Perinatal Injuries Gap Analysis

Component of the Perinatal Safety Roadmap

Patient Safety | Perinatal Safety

Specific Action(s)	Gap Analysis Questions	Yes	No	If answered question "No" – identify the Specific Action plan(s) including persons responsible and timeline to complete.
Patient Education				
1) Provide patient/family education.	1a) The facility has a process in place to provide information to the patient about risks, benefits and alternatives for maternal intra-partum procedures.	☐	☐	
	1b) The facility has a process in place to educate the patient and/or family about newborn screening per the Department of Human Services (DHS).	☐	☐	
Elective Delivery				
2) Scheduled induction and/or Caesarean.	2a) The facility has a hard stop policy in place to prevent elective deliveries < 39 weeks without medical indication.	☐	☐	
	The facility's practices include at minimum:			
	2b) Medical indications for scheduled delivery are defined.	☐	☐	
	2c) Hospital staff is authorized to not schedule an elective delivery before 39 weeks and 0 days of gestation.	☐	☐	
	2d) Providers are required to obtain approval from physician leadership before performing an elective scheduled delivery before 39 weeks.	☐	☐	
	The facility utilizes the following criteria to establish gestational age for all elective deliveries:			
	2e) Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater.	☐	☐	
	2f) Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography.	☐	☐	
	2g) It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result.	☐	☐	
	2h) The facility has a process in place to document both gestational age and medical indications for delivery as a pre-requisite to schedule delivery prior to 39 weeks.	☐	☐	
	2i) The facility has developed and maintains a list of medical indications for delivery prior to 39 weeks.	☐	☐	
	2j) The facility has accepted the following list of evidence and consensus based medical indications for delivery prior to 39 weeks. The facility should not be limited to this list; additional criteria can be added using evidence and expert opinion based on practice.	☐	☐	
	Indications include, but are not limited to the following: **Fetal indications** Growth restriction Fetal anomalies Multiple gestation Fetal demise Isoimmunization Abnormal fetal testing **Obstetric indications** Placenta abnormalities; previa, abruption Previous uterine surgery (classical C-section, myomectomy) Amniotic fluid abnormalities PROM **Maternal indications** Hypertensive disease Diabetes Lupus Renal disease Pulmonary disease Liver disease Coagulation defect			

Specific Action(s)	Gap Analysis Questions	Yes	No	If answered question "No" – identify the Specific Action plan(s) including persons responsible and timeline to complete.
	2j) The facility has a quality improvement process in place to review all deliveries less than 39 weeks, for appropriateness of the medical indications.	☐	☐	
Fetal/Uterine Assessment				
3) Estimated fetal size Fetal heart rate	3a) The facility requires that all patients have estimated fetal size documented prior to delivery. 3b) The facility requires that the fetal heart rate assessment is documented in the medical record using the National Institute of Child Health and Human Development (NICHD) terminology. 3c) The facility has a policy in place that outlines the appropriate and safe administration of uterotonics relative to fetal heart rate assessment.	☐ ☐ ☐	☐ ☐ ☐	
4) Pelvic exam	4a) The facility requires provider/RN do a vaginal exam and document dilatation, effacement, station, presenting part prior to the induction/augmentation as clinically appropriate.	☐	☐	
5) Uterine contractions	5a) The facility has standard practices in place for the appropriate and safe administration of uterotonics relative to uterine contractions. 5b) The facility has standard practices in place for documenting uterine activity in the medical record using the National Institute of Child Health and Human Development (NICHD) terminology. 5c) The facility has standard practices in place for the management of abnormal uterine contractions.	☐ ☐ ☐	☐ ☐ ☐	
Operative Vaginal Delivery				
6) Operative Vaginal Delivery	6a) The facility has standard practices in place for appropriate and safe performance of operative vaginal delivery. The guidelines may include: alternative labor strategies, prepared patient, high probability of success, maximum number of application and pop-offs predetermined, exit strategy available, communication and documentation with infant caregivers about use of operative vaginal delivery. 6b) The facility has a quality improvement process in place to review operative vaginal deliveries that fall outside the facility's standard practices.	☐ ☐	☐ ☐	
Maternal/Obstetric Morbidity and Mortality Reduction Strategies				
7) Management of Hypertensive Emergencies	7a) The facility has a process in place for assessment and management of hypertensive emergencies which include blood pressure parameters and medication regimen, e.g., standard order sets or protocols.	☐	☐	
8) Postpartum hemorrhage	8a) The facility has a process in place for assessment and management (medical/surgical/mechanical) of postpartum hemorrhage which includes risk assessment and management of the patient, staff recognition and response, e.g., standard order sets and medication regimen. 8b) The facility has a plan for management/transfusion/transfer for the patient with massive blood loss, e.g., massive transfusion protocol, inter-facility transfer guidelines, surgical options, uterine tamponade balloon.	☐ ☐	☐ ☐	

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9) VTE prevention	9a) The facility has a process in place for assessment and management of VTE prevention which includes mechanical prophylaxis for all C-sections, unless contraindicated and pharmalogical interventions as appropriate, e.g., SCIP protocol.	☐	☐	
10) Peri-operative infection prevention strategies	10a) The facility has a process in place for routine administration of appropriate weight based pre-operative antibiotics within 1 hour prior to incision, e.g., pre-op order set.	☐	☐	
11) Minnesota Maternal Mortality reporting requirement	11a) The facility has a process in place to ensure awareness of and compliance with the Minnesota Maternal Mortality reporting Statute #4615.0080 among hospital Quality, and Obstetric and Emergency Department providers.	☐	☐	
Trial of Labor after Previous Caesarean Section				
11) Trial of labor after previous Caesarean	11a) The facility's process for possible vaginal births after Caesarean delivery (VBAC) includes counseling and offering a trial of labor (which should include referral to another hospital) after previous Caesarean delivery (TOLAC). 11b) The facility has a process in place for appropriate and safe administration of uterotonics relative to TOLAC which includes no third trimester prostaglandins.	☐ ☐	☐ ☐	
Provider and Nurse Training				
12) Provider and staff education	**The facility provides periodic interdisciplinary education which includes:** 12a) Education for providers and nurses on electronic fetal monitoring using the National Institute of Child Health and Human Development (NICHD) common language. 12b) Maternal/newborn team crisis training on issues such as: shoulder dystocia, Postpartum hemorrhage, emergency delivery, newborn resuscitation, hypertensive emergency. 12c) Training on individual communication skills and team collaboration, e.g., SBAR, TeamSTEPPS, briefs, debriefs, handoffs, simulation.	☐ ☐ ☐	☐ ☐ ☐	

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