI 0.78 to 1.00

Knowledge Translation (KT) Strategies

- Most KT strategies emphasize education and persuasion
- Only 1 KT strategy— of local Opinion Leaders* -- focused on obstetrical care (n=2 trials)
 - *highly-respected colleagues, no formal power
- KT strategies were complex, costly interventions with modest or no desired effects.

Example of a Complex Knowledge Translation Strategy

- Our cluster RCT of 22 Ontario, Canada hospitals
- 11 hospitals in experimental group and 11 in control group
- Control group: no intervention

Intervention Group

- Local opinion leaders plus unit managers trained in best evidence and techniques to persuade colleagues to adopt best practices
- Ongoing support from trial team for one year

Results: No beneficial or harmful effects, except for clues regarding effective strategies...

An Institutional Ethnography Aimed at Understanding the L&D Unit Culture*

A follow-up study which asked the question, “Why was the Opinion Leader Intervention effective in 2 out of 11 hospitals?”

*Angus J, Hodnett E, O’Brien-Pallas L. Implementing evidence-based nursing practice: a tale of two intrapartum nursing units. *Nursing Inquiry* 2003; 10: 218–228.

Successes & Failures 2: Going Beyond RCTs and Systematic Reviews...

A Different Way to Study the
Problem...

Attaining and Maintaining Best Practices in the Use of Caesarean Sections:

An Analysis of 4 Ontario, Canada Hospitals

The Context

- Provincial data continued to show rise in Ontario CS rate
- Prior KT studies had all focused on strategies to reduce CS rates in settings with high rates, with little or no success

What if we shifted the focus, to learn from hospitals which had not followed the trend, e.g. had maintained or lowered their CS rates while others were rising?

The Four Hospitals

Chosen based on Provincial data showing lower CS rates, and as representative of the types of hospitals in the Province:

- Small rural Level 1 hospital
- Large urban Level 1 hospital
- Large Level 2 hospital
- Large Level 3 teaching hospital

Methods

- Multi-disciplinary team*
 - Multi-method approach: written policies and obstetrical data from each hospital, site visits, group and individual interviews, staff surveys
- * midwife, nurse, family physician, obstetrician, hospital administrator, and academic expert in knowledge translation

RESULTS

12 Critical Success Factors, Grouped
into 4 Categories

Attitudes

1. Pride in low CS rate
2. Hospital Culture: Birth is a normal physiological process
3. Commitment to 1:1 Support by Nurses

Program Organization

4. Strong Leadership
5. Effective Multidisciplinary Teams
6. Timely Access to Skilled Professionals

Knowledge and Information

7. Obvious, Strong Commitment to Evidence-based Practice
8. CQI (Continuous Quality Improvement Program)
 - Patient and staff feedback, regular evaluations of staff, chart audits
9. Accessible and Interactive Database

Connections – Both Internal & External

10. Continuity and Coordination of Care

11. Networking

Managing Change

12. Ability and Willingness to Manage Change

- Change is the norm
- Need to continually monitor and adjust performance

The Big Question:

How to move from descriptive to prescriptive:

How does one change a hospital culture, such that it embodies the 12 attributes?

Successes & Failures 3:

Going beyond health care research
to research in other disciplines

What can we learn from behavioural economics?

A Practitioner's Guide to Nudging. Kim Ly, Nina Mažar, Min Zhao and Dilip Soman. 15 March, 2013.

<http://www.rotman.utoronto.ca/-/media/Images/Programs-and-Areas/behavioural-economics/GuidetoNudging-Rotman-Mar2013.pdf>

Research in behavioural economics has shown that changes in the environment can cause big shifts in behaviour.

These changes to the environment are called “nudges.”

Rather than placing restrictions, or trying to persuade or educate, nudges influence behaviour by changing the way options are presented in the environment.

Keys to Successful Nudging

1. To encourage an activity, *make it easy*.
2. One cannot implement evidence-based policy without evidence.
3. Document your results and share them widely.

How to make it easy for staff
to perform the desired
behaviours?

Three examples from practice and
research

1: An L&D Unit Manager in Adelaide, Australia decreased the use of continuous EFM during normal labour

2: The PLACE Pilot Trial:
Radical changes to a labour
room change the behaviour of
those in it

Hodnett E, Stremler R, Weston J, McKeever P.
*Re-Conceptualizing the Hospital Labor Room: The
PLACE (Pregnant and Laboring in an Ambient
Clinical Environment) Pilot Trial. BIRTH 36:2 June
2009.*





The Ambient* Room

**Creating a peaceful, relaxing atmosphere which promotes free movement*

- No hospital bed. Double-sized mattress & pillows, on floor in corner
- DVDs of beaches, waterfalls
- Ipods of various kinds of music
- Dimmed lighting







Results

(Small pilot RCT; n=40)

- ↓ Oxytocin augmentation of labour
- More time spent not in labour bed
- Overwhelmingly positive evaluations of ambient room—calming, music, DVDs, freedom of movement
- Some care providers did not like mattress on floor! But they loved the DVDs
- Most women in both groups wanted ambient room for next labour

CONCLUSIONS

Clinical interventions for individual women have modest or no impact on likelihood of CS in typical North American L&D units.

KT interventions are complex,
costly, and have relatively small
impact.

It's time to consider simple but radical changes to the environment for care, which may:

- Nudge the stakeholders to behave differently
- Change the unit culture

A very exciting area for future research and innovative practice!

Vielen Dank!