Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company’s public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.
Collaborative Approach to Reduce Severe Maternal Morbidity for Obstetric Patients Presenting to the Emergency Department

Health Care Advocacy Issue

In the United States, there has been an increase in obstetric adverse events. The Centers for Disease Control and Prevention defines adverse outcomes as severe maternal morbidity (SMM) and mortality. In our organization there was an increase in SMM among patients presenting to the emergency department. Root cause analyses revealed several contributing factors.

Need for Leadership Intervention(s)

Nursing and physician leadership collaboration among obstetric, emergency, and NICU departments created a task force to improve maternal outcomes.

Target Audience

Obstetric and emergency departments’ nursing and provider leadership; NICU team

Leadership Plan

The task force used clinical inquiry, evidence-based decision making, innovation, teamwork, and a commitment of financial support and resources to address the issues.

Leadership Plan Implementation Method

The plan–do–study–act framework was used to support modifications and innovative change solutions. Modifications to existing processes included the obstetric–emergency departments’ triage workflow algorithm, policy, and emergency activation of the obstetric response team.

Innovative solutions to address process gaps included evidence-based scenarios for simulations–drills, point-of-care testing, and an automated daily patient disposition report.

Metrics

Data analysis revealed a decrease in patient arrival to obstetric providers and an increase in birthplace triage volumes for Fiscal Year 2021. To accommodate the shift in patient triage volumes, additional human and capital resources were acquired to support expanded operations in birthplace triage. A nurse navigator role was also created to support the continuum of care for patients seen in the emergency department and birthplace. These changes resulted in zero root cause analysis (RCA) for adverse events, a decrease in SMM in the emergency department. Sustainment of initiatives include continuous monitoring, tracking, and reporting of measurable outcomes to key stakeholders and executive leadership teams.

Creating an Inpatient COVID-19 Vaccination Program for Postpartum Patients

Health Care Advocacy Issue

COVID-19 vaccine hesitancy is an issue affecting cities across the nation. Only 63.2% of adults over the age of 18 years were fully vaccinated in Philadelphia, a predominantly ethnic Black city, despite the vaccine being available. Vaccine hesitancy is prevalent in the Black community due to distrust of the medical community and long-standing structural racism. Although obstetricians recommend COVID-19 vaccination during pregnancy, hesitancy still exists among pregnant women. Reasons behind this hesitancy include lack of data about COVID-19 vaccine safety in pregnancy and fear of harm to fetus. This vaccine hesitancy was noted in the obstetrics department in a large, urban, academic medical center in Philadelphia, where more than half of the obstetric patients are Black.

Need for Leadership Intervention(s)

Antenatally, providers encouraged women to be vaccinated. For postpartum women, nurses and providers wanted to remove existing barriers for vaccination. A need was identified to create an inpatient COVID-19 vaccine program for postpartum women.
Target Audience
Unvaccinated postpartum patients.

Leadership Plan
An interdisciplinary team was assembled to design and implement the program, including frontline staff. The Pfizer vaccine was chosen, because during the planning phase, a "pause" was placed on the single-dose Janssen vaccine.

Leadership Plan Implementation Method
Before implementation, staff and providers were educated on the process using tip sheets. Patients were approached by the provider during admission to the birthing suite and assessed for vaccine readiness. The electronic health record (EHR) was modified to accommodate order entry for vaccination on transfer to the postpartum unit.

Orders were reviewed by the pharmacist daily and communicated to the charge nurse. Nurses obtained consent using a script. After administration, patients were observed for 15 minutes. During this time, the nurse documented the vaccine and clinical observations in the electronic health record and assisted the patient in scheduling their second dose at our outpatient vaccine clinic.

Metrics
In a 3-month period, a total of 44 patients received the first dose of the Pfizer vaccine.

Application to/Implications for WH, O, or N Leadership
This program can be easily replicated in other postpartum settings to improve vaccination rates.

How Every Postpartum Hemorrhage Harms Every Other Birthing Person on the Unit

Health Care Advocacy Issue
Every birthing person on a unit is harmed when a postpartum hemorrhage (PPH) occurs because staff, blood, medication, supplies, and more are diverted to attend to the crisis. When caring for a woman with PPH, multiple nurses are pulled from their existing patients (often set up as 1:1 nurse:patient ratio) to assist, thus increasing the chances of another safety event. Instead, unit staff should minimize the risk for PPH with limited obstetric interventions, support physiological birth, prepare for PPH (i.e., through simulations, maintaining the hemorrhage cart, making medications easily available, having a blood replacement plan in place, closely assessing the postpartum patient). Plan to reduce elective inductions and multiple obstetric-unit closures that have created a bottleneck situation in care resources during a highly acute care situation. Information is provided on the obstetric-unit closures in Philadelphia during the last 20 years. Risk predictive models are limited in their utility, but known risks exist.

Need for Leadership Intervention(s)
Legislation to stop maternity-unit closures in hospitals, a national program for safe obstetric-unit staffing and experience on the unit, more-than-adequate staffing ratios, early preparation and simulation plans for PPHs, hemorrhage carts, medication at quick access, safe staffing in the birthing room, minimization of risk for PPH.

Target Audience
Nurses, certified nurse-midwives (CNMs), obstetricians, hospital leadership, legislators.

Leadership Plan
Review current unit safety data (numbers and costs associated) with hospital administrators and legislators, develop education plan with unit education leadership, minimize risk for PPH with appropriate patient assignments, minimize labor interventions, support physiological birth.

Leadership Plan Implementation Method
Meet with stakeholders, develop goals, develop legislation to provide safe and consistent care, provide quarterly education, move resources closer to the patient (blood, medication, hemorrhage cart).

Metrics
M and M analysis of staffing and patient mix, quarterly government-funded mandatory obstetric safety education (didactic and simulation), goal setting, safety evaluations, improvement in resource availability.

Application to/Implications for WH, O, or N Leadership
Obstetric.