Staff "Shine" During Healthcare Risk Management Week, Cont'd.

In cases where the patient has a historical blood type recorded within the HCA Richmond Market hospitals, the routine typing and screening procedure is done and results are compared to the historical type. If there is a discrepancy, a second confirmation specimen is obtained for appropriate testing. If the confirmation specimen matches the recent draw, then the supervisor is consulted regarding the need to amend the patient's history within Meditech.

The revised policy regarding confirmation of blood type was communicated to all staff and the appropriate upgrades were made within the Laboratory Information Systems to support the second draw. The new process was also communicated to the ED physicians and staff, Surgical Services, Pre-Admission Testing, and Nursing Services. Flyers were distributed to physician lounges and a mass mailing was sent to all hospital staff.

Delays resulting from the need for a second draw have been minimal and one error was detected prior to reaching the patient through the new process. All five HCA affiliated facilities within the Richmond Market have adopted and implemented this safety initiative.

Radiology Services was honored with the **first place Gold Award** for their efforts to **reduce patient, staff and visitor injury within the MRI Suite.** For example, there had been situations where patients with pacemakers were getting into the MRI suite before anyone realized the patients had pacemakers. Staff took the initiative to review current policies and procedures to make the necessary changes to improve safety not only in the clinical department, but for all individuals entering the area.

Zones were established within the department for safer MRI practice, and the screening form was revised with initial completion to be done by nursing and a second review by MRI staff prior to patients entering the suite. ***Central Scheduling was taught to screen outpatients. New signage was posted listing items inappropriate for the suite, the door frame was painted bright orange with a WARNING sign*** posted outside the scan room and ***ear plugs were provided*** to anyone in the scan room during the procedure.

The MRI staff has essentially become the active gatekeepers to all who enter the scan rooms. House-wide education has been conducted by those gatekeepers at staff meetings, new employee orientation and through annual mandatory safety training. Since the changes were implemented, these types of events have been reduced dramatically.

We believe everyone in our organization is a 'Risk Manager' and is afforded the opportunity to have a positive impact on safe outcomes of conducting the business of healthcare. The response to our contest was a clear indication they take their role seriously and their intent is certainly one driven by *"Safety in Numbers."*

This contest was well received by the staff and plans are underway to include another contest for the "Excellence in Risk Management" Award during next year's Healthcare Risk Management Week in June.

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Could This Happen at Your Hospital?

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A new grandmother went in to check on her 3-day old grandson in order to let her daughter rest a bit longer. The baby "would not wake up." The family rushed the baby to the hospital of delivery, a level 1 community hospital. When urine cultures came back positive, the baby was transferred to our facility which is the children's hospital for Oklahoma. The baby was admitted through the emergency department and a full work up was done. The baby was so dehydrated that two spinal taps had to be performed to collect enough fluid for analysis. Since the baby was breastfeeding, a lactation consult was ordered on admission to the hospital infant unit.

When the International Board Certified Lactation Consultant (IBCLC) made first contact, the baby was on IV fluids, under photo therapy and being fed formula because the mother was unable to express any milk. The first-time mother had such painful breast engorgement that she could not even lie down. She could only rest by sitting up in the child bed in the room with pillows propped around her to support her painful breasts. She had been trying to pump with the hospital's electric pump without any success. The IBCLC immediately recommended ice packs to reduce the swelling and pain.[1] After several hours of alternating ice pack treatment, the mother was finally able to begin expressing some milk. Once the breast engorgement was reduced, the IBCLC scheduled a visit to assist the mother and evaluate a breastfeeding session.

Initial test results indicated no infections, so the baby was treated for dehydration and an elevated bilirubin. Insuring adequate oral intake was a priority to prepare for discharge home. As the IBCLC gently questioned the traumatized mother about her recent breastfeeding history, she learned the following:

- The mother had an uncomplicated vaginal delivery, and

(Continued on Page 13)

Could This Happen at Your Hospital?, Cont'd.

the baby was born healthy at term.

- Breastfeeding was initiated after the baby stayed several hours under the warmer in the nursery.
- The baby stayed with the mother off and on during the day. The baby received some formula feedings while in the nursery.
- The mother reported some initial difficulty with getting her baby to latch on.
- The mother stated that the nursing staff tried to help and gave her two types of "nipple shields" to facilitate latch on, telling her she had "flat" nipples.
- The mother and baby were discharged home at 48 hours, breastfeeding with "nipple shields."
- The baby's first checkup with a physician was scheduled for two weeks.

When the mother reported that she thought the nipple shields helped and her baby sucked better with the "red one," the grandmother pulled both nipple shields out and discovered that the mother had been given a red, preterm bottle nipple to place over her own nipple for breastfeeding. It was now clear what had caused the baby to become so dehydrated and led to his hospital admission — **inappropriate breastfeeding information and instruction. Bottle nipples are not nipple shields.** A baby cannot transfer milk at the breast through a bottle nipple. So this baby was sent home basically nursing on a "pacifier." The mother also suffered severe, painful engorgement which could have led to mastitis and/or a breast abscess and a rapid, possibly irreversible decrease in milk production.[1]

A closer look at this situation reveals several opportunities for implementing best practices which would have avoided this chain of events[2-5]:

- During the first hour of life, baby should have been placed skin to skin with the mother and given an opportunity to breastfeed. Many babies can latch on at this time with little to no help.
- Mother and baby should have been kept together 24 hours a day to allow for breastfeeding on cue of the baby.
- The baby should not have been supplemented with formula unless medically indicated.
- Hospital staff should have been trained and competent to provide basic breastfeeding support, including assisting with latch-on.
- Since they were experiencing difficulty with breastfeeding, mother and baby should have been seen by an IBCLC as soon as possible, ideally within 24 hours.
- A plan to insure adequate intake for baby and to protect mother's milk supply should have been developed and explained to the mother. (Early use of a real nipple shield should always include milk expression.)
- The mother should have been educated about breastfeeding with evidence-based information and given resources for skilled breastfeeding support after discharge.
- After discharge, a follow-up visit with an IBCLC should have been arranged for further evaluation of the baby's weight gain and mother's milk production.

Fortunately for this mother and baby, skilled support from an IBCLC and knowledgeable nursing staff and physicians insured that the mother's milk supply was not compromised, mastitis was avoided and the baby could latch effectively and transfer adequate quantities of milk at breast. The mother's nipples were also evaluated and found to be normally everted. The baby was discharged fully breastfeeding, the mother was thoroughly educated on signs of adequate intake for her baby, a follow-up weight check was scheduled for two days after discharge and the mother was offered post-discharge support from the hospital's lactation center.

The author conducts a lactation training program.

Currently in the United States, breastfeeding initiation rates have reached an all-time high of 75% with many hospitals reporting initiation rates of 80-90%.[6] While maternal/child health advocates celebrated the achievement of this first Healthy People 2010 breastfeeding goal, the reality is that duration rates, and in particular exclusive breastfeeding rates, have remained relatively flat. In fact, many babies leave the hospital not fully breastfeeding and thus are much more likely to be weaned in the first six weeks.[7] The American Academy of

(Continued on Page 14)

Could This Happen at Your Hospital?, Cont'd.

Pediatrics and numerous other healthcare-related organizations recommend exclusive breastfeeding for six months with continued breastfeeding to at least the age of one year or more. The current national average for exclusive breastfeeding at six months is only 11%.

Because the care given to breastfeeding mothers and newborns in the hospital impacts breastfeeding duration rates, the US Centers for Disease Control conducted its first national survey of maternity hospitals and birthing centers.[8] The goal of the CDC's survey was to identify the number of Baby-Friendly practices occurring in U.S. hospitals. The World Health Organization's Baby-Friendly Hospital Initiative (BFHI) is the model for evidence-based breastfeeding care. Hospitals that have achieved Baby-Friendly certification have well-trained staff, higher breastfeeding initiation rates, higher exclusive breastfeeding rates at hospital discharge and higher breastfeeding duration rates.[9] CDC survey results indicate "substantial prevalences of maternity practices that are not evidence-based and are known to interfere with breastfeeding."[8]

Published in the CDC's June 2008 Morbidity and Mortality Weekly Report, results were tabulated on a 100-point scale, a report card on breastfeeding support in US hospitals.[6] Grouped into seven main categories, from labor and delivery to breastfeeding support after discharge, the overall grade for US hospitals was an "F" with an average of 63 out of 100. The two categories with the absolute lowest scores were breastfeeding support after hospital discharge [40] and staff breastfeeding training and education [51]. When mothers receive optimal breastfeeding care in the hospital, they are eight times more likely to continue breastfeeding to at least six weeks.[10] With adequately trained staff and referral to appropriate breastfeeding support after discharge, the unfortunate incident described here could have been avoided.

A universal complaint of breastfeeding mothers is the inconsistent information they receive. While many HCA affiliated hospitals may have one or more IBCLCs on staff, some IBCLCs are challenged to work with nurses and physicians that do not themselves have enough education and training to provide competent, basic breastfeeding support. Smaller hospitals without the volume to justify hiring an IBCLC are also challenged to provide consistent, evidence-based care to breastfeeding families. When hospital staff is well-trained, mothers and families are more likely to receive accurate, consistent information and support from the entire health care team. The IBCLCs on staff can also better utilize their expertise to focus on more complicated breastfeeding situations and even provide some of the needed staff education.[11]

The CDC will soon be sending benchmark reports to individual hospitals that completed the maternity practices survey. Now that we have a national and state-by-state report, we will soon have a report card for individual hospitals, giving us an opportunity to identify areas for improvement. HCA affiliates are in a unique position to make rapid and substantial improvement due to the work of HCA's existing Lactation Consultant Workgroup.

Launched initially in 2004 to work on the Perinatal Safety Initiative on "Kernicterus As A Never Event," the Lactation Consultant Workgroup was continued due to the excellent, evidence-based work they had completed. Best practice policies have been recently updated and can serve as a guide to hospitals wanting to update or improve their own policies. Recommendations on various available offerings for quality staff education on breastfeeding are currently being developed. The Lactation Consultant Workgroup has also been used as an ongoing resource for all HCA affiliated hospitals whenever questions have arisen related to the care of breastfeeding mothers and children.

Moving a hospital to evidence-based breastfeeding care often requires more than just implementing a policy. It requires a culture change. The BFHI is the model for making that culture change. To date, Kaiser Permanente hospital system has the most Baby-Friendly certified hospitals in the United States.[12] Currently there are no HCA affiliates that are Baby-Friendly certified. If HCA affiliated facilities took the lead on this initiative, we could have a major impact on breastfeeding rates around the country and thus improve maternal and child health far beyond the few days stay in the hospital. At the very least, we could avoid readmitting newborns who "wouldn't wake up."

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