Maternal Risk Assessment Tool for Newborn Drops in the Mother–Baby Unit

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Purpose for the Program

There remains a gap in effective prevention strategies to reduce the rate of newborn drops in the immediate postpartum period in hospitals. To develop a process for effective drop prevention, a risk assessment tool that will help identify mothers at risk of dropping their newborns is crucial.

Proposed Change

To design a drop risk assessment tool, common patient characteristics were identified by retrospective analysis of the infant drops that occurred within the institution, combined with review of the literature and consultation with maternal–child experts.

Implementation, Outcomes and Evaluation

The tool is being piloted to evaluate effectiveness in the mother–baby unit using a retrospective, case controlled analysis to compare variables from the infant drop risk assessment tool to a control group matched by maternal age and birth month and year. On average, the newborn was dropped at 2.3 days of life, and 100% of the cases occurred between 2:00 AM and 7:00 AM. Compared with controls, there was a statistically significant difference in maternal prepregnancy and birth body mass index, duration of labor, and gestational age as indicators for potential infant drop. There were also higher incidences of nonelective cesarean and exclusive breastfeeding in the drop group than in the control group. The next phase is to further investigate the cesarean rate and indication for cesarean, analyze the pilot data, and modify the tool.

Implications for Nursing Practice

Having an effective assessment tool to determine mothers at risk of dropping their newborns will assist to establish interventions for prevention of newborn drops.

Building a Successful Perinatal Patient Safety Program

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Keywords
patient safety
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Purpose for the Program

To highlight the components of a successful perinatal patient safety program (PPSP).

Proposed Change

To reduce clinical errors, improve patient outcomes, improve process outcomes, increase patient satisfaction, increase staff satisfaction, and reduce malpractice claims.

Implementation, Outcomes and Evaluation

Development of the PPSP started with the existing nurse leadership group. Funding for the PPSP was provided by the Office of General Council, and incentives from reduction of malpractice insurance were put into place when certain process measures were met. Components of PPSP included the purchase of simulation equipment, critical events scenario development, simulation training for champions, TeamSTEPPs training for all obstetric nurses and physicians, use of the California Maternal Quality Care Collaborative (CMQCC) evidence-based practice toolkits, and use of a nurse–physician co-leadership model.

Process measures included the percent of staff who received TeamSTEPPs training, number of interprofessional simulations completed each month, bundle compliance for 13 elements from each CMQCC toolkit, and attendance of implementation teams at monthly mentor meetings. Outcome measures were reduction of severe maternal morbidity (SMM) related to hemorrhage and preeclampsia at the affiliate and system level. The affiliate’s SMM rate decreased from 15% to 4% for preeclampsia and from 40% to 6% for hemorrhage. The system SMM rate decreased from 13% to 9% for preeclampsia and 20% to 8% for hemorrhage.

Implications for Nursing Practice

This project demonstrates the value of a multi-pronged approach to implementation of evidence-based practice, including the use of TeamSTEPPs tools and a nurse–physician co-leadership model.