Safer Care Victoria

JUNE 2019

Better births for women collaborative: information pack

A Breakthrough Series Collaborative

Institute for Healthcare Improvement

Contents

Introduction

BACKGROUND INFORMATION

Women having their first birth vaginally in Victoria are four times more likely to experience a severe perineal laceration (third- or fourth-degree tear) compared to those having a subsequent birth vaginally[1].

A third- or fourth-degree perineal tear is a significant birth-related complication that may lead to long-term disability. It is important these tears are prevented, and where they do happen, they are recognised so that appropriate treatment can be provided. Third- and fourth-degree tear rates may reflect the quality of intrapartum care or differences in the accuracy of identification and reporting[2].

In Victoria in 2017-18, the state-wide rate of third- and fourth-degree perineal tears in unassisted births (Indicator 1ci) was 3.2 per cent. The rate was higher in public hospitals (3.6 per cent) than in private hospitals (1.0 per cent). In the same period, the state-wide rate of third- and fourth-degree tears in assisted births (Indicator 1cii) was 4.7 per cent. The rate was again higher in public hospitals (5.5 per cent) than in private hospitals (2.5 per cent). There was significant variation between individual hospitals in both unassisted and assisted vaginal births, from zero to 20.0 per cent and zero to 11.1 per cent respectively[3].

For the women sustaining these injuries, the consequences can be long-term or lifelong, and impact on their physical and psychological wellbeing. The resulting trauma has been shown to have a detrimental psychosocial impact, with many women requiring ongoing intervention. It has also been shown that the trauma of sustaining a perineal tear and its complications can affect subsequent births choices where a vaginal birth is forsaken, increasing rates of elective caesarean section.

Utilising our partnership with the with the Institute for Healthcare Improvement (IHI), the Better births for women collaborative will further test and spread the success of evidence-based clinical care bundles to reduce third- and fourth- degree perineal tear rate, with work focussing on five clinically endorsed interventions.

The Better births for women bundle has been shown to improve outcomes for women during childbirth and reduce the incidence of severe perineal trauma. The bundle includes:

- Application of warm perineal compress during labour
- Hands on to support the perineum, with gentle verbal guidance
- Episiotomy performed when indicated (during instrumental delivery and at 60 degrees)
- Genito-anal examination on all women post birth
- Grading of perineal tear based on RCOG grading and reviewed by experienced clinician.

Through facilitating the Better births for women collaborative, we will partner with clinicians to better detect and manage risk factors to prevent perineal trauma. We will improve the care experience of women through shared decision making in risk factor management.

WHAT IS THE SCOPE OF THE BETTER BIRTHS FOR WOMEN COLLABORATIVE?

The Better births for women collaborative will focus on leadership for success, the clinical bundle of care interventions and the experience of women prior to birth. We acknowledge there have been suggestions to focus on pathways for care once the a third- or fourth-degree tear has occurred. This collaborative is limited to prevention of tears and therefore till not measure outcomes beyond that.

In scope

As part of our commitment to reducing avoidable third- and fourth-degree tears, the Better births for women collaborative will focus on designing, testing and implementing change ideas related to:

- Providing leadership and governance
- Application of evidenced based clinical care
  - Providing education and raising awareness to all women during pregnancy
  - Intervention 1: Application of warm perineal compress during labour
  - Intervention 2: Hands on to support the perineum, with gentle verbal guidance, for all vaginal births (assisted and spontaneous)
  - Intervention 3: Episiotomy performed when indicated
  - Intervention 4: Genito-anal examination on all women post birth
  - Intervention 5: Grading of perineal tear based on RCOG grading and reviewed by experienced clinician
- Partnering with women to improve the experience of care

Out of Scope

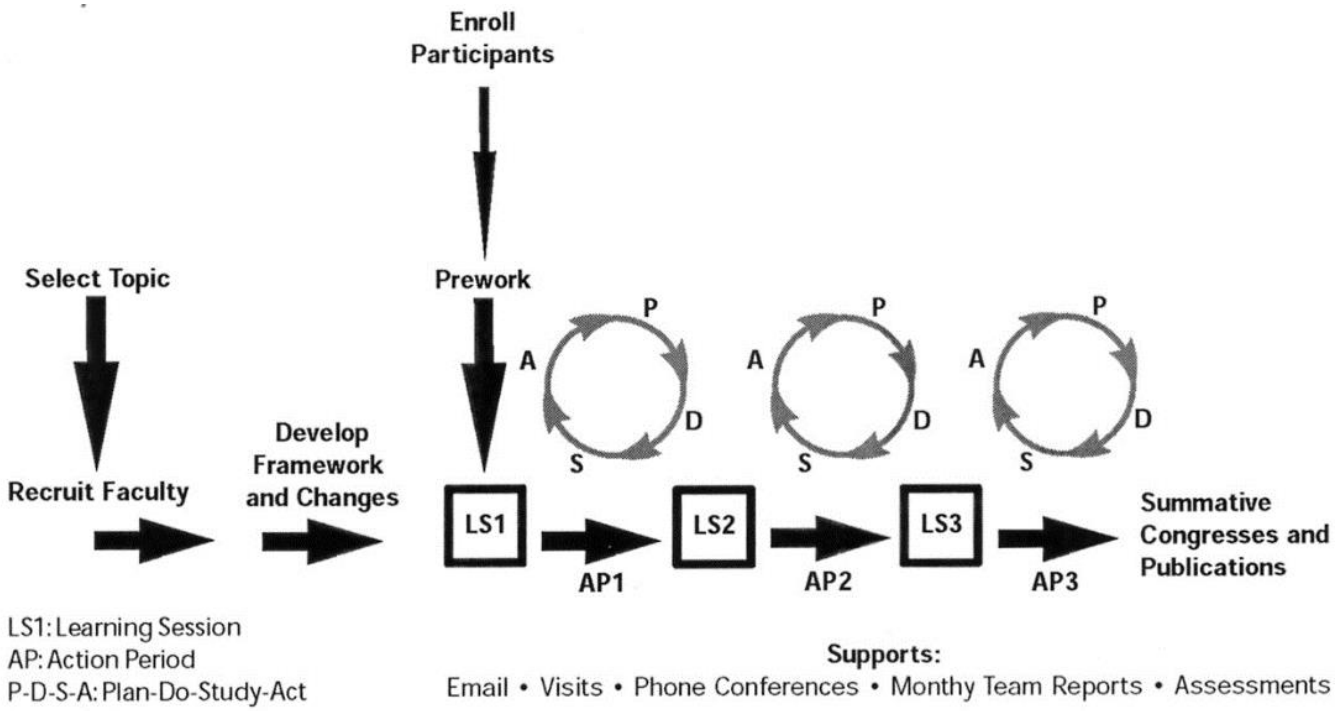
Preparation for discharge and ensuring the right care is in place for appropriate follow up and support following a perineal tear are essential components of the care women should receive. While we acknowledge the importance of ensuring best-practice care following a perineal tear, repair of a tear, discharge planning and post-discharge follow up are not in focus for this work.

What is a Breakthrough Series Collaborative?

A Breakthrough Series Collaborative (BTS) involves health services working intensively together, with the support of SCV and the IHI, to achieve significant improvements. Over 12 months teams participate in three face-to-face learning sessions and three service-based action periods. In addition, teams maintain continual contact with each other, the SCV and IHI team members through conference calls, online discussions, email and monthly progress reports.

At **Learning Sessions**, maternity service teams meet to share their experiences and learn about quality improvement methodology and the proposed changes to clinical care. During **Action Periods**, service teams work together to embed and test changes using a Model for Improvement.

Diagram of a IHI Breakthrough Series Collaborative



PLANNED KEY DATES 2019- 20

Activity	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July
Expression of Interest Open	24													
Q&A call		11												
Expression of Interest Closed		17												
Health Service Notification of participation		19												
Orientation call		31												
Learning Session 1 Pre-work Submission			5											
Learning Session 1			8-9											
Action Period 1 (AP1)			12 Aug-20 Oct 2019											
AP1 Site Visits			To be scheduled											
AP1 Online Meetings			To be scheduled											
AP1 Data Submission				19	17									
AP1 Progress Report Submission				TBC	TBC									
Learning Session 2 Pre-work Submission					17									
Learning Session 2					23-25									
Action Period 2 (AP2)					28 Oct 2019-1 March 2020									
AP2 Online Meetings					To be scheduled									
AP1 Site Visits as required					To be scheduled									
AP2 Data Submission						21	19	16	20	19				
AP2 Progress Report Submission								TBC						
Learning Session 3 Pre-work Submission									23					
Learning Session 3										3-5				
Action Period 3 (AP3)										6 March-July date to be confirmed				
AP3 Data Submission											16	21	18	
AP3 Holding the gains online meeting														TBC

How can my health service participate?

EACH PARTICIPATING SERVICE WILL NEED:

Executive sponsorship

This person needs to support and engage with the work and attend Learning Session 2 on 23, 24 and 25 October 2019. See the 'Getting started' section on page 9 for more information.

A dedicated team

Your core collaborative team needs to include an executive sponsor, team leader, an obstetrician, midwife, consumer and member with quality improvement experience. Your wider team (an extra six to 12 members) should include influencers in your organisation who can drive commitment to the work, and a member responsible for data entry.

Time to do the work

In our experience, optimal results are achieved when teams can devote at least 30 hours per week to the project (shared between team members). This includes online meetings and work in the clinical space.

Testing and implementation

The collaborative team needs to be committed to testing and eventually implementing **all** elements of the bundle. The core team needs to be able to attend all learning sessions (three two-day sessions).

WHAT WILL BE PROVIDED?

Improvement resources:

- Three two-day learning sessions
- Ongoing phone and online support from SCV and IHI
- Access to clinical experts
- Improvement teaching and coaching
- Access to the IHI Open School
- Networking opportunities with other participating services
- Site visits to support the service team
- Support to generate, review, understand and present data

Change package resources:

- A change package will be provided to you during Learning Session 1.

Our collaborative leadership team

PROJECT DIRECTORS

- **Gemma Cooper (SCV)**
- **Jennie Ross (IHI)**

The project directors are responsible for overall management of the Breakthrough Series process, including:

- coaching the clinical lead and faculty in methodology
- managing pre-work development, recruiting, Q&A sessions
- creating and facilitating meetings
- coaching at Learning Sessions and during Action Periods
- working with the improvement advisors to track progress.

Contact gemma.cooper@safercare.vic.gov.au

IMPROVEMENT ADVISORS

- **Rebecca Reed (SCV)**
- **IHI support**

The improvement advisors are the experts in improvement theory and methodology. Their role includes:

- coordinating development of theory for the topic
- building the change package
- designing a measurement system and addressing measurement issues
- teaching and coaching faculty and teams on using the Model for Improvement
- compiling and reviewing monthly reports
- assessing progress
- recommending strategies to achieve goals.

Contact rebecca.reed@safercare.vic.gov.au

CLINICAL LEAD

- **Dr Nicola Yuen, Maternity and Newborn Clinical Network, Safer Care Victoria**

The clinical lead is an authority in the collaborative topic who helps create a shared vision and leadership. Their role includes:

- helping to form and guide the faculty
- assisting with development of the change package and measurement strategy
- chairing and teaching at Learning Sessions
- coaching and mentoring teams
- reviewing collaborative progress.

FACULTY

Faculty for a Breakthrough Series Collaborative bring clinical and consumer expertise in the topic and, in some cases, experience in the Model for Improvement methodology. They represent multiple disciplines and organisational structures.

The faculty role includes:

- specifying goals
- identifying high leverage changes
- supporting services to establish their teams
- supporting services to engage with consumers
- assisting teams with pre-work
- teaching and coaching at Learning Sessions and during Action Periods
- advising the clinical lead and directors about teams' progress.

Getting started

- Confirm your executive sponsor
- Confirm your day-to-day team leader
- Initial steps
- Create your team
- Connect to the collaborative's web platform
- Participate in your orientation call
- Learn about the Model for Improvement
- Prepare for Learning Session 1

CONFIRM YOUR EXECUTIVE SPONSOR

Active partnership between service leadership and the collaborative team is essential to achieve results.

Based on feedback from health services who participated in the WHA National Collaborative, the teams that were able to demonstrate significant improvement were those with executive leadership and support for the life cycle of the collaborative.

Teams succeed when a senior leader sponsors the work, keeps informed and provides resources and time allocation for work of this nature to occur.

The executive sponsor is responsible and accountable to the service for performance and results of improvement work. They are not an active member of the collaborative team but support their staff to achieve their aim through leadership and engagement.

Executive sponsors:

- Encourage the improvement team to set appropriate goals and agree on the team charter
- Provide the team with resources, including staff time and operating funds - our experience is that the total resources required to do this work will be at least one full-time equivalent (FTE)
- Ensure that improvement capability and other technical resources are available to the team
- Regularly review the work of the team and communicate with senior leaders including the Board
- Communicate to internal and external audiences the importance of the project and its emerging results
- Develop a plan to spread the successful changes from the improvement team to the rest of the organisation.

CONFIRM YOUR DAY-TO-DAY TEAM LEADER

The day-to-day team leader is the critical driving component of the project.

The team leader ensures changes are tested and implemented and they oversee data collection. It is important that the team leader understands the details of the system and the effects of making change(s) in the system. This person also needs to be able to work effectively with the obstetrician and midwife champion(s), other technical experts and leaders. Usually, the team leader devotes a significant amount of their time to the improvement team's work, often 30 percent or more.

A team leader should:

- Have a working knowledge of the area selected
- Be able to organise and coordinate a functioning team that works at an accelerated pace
- Have time allocated by senior leadership to work on this project
- Connect regularly with the executive sponsor to share updates
- Be motivated and excited about change and creating new designs.

INITIAL STEPS

The executive sponsor and team leader should meet as early as possible and complete the following:

- Review the Better births for women collaborative project charter
- Identify how the project aims fit with the organisation's strategic goals
- Set specific organisation aims
- Identify whether the team leader will also be the organisational leader
- Identify team members
- Discuss the resources available for the project, specifically the allocation of time for the improvement team's leader and other team members
- Plan a kick-off meeting for the team
- Discuss plans for a regular team review schedule for the sponsor's ongoing connection to the team (minimum of monthly).

CREATE YOUR TEAM

Team members should:

- Have a working knowledge of the area selected
- Be able to work together as a team that functions at an accelerated pace
- Have time allocated by the sponsor to work on this project, and are motivated and excited about change and creating new designs
- Make the work of the team visible to the departments/services that will be involved by sharing results and inviting other staff members to attend team meetings.

For each team member ask the following:

  - Is the person respected for his/her judgement by a wide range of staff?
  - Does he/she enjoy a reputation as a team player?
  - What is the person's area of skill or technical proficiency?
  - Is he/she an excellent listener?
  - Is this person a good verbal communicator within front line groups?
  - Is this person a problem solver?
  - Is she/he disappointed with the current system and processes and wants to improve things?
  - Is this person creative, innovative and enthusiastic?
  - Is she/he excited about change?

- Is this person willing to take a risk and be comfortable with change?

It may also be helpful to consider characteristics of the team as a whole, for example:

- Are there differing learning and/or behavioural styles among team members that may complement each other or cause difficulties within the team?
- What might be the tensions/difficulties within the team?
- Can the team members huddle and meet regularly (minimum of once a week)?

Core team

A highly functioning improvement team is critical to your organisation's success in achieving your aims.

In addition to the team leader, members include obstetric, midwifery and other professional leaders; quality improvement experts; other front-line professionals; and women and/or family members/carers.

Your core team should include members with day-to-day leadership, organisational leadership and technical expertise. There may be one or more members that represent each dimension, and one individual may serve in more than one role, but all three components should be represented. Staff from quality, redesign, strategy or innovation departments with experience in improvement methods should be included in the core team. This team will form the nucleus for improvement activities and will participate in BTS collaborative learning session and activities. There is no prescribed number of people although it must be more than one person. We recommend three to five members for the core team.

Organisational leadership

Improvement of this kind requires changes in an organisation's infrastructure and culture. Changes in communication and cooperation provide the foundation for interventions that cross traditional intra-department lines, which are necessary to develop an overall system of care and safety for women, families, and staff. The system leader is responsible for providing leadership for these changes and should have responsibility for all the primary areas that will be affected by or involved in the changes.

This person should:

- have enough authority in the organisation to implement new changes
- have authority to allocate time and resources necessary to achieve the frontline team's aim
- expect to participate in spreading the changes throughout the organisation and to other organisations
- be a member of the team and participate in meetings and activities.

Sometimes the organisational leader is the same person who serves as team leader or is also a technical expert.

Technical expertise

A technical expert is someone who knows the subject intimately and who understands the affected processes of care. For this team, a midwife and obstetrician are essential. Consider other key professionals such as clinical educators.

Additional technical support may be provided by an expert on improvement methods, such as an improvement and innovation advisor or member of your service's quality, redesign, innovation or strategy team. This expert can help a team determine what to measure; assist in design of simple, effective measurement tools; and provide guidance on collection, interpretation, and display of data. Health services with an improvement or innovation advisor should consider including this person in the work. If your health service has this resource, we strongly encourage you to connect with this person.

Consumers (women with lived experience of a third- or fourth-degree perineal tear)

Consumers bring another kind of technical expertise to the improvement team. Women have experience with the system and can identify the needs and wishes of women from their own perspective, especially if they have had severe perineal trauma. We recommend each team include at least one (ideally two) women - with one attending learning sessions - or find a way to partner with consumers in this work within your health service.

Wider team

The wider team of six to 12 members will be influencers in the organisation who can drive commitment and attention to the work and support the frontline clinicians to test and measure changes. This group may be a mix of clinicians and managers but must include clinical champions and a member responsible for data entry.

Clinical champions

It is critical to have at least one obstetrician and one midwife champion on the team.

These champions should have a good working relationship with colleagues and with the day-to-day leader and should be interested in driving change in the system. Look for an obstetrician and a midwife who are opinion leaders in the organisation, to whom others go for advice, and who are not afraid to implement change.

Key contact

The key contact may be the team leader, but not necessarily. This will be the person that the SCV-IHI team will primarily communicate with. Only **one** key contact should be nominated.

CONNECT TO COLLABORATIVE'S WEB PLATFORM

We will create a virtual home for the Better births for women collaborative. This is where you'll find everything you need: documents, logistics, meeting and call information, working parties and more.

You should make a habit of checking in regularly as this is the primary way the IHI and SCV will communicate with you.

PARTICIPATE IN YOUR ORIENTATION CALL

An orientation call is a one-hour call for new teams, the collaborative director, and the project director to review the BTS Collaborative mission and goals, measurement strategy, and monthly activities. The call is also an opportunity to review your team's aim statement and plan for the year ahead.

Connection information will be provided to participating services closer to 31 July.

LEARN ABOUT THE MODEL FOR IMPROVEMENT

Between the learning sessions, participants will actively try new ideas within their organisations. Within our collaboratives, we use a simple approach to improvement called the Model for Improvement (source: *The Improvement Guide*). All teams are expected to have a basic understanding of improvement methods at Learning Session 1.

If your team or individual members of the team have not had experience with the Model for Improvement or a similar improvement methodology, we encourage you to complete one of the following self-study options:

- View the first three Quality Improvement courses on the IHI Open School website. These are available for free.
    1. QI 101: Introduction to Health Care Improvement
    2. QI 102: How to Improve with the Model for Improvement
    3. QI 103: Testing and Measuring Changes with PDSA Cycles
- Read the introduction and chapters 1-8 of book *The Improvement Guide*
    - Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance, 2nd edition*. San Francisco, California: Jossey-Bass Publishers; 2009.
- Go to the IHI website: Improvement Capability and review the Getting Started content.

PREPARE FOR LEARNING SESSION 1

This BTS Collaborative will have three learning sessions. These are an excellent opportunity to experience the "all teach, all learn" dynamic and to energise your team's improvement process.

Learning sessions create time for sharing successes among teams, interaction with faculty, learning about new changes for testing, solidifying skills in the Model for Improvement, and planning changes in your home organisation. Sessions will be two days long at a location in Melbourne.

To prepare for a learning session:

- **Complete your team storyboard**: including description of your health service, team members and pilot ward or service. The storyboard will also include your aim and some initial data. Your storyboard will need to be printed and brought to the learning session. Prework templates and instructions will be shared with you once you've been confirmed as a collaborative participant.
- **Arrange travel and accommodation (if needed):** information about the meeting location and hotel room block will be distributed by SCV.
- **Organise your travel team:** each service team is entitled to send up to five team members to each learning session. Enrolment information will be distributed by SCV. All attendees from each team will need to be enrolled before arriving at the learning session. Please confirm numbers with us as soon as possible, as cancellations are costly.

Our learning sessions are "paperless". Participants will not receive paper copies of the slides from the content sessions. This is done to reduce paper waste. However, slides are made available on the web platform before the meeting, whenever possible. If you have team members who prefer paper copies of materials are available to them at the meeting, please print these in advance and bring them along with you. Key BTS Collaborative documents and any forms that you need to fill out during the meeting will be made available to you.

LEARNING SESSION DATES AND OBJECTVES

LEARNING SESSION 1: 8TH AND 9TH AUGUST 2019

Key themes	• Building will • Understanding the problem • Learning improvement methodology
Objectives	• Create a vibrant learning community where sharing is the norm • Understand that changing processes are necessary to improve • Learn how to use the Model for Improvement and PDSA cycles to make sustainable change • Understand driver diagrams and how they will be used to accomplish the aims • Understand the measurement plan and how to collect and display data to know if change has resulted in improvement • Set specific local aims to achieve and make progress on the system level aim • Develop a local plan for Action Period 1.

LEARNING SESSION 2: THURSDAY 23, THURSDAY 24 AND FRIDAY 25 OCTOBER 2019

Key themes	• Sharing progress in testing • Networking • Getting ideas to test in next action period • Reinforce change methodology
Objectives	• Review the Model for Improvement as it relates to project execution • Revisit Action Period 1 PDSAs to identify areas of success and areas of improvement • Further develop participant capability in planning and implementing PDSA cycles, using run charts, and data tracking • Sharing preliminary Bright Spot successes • Understand how to develop reliable processes and reduce variation • Revisit best practices for setting aims • Learning about moving from testing to implementation • Develop a local plan for Action Period 2.

LEARNING SESSION 3: WEDNESDAY 4, THURSDAY 5 AND FRIDAY 6 MARCH 2020

Key themes	• Moving from testing to implementing • To spread, sharing successes, networking
Objectives	• Nurturing an all-teach, all-learn culture among hospitals and building a continuous learning network • Making sense of data and analysing for improvement • Sharing data, changes, challenges and improvements: engaging in storyboard presentations • Emphasise the importance of patient and family centred care • Dissemination and spread: diving deeper into the theory and practice of spread and dissemination within organisations • Local bright spots: engaging bright spots and leveraging their successes.

What changes are proposed?

CLINICAL BUNDLE OF CARE

1. **Application of warm perineal compress during labour**
   - Apply during second stage of labour/when perineal stretching begins
   - Ensure correct temperature is used (between 38C and 44C)
   - Provide communication and gain consent from patient to use warm compress.
2. **Hands-on to support the perineum**
   - Support with dominant hand and application for counter pressure with non-dominant hand for the perineum
   - Gentle verbal guidance and encourage slowed/shallow maternal breathing.
3. **Episiotomy performed when indicated (during instrumental delivery and at 60 degrees)**
   - When forceps or vacuum assisted delivery
   - At a 60-degree angle
   - Use of Episcissors are recommended
   - Provide communication and gain consent from patient to perform episiotomy.
4. **Genito-anal examination on all women post birth**
   - Performed by experienced clinician
   - Inclusion of PR examination on all women, including those with intact perineum
   - Provide communication and gain consent from patient to perform examination.
5. **Grading of perineal trauma**
   - All tears graded as per the RCOG guidelines
   - All tears reviewed by a second experienced clinician (midwife or doctor)
   - Discuss findings and proposed treatment with woman.

WHAT ARE WE TRYING TO ACCOMPLISH?

By July 2020 the Better births for women collaborative will reduce harm to Victorian women by preventing 50 per cent of third- and fourth-degree perineal tears across participating maternity services.

We will partner with clinicians to better detect and manage risk factors to prevent perineal trauma. We will improve the care experience of women through shared decision making in risk factor management.

This will be accomplished by achieving the following goals:

- 95%, or higher, compliance with the five key aspects of clinical care bundle
- 95% or higher, compliance with each of the individual clinical care bundle interventions
- 95%, or more, women are engaged in shared decision making in risk factor management

HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?

Family of measures

Measurement is a critical part of the Better births for woman collaborative. Measures help teams evaluate the impact of strategies and interventions tested and adapted throughout the initiative. Additionally, measures are used to assess progress toward the collaborative goals. They represent what we think are useful for establishing baseline performance and are sensitive to improvements made during the life of the collaborative, while paying attention to the feasibility for sites to collect and report.

(Please note: these are drafts to be refined with participating health services)

Outcome measures

- Number of third- and fourth-degree tears in total
- Number of third- and fourth-degree tears in spontaneous vaginal deliveries (SVD)
- Number of third- and fourth-degree tears instrumental assisted deliveries (IAD)

Process measures

- Percentage of women who have a warm perineal compress applied during the second stage of labour at the start of perineal stretching
- Percentage of women who receive (with a spontaneous vaginal delivery), gentle verbal guidance and hands-on technique, to encourage a slow, controlled birth of the fetal head and shoulders
- Percentage of women who have the episiotomy technique applied when episiotomy indicated
- Percentage of women who receive a genito-anal examination as part of their post-birth care
- Percentage of women with documented perineal trauma who have their injury graded as per bundle expectations
- Percentage of women with perineal trauma who have documented discharge/follow up plans for ongoing support.

Balance measures

- Percentage of episiotomies
- Percentage of women who have caesarean sections.

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[1] The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2017, Victoria's Mothers, Babies and Children, Safer Care Victoria, Victorian Government, Melbourne.

[2,3] Hunt RW, Davey M-A, Ryan-Atwood TE, Hudson R, Wallace E, Anil S on behalf of the Maternal and Newborn Clinical Network INSIGHT Committee 2018, Victorian perinatal services performance indicators 2017-18, Safer Care Victoria, Victorian Government, Melbourne.