AWHONN
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

COLORADO AWHONN

SECTION NEWSLETTER

Volume 9, Issue 3 September 2021

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AWHONN Mission:
Promote the health of women and newborns

AWHONN National Goals:
Public visibility
Knowledge transfer
Build membership

CO AWHONN Goals:
Promote member engagement through partnerships

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Section Chair Report

Hello Colorado AWHONN members!

It was wonderful to see so many of you at our State Conference on September 10th. We thought it was a great event and I have many kudos to share with the planning committee. I've heard from members across the state how meaningful it was to be together and celebrate the work we do and what has been accomplished in the time we have been apart. It truly filled my cup.

There are many new changes at both Colorado AWHONN and National AWHONN. I'd like to congratulate your newly elected leaders for 2022-2024.

Samantha Smeak BSN, RN will be your new CO AWHONN Section Chair. Sam is a bedside RN at the UCHealth Poudre Valley Hospital in the Women's Care Unit. She has been a leader at CO AWHONN since 2018 as the Northern Chapter Coordinator. She has also coordinated the state conference, most recently in her hometown of Fort Collins. Sam is an adjunct faculty OB clinical instructor with the University of Northern Colorado. She received her BS from Ohio State University and her BSN from Mount Carmel College of Nursing. Her true passion for her community and animals is reflected in her volunteer work.

Rainy Tieman DNP, MSN-Ed, RNC-OB, RNC-MNN, C-EFM, C-ONQS will be your new Secretary/Treasurer. Rainy is the Clinical Nurse Manager of Labor and Delivery at St Mary's hospital in Grand Junction. She received her doctorate from Chamberlain College of Nursing and is an adjunct nursing instructor for Colorado Mesa University. She has been a leader at CO AWHONN for the past 5 years as the Western Slope Coordinator and as the Communications Coordinator. She has worked on the conference planning committee since 2017, coordinating the poster presentations. Rainy has presented at both state and national conferences and has published several articles in the Journal of Obstetric, Gynecological, and Neonatal Nursing.

Sam and Rainy will begin their new roles January 1st. Please congratulate them when you next see them.

We give a big thanks to outgoing National President Cyndy Krening. It has been great to have a Colorado leader leading National AWHONN. Cyndy. I know it's been a challenging year to lead, and we thank you for all you have done moving AWHONN National forward.

We have a new CEO at the lead of AWHONN National Jonathan Webb. “Jonathan has the experience, background, and leadership competencies to advance AWHONN’s membership and mission,” said AWHONN Board President Cyndy Krening, MS, CNS, RNC-OB, C-EFM. “The Board of Directors was unanimous in selecting Jonathan as the leader we need to guide AWHONN into the future.”
“I am excited about the opportunity to work alongside the AWHONN staff and membership to boldly enter into new spaces to address the maternal mortality crisis in America, support the vision of making a difference in the lives of women and newborns, and to strengthen the organizational efforts towards leadership in equity,” said Webb.

There are several events of interest coming up you might be interested in. October 29th is the Colorado Center for Nursing Excellence's Diversity and Inclusion Summit. If you came to the conference and saw Mauritha Hughes' fantastic presentation this is the event she was speaking of. This is an all-day virtual conference, and you can see the details here- https://ccne.swoogo.com/Diversity_Inclusion_Summit

Friday November 5th is the Harvey Cohen Maternal Mortality Conference. I love this conference because it brings nurses, midwives, and docs together. The format is all case studies and I always get a lot of new information for clinical practice when I attend. This conference will be in person at the Hyatt- DTC. I hope to see you there! https://www.eventbrite.com/e/annual-harvey-cohen-md-maternal-morbidity-mortality-summit-2021-registration-114343713124

I wish you all a happy fall and as always thank you for all you do for Colorado Moms and Babies.

Isabelle Campanella MSN, RNC

CO AWHONN Section Chair

Legislative Happenings

HELP US ESTABLISH

Colorado's Maternal Health Awareness Day!

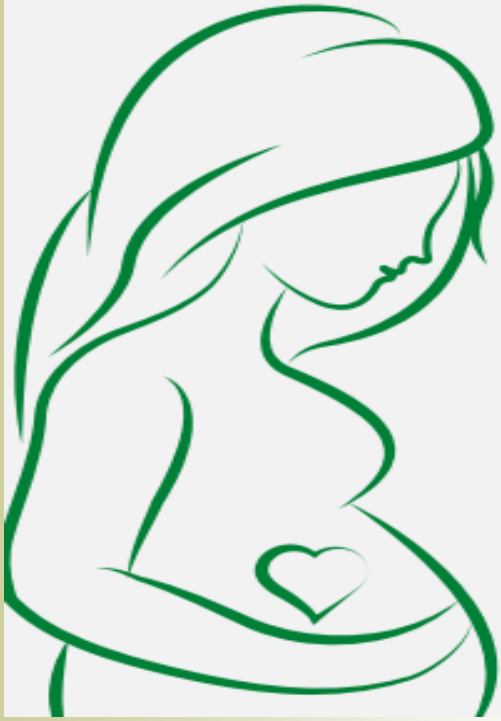
We are hopeful to have a day of recognition to improve the care of birthing people and to honor the memory of lives lost.

Levels of Engagement

Level 1: Stay informed
Join our email list to remain informed of progress, meetings, and events.

Level 2: Be involved
Attend meetings at your convenience to show support and share your ideas.

Level 3: Collaborate
Be fully engaged and essential to the success of this project, galvanize additional support and help expand our coalition around this work.



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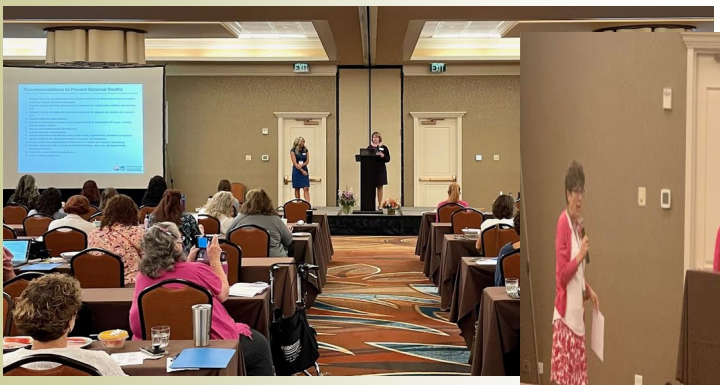
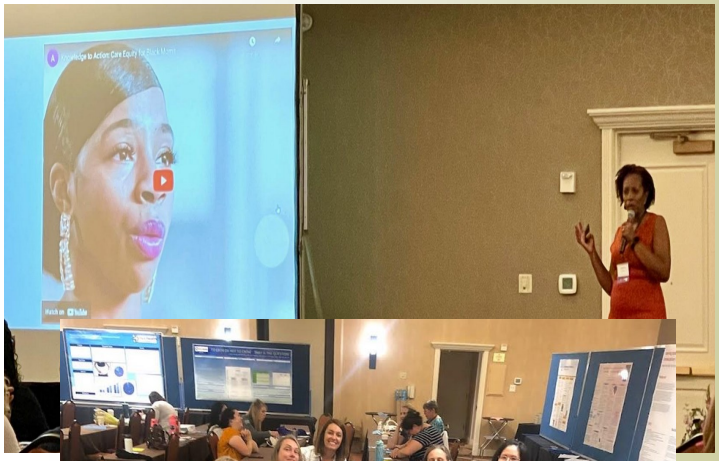
#123forMoms

2021 Colorado AWHONN Conference!

Thank you everyone for making Colorado's 2021 Conference one to remember!



2021 Colorado AWHONN Conference!



Poster Presentations

Abdominal Binder Research Study

A Comparison of Abdominal Binders for the Management of Post-Operative Pain after Cesarean Delivery: A Randomized Controlled Trial

Corie Hoskins, RNC BSN & Amy Dempsey, RNC MSN

Nursing Research Fellowship Program
Mom/Baby Department, Lutheran Hospital

SCL Health LUTHERAN

Purpose

The purpose of this study was to determine if the use of abdominal binders in the immediate postpartum period after Cesarean section, decreased opioid use for pain management. Previous research suggests that this intervention may be helpful but few studies have reached statistical significance with our specific population.

Hypothesis

Postpartum women will use fewer opioids to treat pain in the first 48 hours after Cesarean delivery with the use of an abdominal binder than women who do not use an abdominal binder.

Method

Patients that were eligible to participate in this study were consented by a designated investigator. They were randomly assigned to one of two groups; an intervention group that receives an abdominal binder (group A) or a control group that does not receive a binder (group B).

Both groups rated their pain using a visual analog scale (VAS) at 24 and 48 hours post delivery. The participants assigned to group A were also given a survey at 48 hours to describe their experience with the binder.

Exclusion Criteria

- Admitted to the Mom Baby Unit greater than 4 hours after delivery
- Less than 18 years old
- Had IV narcotic within the past hour prior to consent
- General anesthesia for cesarean delivery
- Patients who received a vertical incision for delivery of baby
- Patients with a BMI of > 45
- Patients who required opioid other than Oxycodone. This included patients with an allergy to oxycodone or who were taking methadone or suboxone.
- Patients who preferred to use their own binder (non-hospital issued)

Discussion

This study supports findings from other similar studies with regards to the use of an abdominal binder for postoperative Cesarean Section pain. The greatest strength of this study is its format as a randomized controlled trial, which is considered the hallmark of evidence-based practice. One limitation identified was the slow enrollment process which spanned 25 months as well as some inconsistent data collection. Based on the results of this study, the use of an abdominal binder is a low-cost, appropriate intervention that may decrease the woman's need for oxycodone and is definitively shown to help reduce post-operative pain.

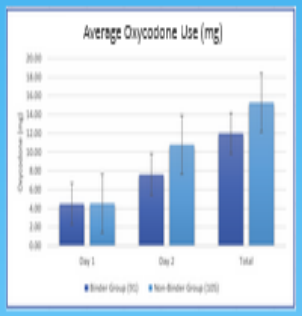
Results

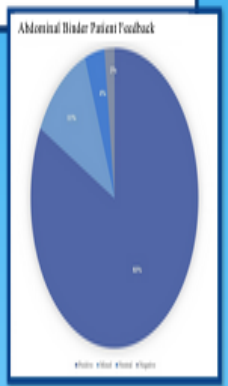
The primary variable measured was opioid use over the first 48 hours post-delivery. In order to achieve statistical significance the researchers aimed for a 50% reduction in opioid use. Data was collected from 8/1/2018 – 9/10/2020.

Of the original sample size of 220 participants, 196 completed the study and of those, 159 completed the VAS scores for both Day 1 & 2. The demographic differences between the two randomized groups proved to be statistically similar.

The average oxycodone use was less in the binder group than the control group however did not reach statistical significance (p=0.10). The average VAS scores between the two groups were similar at baseline and Day 1 post-op, however, they reached statistical significance on Day 2 (p=0.002) with the control group reporting an increase in pain and the binder group reporting a decrease in pain as compared to Day 1.

Qualitative feedback from the binder group was 83 % positive with 2% negative, 4% neutral and 11% mixed however, 96% would recommend this intervention to other C-section moms.





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Poster Presentations

Saint Joseph HOSPITAL | SCL Health CENTER FOR WOMEN & INFANTS

OBSTETRIC ESCAPE ROOM

Cyndy Krening, MS, RNC-OB, C-EFM; Karen Kaley, BSN, RNC-MNN; Annette Venhuda, BSN, RNC-MNN

MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER

Introduction/Background

Traditional annual competency validation has included posters, didactic, e-learning, and skills check-offs. Studies have shown that adult learners benefit from kinesthetic learning. Additionally, there has been evolving literature about the use of escape rooms to facilitate active learning.

Escape rooms create an environment where teams work together to solve problems that lead to additional clues. The goal is to ultimately escape from the room. This concept is easy to apply to one or more healthcare skills.

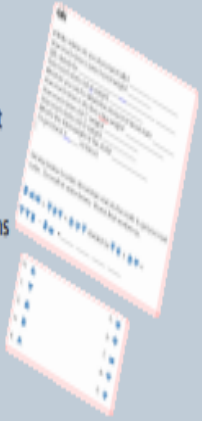
Objectives

- Recall adult learning styles and their application to annual skills validation
- Identify 5-10 relevant, unit-specific skills for inclusion
- Create varied templates for skill demonstration to include props
- Discuss organization and flow of stations, locks, containers, props and worksheets to facilitate learning and ESCAPE!
- Create an innovative and fun environment for competency validation
- Enhance staff teamwork

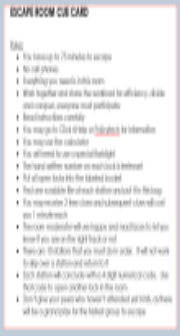
Methods

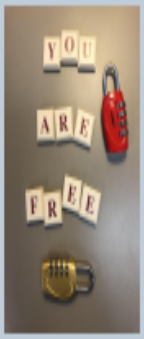
The unit Education Committee identified ten competencies that were priorities for annual staff validation. These included new, problem prone, and high risk/low volume skills:

Midline catheter dressing change
- Blood administration
- Postpartum bladder management
- Quantitative blood loss
- Code Cart
- Obstetric hemorrhage medications
- Maternal hypoglycemia
- Newborn hypoglycemia
- Newborn screening
- Newborn supplementation



A worksheet was created for each skill to include demonstration of knowledge, concluding in calculations to reach a 4 digit number. Each number opened a distinct lock in the room revealing another skill based worksheet. Some of the props in the room included maternal and newborn mannequins, blood clots, skills station supplies, decoys, black light marker and flashlight, calculator, policies, tip sheets, and algorithms available electronically, and colorful locks on varied containers and carts. During their timed session in the Obstetric Escape Room, 16 teams of 5-7 RNs and a CNA worked together to successfully complete each skills station and reveal a numeric code to another lock. A scrabble tile with a letter on it was collected by the team at each station. The ten tiles had to be unscrambled to reveal a phrase that allowed them to escape. The winning team received vacation priority for the next year.


ESCAPE ROOM CUE CARD



SCAN ME

Feedback

All teams escaped! Written evaluations from the staff about their experience were overwhelmingly positive. They loved working as a team to solve relevant problems under some pressure, utilizing unit resources. They also loved the chance to complete their annual skills fair in a new and creative way. Staff not only had fun but learned along the way which is an important goal for competency validation.

The Education Committee members felt that this concept was an overwhelming success, although might be more effective with 5-7 skills. Although the CNAs had a smaller role in escaping, they functioned as members of the team and added their expertise. Staff were observed taking on roles of team leader, problem solver, encourager, mathematician, resource locator, and supply gatherer.

Implications for Practice

The planning and implementation of an escape room can be applied to any environment where skills need to be demonstrated and teamwork improved.

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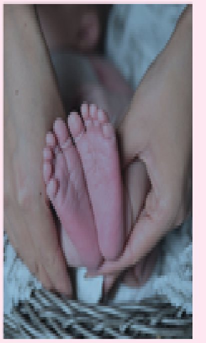
Poster Presentations

Colorado Christian University
School of Nursing and Health Professions

Jefferson County Colorado Public Health

Community Support for Women with Opioid Use Disorder & Their Newborns – A Toolkit to Support Breastfeeding

Cheryl King, MSN, RN, CNS
Colorado Christian University



Significance of Problem

- Pregnancy is an exciting time for most women and it becomes complicated when the woman uses or misuses opioids.
- Opioid use disorder (OUD) is a problematic pattern of opioid use that causes significant impairment or distress (American Society Of Addiction Medicine [ASAM], 2019).
- Women with OUD and their fetus/newborn are at higher risk for negative outcomes.
- Maternal OUD is a vulnerable population in the community.

➢ <u>Opioid Use Disorder – Statistics</u>
  - ➢ Women with OUD → 15-44 years ↑ over the past several years (CDC, 2019).
  - ➢ At delivery women with OUD has quadrupled (1999 to 2014) (Haight et al, 2018).
  - ➢ Hospital birth data for newborns with Neonatal Abstinence Syndrome (NAS) has increased fivefold (2004-2014).
  - ➢ By 2014, NAS Dx = ~14.4 infants per 1000 births.
  - ➢ Total Cost = $462 million in hospital Medicaid costs (Winkelman et al, 2018).

Newborns with NAS/NOWS*	2011 (per 1000 hospital births)	2016 (per 1000 hospital births)
Colorado Data: 69%	2.6/1000	4.4/1000
Pregnant Women at Risk for OUD*	2018-2019	NAS/NOWS Cases (Spring 2020)
Colorado	108	74
Local County	16	11

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In Colorado, 324 opioid-involved overdose deaths (a rate of 6.3) were reported in 2018.

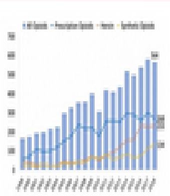


Figure 1. Number of overdose deaths involving opioids in Colorado, by opioid category. Drug categories presented are not mutually exclusive, and deaths may have involved more than one substance. Source: CDC WONDER, 2020.

Purpose/PICOT Question

The purpose of this DNP scholarly project was to develop a comprehensive interprofessional *educational program and toolkit* based on an extensive literature search in collaboration with a local county public health department to facilitate understanding among community health professionals regarding the unique benefits of *breastfeeding* for the mother with OUD and her newborn.

In community professionals (P), what is the effect of education using the breastfeeding toolkit intervention (I) compared with current practice standards (C) on the support to continue breastfeeding for women with opioid use disorder and their newborns (O) within 3 months of the intervention (T)?

Review of Literature

Sources examined for relevant evidence came from:
- Colorado Christian University (CCU) Clifton Fowler Library
- Professional organizations for policy statements and practice guidelines

Search Engines Used:
- The databases selected were CINAHL, Cochrane Library, OVID, PubMed Databases, and Academic Search Premier.
- 5000 articles (1992 through 2020)

Key Words:
✓ Perinatal substance abuse, opioid use in pregnancy, neonatal abstinence syndrome, neonatal opioid withdrawal syndrome, opioid use disorder, neonates/newborns/infants, breastfeeding/lactation and opioid use, and community care

Inclusion/Exclusion Criteria:
✓ To be included to support the project plan the following inclusive criteria were used: experimental studies, randomized controlled trials (RCT), a systematic review of RCTs, quasi-experimental studies, qualitative studies, expert opinions, clinical practice guidelines, and case reports.
✓ The exclusion criteria included articles published in a language other than English, meta-synthesis studies, non-experimental studies, articles older than 2012.

To summarize, 430 peer-reviewed articles were examined, of which 38 articles were found to be significant. These 38 were selected for an in-depth review and analysis for the level of evidence and quality of work.

Synthesis of Evidence

Appraisal Relevant Evidence	
Level of Evidence	
Level	**Number**
I	16
II	4
III	1
IV	5
V	0
VI	11
VII	1
Total Articles Reviewed = 38	
Quality/Grading	
A	22
B	14
C	2

In synthesizing the literature in the evidence table →
✓ Women with OUD face ***numerous barriers*** to breastfeeding.
✓ ***Breastfeeding rates*** among women with OUD remain ***low.***
✓ ***Practice change lags*** behind policy in breastfeeding in women with OUD.

Evidence indicates complex health and social needs of women with OUD can be obtained through an ***interprofessional*** approach. ***Education*** to community professionals emphasizing breastfeeding is encouraged and recommended for women with OUD and their newborns.

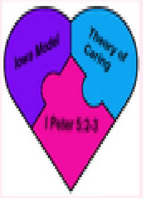
Recommended Practice Change

"Any response to the many barriers facing the families of pregnant women with opioid use disorders must be grounded in solutions within the community that reflect best practices (e.g., evidence-based practices) as well as perspectives, resources, and policies that address the needs of the community" (SAMHSA, 2016, p. 9).

- Give women with OUD **consistent messaging** regarding breastfeeding.
- Educate professionals in the community to understand the **unique benefits** of breastfeeding for the newborn of the woman with OUD.
- ***Breastfeeding Toolkit*** – foundational and interprofessional.
- Include community professionals beyond the Health Department.
- Explore the efficacy and support provided by the toolkit.

Implementation

Theoretical Frameworks

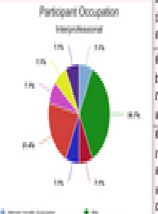


Methodology & Design
- ❑ Sample and Setting
  - Where – **Local County Health Department**
  - Who – **Community Professionals within the Community Health Services and Health Promotion/Lifestyle Management Divisions**
  - Participants - **11 interprofessional staff members**
- ❑ Type of Project
  - ***Evidence-Based Quality Improvement Project***
- ❑ Data Collection/Tools
  - ***Both quantitative and qualitative measures***
  - Likert scale (quantitative) and open ended (qualitative) questions on surveys to assess overall knowledge of breastfeeding, breastfeeding with OUD, attitudes of breastfeeding with OUD
  - National Centre for Education and Training on Addiction: ***Health professionals' attitudes towards licit and illicit drug users: A training resource*** (2006)
- ❑ Interventions – Conducted in 3 phases over 3 months
  - Main intervention was the provision of webinar educational offering:
    - Benefits of breastfeeding
    - Evidence-based practice (EBP) support for breastfeeding for women with OUD and prevention of neonatal opioid withdrawal syndrome (NOWS)
    - Addressing stigma and biases
  - Breastfeeding Toolkit that included EBP resources was provided as the second intervention
  - Protection of human subjects – This DNP scholarly project was approved by the Institutional Review Board of the College of Adult and Graduate Studies at Colorado Christian University, IORG# 0010176, IRB# IRB00012085, on 8/31/2020.
    - Participation was voluntary with the participant's name and other data codified to protect their identity.
    - The participants signed a consent to participate in the project and had an opportunity to ask questions.
  - Due to the COVID-19 Pandemic restrictions and social distancing in place at the time of the project the project was conducted remotely using a webinar platform, email communications and Qualtrics XM ® for survey deployment.

Results/Evaluation

Quantitative Data – revealed 5 questions with significance from pre- to final-surveys

Survey Questions	Results			
	alpha	t(10)	p	Sig
#7: To what extent do you agree that women with opioid use disorder should breastfeed their newborns?	0.05	-3.32	0.008	yes
#8: To what extent do you agree with the following statement: "Opioids cross through the placenta and exert an effect on the fetus"?	0.05	-2.61	0.026	yes
#12: To what extent does breastfeeding prevent neonatal opioid withdrawal syndrome?	0.05	-3.07	0.012	yes
#13: How aware are you of research evidence to support breastfeeding for women with opioid use disorder?	0.05	-4.18	0.002	yes
#14: To what extent do you support breastfeeding for newborns whose mother has opioid use disorder?	0.05	-3.71	0.004	yes



Conclusion

Pregnancy is a very exciting and vulnerable time for women, especially those with OUD. The fetus is exposed to opioids through the placenta. Negative outcomes can occur without interventions. Breastfeeding is a healthy option for the newborn when the umbilical cord is clamped and the opioid supply is eliminated. Opioids do cross into breastmilk, so to diminish the risk of NOWS for the newborn the woman should breastfeed while receiving an interprofessional treatment toward sobriety. This is where community health professionals can impact women with OUD to breastfeed their newborns as the practice standard.

This evidence-based quality improvement project demonstrated the following implications for clinical practice change:
- ➢ A comprehensive educational offering based on evidence-based research and professional practice standards improved understanding in community health professionals on the unique benefits of breastfeeding for women with OUD and their newborns.
- ➢ The "Breastfeeding Toolkit" created an increased awareness in community health professionals to support women with OUD to breastfeed their newborns.
- ➢ Interprofessional collaboration is needed to provide for the unique care needs of women with OUD and their newborns.
- ➢ Participants acknowledged that the newborn was exposed to opioids during pregnancy and would benefit from continuing breastfeeding to diminish the potential development of NOWS in the community setting.
- ➢ The qualitative data analysis responses indicated 5 themes each with subthemes identified as:

Theme	Subthemes
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

- ➢ It is acknowledged that there was no significant difference in responses to the "Health Professionals' Attitudes Toward Licit and Illicit Drug Users" adapted with permission from the National Centre for Education and Training on Addiction (NCETA) after bias training during the educational offering. The participants demonstrated a high regard for stigma and biases in this vulnerable population as found in the results from the pre-survey and that carried through to the final survey.

Recommendations:
- ➢ Due to the limited number of participants, replicate the project with another cohort from the health department.
- ➢ Due to the COVID pandemic, repeat the project using face-to-face educational offerings to increase engagement and participation.
- ➢ County health department to use the "Breastfeeding Toolkit" as a platform to further educate and support community professionals regarding the benefits of breastfeeding for women with OUD and their newborns.
- ➢ Continue to add new evidence-based research, practice standards, and policy statements to the "Breastfeeding Toolkit".
- ➢ Create teaching tools and handouts from the resources in the "Breastfeeding Toolkit" for client education.

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Thank you to:
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- JCPH, Dr. Margaret Huffman, and Dr. April Hills, as the guiding light through this project and believing in its potential.
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-My DNP cohort, who will always be in my heart and my prayers.

Poster Presentations

Venous Thrombosis Prevention in Pregnancy

Lakeisha Mcnulty BSN, C-EFM, Level IV RN

Children's Hospital Colorado

Colorado Fetal Care Center Labor and Delivery Unit

BACKGROUND

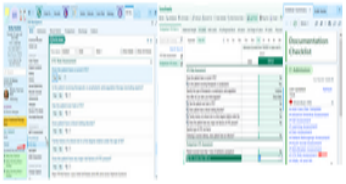
- CDC Surveillance studies of pregnancy related deaths have shown an increase in cardiovascular and cerebrovascular events in pregnant women with chronic health conditions (diabetes, hypertension, etc.)

- Venous Thromboembolism (VTE) is a leading cause of maternal morbidity/ mortality.
- Two categories: Deep Vein Thrombosis (DVT) 80% risk, Pulmonary Embolism (PE) 20% risk.
- 10% maternal mortality rate in the United States.

- California Maternal Quality Care Collaborative Research (CMQCC,2018) created a Maternal VTE Toolkit to assist with the identification & treatment for pregnant women with risk factors present.
- The Colorado Fetal Care Center / Labor & Delivery Unit at Children's Hospital VTE Safety Bundle Committee created a novel Perinatal VTE Epic tool based on CMQCC guidelines.
- The Perinatal VTE Epic tool was implemented on 6/1/2020

METHODS

- All peripartum pregnant women cared for at the Colorado Fetal Care Center (CFCC) were screened for VTE risk factors by using the VTE Epic tool at their first prenatal visit, with in 24 hours of admission , immediately post-delivery ,and at discharge.
- VTE risk score was generated from the Epic tool:



- The attending provider receives a Best Practice notification with suggested treatments based on Perinatal Guidelines.

- Patients were educated on risk factors and prevention via patient created handout.

- While inpatient, the RN encourages activity, hydration, and use of SCD's while in bed.

RESULTS

- From June 1, 2020 to July 1,2021 ,CHC VTE risk assessment was completed on all obstetrical patients admitted to Labor and Delivery, n=100.
- VTE risk factors were identified, and appropriate treatments were administered on 100% of pregnant women inpatient.
- No VTE events occurred inpatient.

IMPLICATIONS

The CMQCC VTE Toolkit suggests:

- Early detection of pregnant women at risk for a VTE by use Perinatal Guidelines at first Prenatal visit, on admission, immediately post- delivery ,and discharge.
- RN completion of VTE Risk Assessment flowsheet
- Patient education on risk factors and prevention via patient handout.
- Promotion of hydration, increased activity, SCD use and/or thromboprophylaxis

CONCLUSIONS

Early and frequent assessment led to identification of VTE risk factors which allows for prophylactic intervention, decreasing the occurrence of a peripartum VTE to 0%.

DISCLOSURES

None

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Poster Presentations

The Magical Milk Tour – A Journey to Improved Exclusive Breastfeeding Rates

Buchanan, Bobbi, MSN, RN, NEA-BC, C-ONQS, Samblanet, Karen, MSN, RNC-NIC, C-EFM, CHSE,
Williams, Ana T., MSN, CNM, IBCLC, Clifton, Nicole, M.D., MSPH , Kahn, Isra, MD, FPH, FAAP

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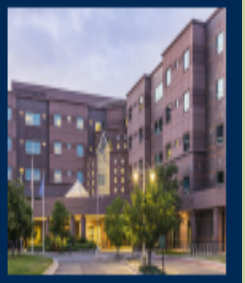


Introduction/Background

Longmont United Hospital is a community hospital with 500 deliveries per year.

- At the start of this project our exclusive breastfeeding rate was 43.3% but had been as low as 30% during the previous year.
- No evidence based infant feeding education had been provided to the BirthPlace staff for several years.

Purpose

To improve our community hospital's breastfeeding rate through policy clarification, education and culture shift.

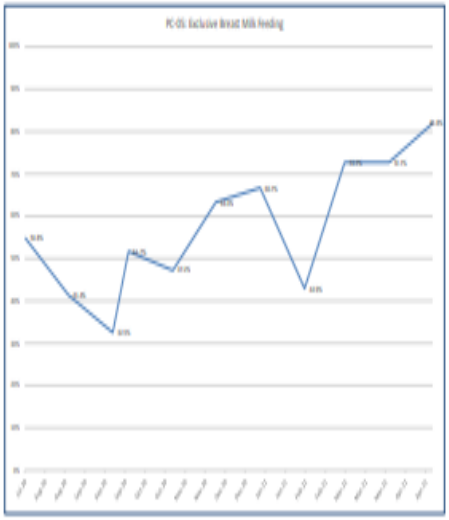
Methods

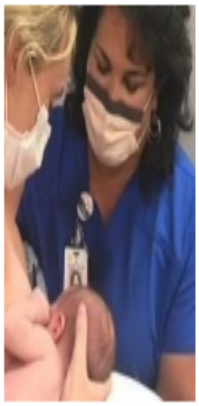
Interdisciplinary Breastfeeding Committee
Breastfeeding Policy Review
Developed Formula Supplementation Guideline
Four Education Modules with Presentation & Quiz –
Developed utilizing Carolina Global Breastfeeding Institute EMPower Trainer Manual: Comprehensive training materials to implement skills-based competency in maternity care and breastfeeding.

1. All You Need is Love - Communicating with pregnant & postpartum patients about infant feeding
2. Help - Observing, assessing and assisting with breastfeeding
3. We Can Work It Out - Teaching hand expression & safe storage of breast milk
4. With A Little Help From My Friends - Teaching safe formula preparation

Resource Sheets

Results





Discussion

- This project was started in November 2020 with the formation of a breastfeeding committee, consisting of nursing leadership, unit educator, lactation consultants, bedside nurses, CNM's & pediatricians.
- All bedside nurses were required to review the breastfeeding policy and sign that they understood the policy and would adhere to it.
- Education was done with 4 recorded modules followed by testing for understanding.
- Hands on skills lab education was also provided to all bedside nurses.

Conclusion/Implication for Practice

Providing breastfeeding education, hands on skills practice, resource sheets and clarity on the breastfeeding policy and expectation that it is to be followed, greatly improved the skills and confidence of the nurses to help patients with breastfeeding.

This education also greatly benefits BirthPlace patients with the increase of the exclusive breastfeeding rate from a low 30% to a rate of 81.8% providing better nutrition for our littlest patients.

Ongoing annual breastfeeding education will take place for all BirthPlace nurses. All new nurses will have this breastfeeding education provided as part of their on-boarding orientation.

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Poster Presentations

Rose Medical Center

Postpartum Depression Screening

Leah May MSN, RN, RNC-MNN, CLC

Mom/Baby

Introduction/Background

- Screening for postpartum depression within the hospital setting is best practice.
- Employees were unaware of resources for mother's who are at risk for postpartum depression.
- Postpartum depression ranges from 6.5%-12.9%, with higher rates in particular populations (Stewart & Vigod, 2016).
- In 2015, the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) recommended the screening of all mothers for postpartum depression during the perinatal and postpartum period (Clevesy et al., 2019).

Review of the Literature

- Literature review was conducted and there are several validated screening tools to identify a risk of postpartum depression.
- Delayed diagnosis of postpartum depression can negatively impact the wellbeing of the mother and disrupt the infant developmentally (Di Florio et al., 2017).
- Risk factors include: history of depression, age, demographic data, diabetes, neonatal intensive care unit (NICU) admission, infertility, complications during pregnancy, birth or with breastfeeding (Postpartum Support International, 2020).

PICO

P: Population: postpartum patients

I: Intervention: implementing screening for postpartum depression within the hospital setting

C: Comparison: no screening of postpartum depression

O: Outcome: increase detection of postpartum depression and offer patients in need resources

Methods and Materials

- There are several validated and reliable tools to screen for postpartum depression. Rose Medical Center decided to use the Patient Health Questionnaire-9 (PHQ-9) to screen all postpartum patients within the hospital. The PHQ-9 is the screening tool used by perinatal mental health counselors who work with high risk mothers delivering at Rose Medical Center.
- A group of experts within the perinatal mental health field were consulted to compile a list of resources to hand out to patients who are at risk for postpartum depression.
- This group determined what needed to be completed after a patient scores within a specific range:
  - 0-9 requires usual discharge teaching
  - 10-14 requires the resource sheet
  - 15 and above requires the resource sheet, MD/Midwife notification along with a case management/social worker consult.
- The resource sheet included a list of books, support groups, information hotlines, and a crisis hotline number for patients to use who are at a higher risk of developing postpartum depression.
- Education was provided to nurses on the postpartum and labor and delivery units about postpartum depression and the screening process for patients.
- March of 2020, all postpartum patients were screened for postpartum depression with the PHQ-9 on the day of discharge.
- Currently, all mothers complete the PHQ-9 at 24 hours while their infant is completing infant screenings to prevent a delay in discharge.

Results

- This is a new practice; prior to implementation, patients were not regularly screened for post partum depression.
- Since implementation, 1-6 patients per month have been identified as at risk for post partum depression and referred to Case Management/Social Worker for treatment and resources appropriately.

Patients Identified At High Risk for Post-Partum Depression

Discussion and Conclusions

- Screening every mother for postpartum depression decreases the stigma around mental health.
- Educating nurses on risk factors and available resources for postpartum depression helps nurses fully care for their patients.
- Undiagnosed postpartum depression can be detrimental to mothers and their infants.
- Rose Medical Center is in alignment with current AWHONN recommendations.
- Postpartum depression screening is now a standard of care at Rose Medical Center.
- Every postpartum mom will continue to complete the PHQ-9 before discharge.
- Nurses now have printed resources for women who are at risk for postpartum depression.

Contact

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303-320-2375

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Poster Presentations

Utilizing Non-Opioid Multimodal Therapies for Postoperative Pain Management in Cesarean Delivery Patients Leads to Decreased Opioid Use

Dana Cherie Steffens BSN, RNC-OB, C-EFM, Level IV RN, Labor & Delivery

Children's Hospital Colorado
Labor & Delivery

BACKGROUND

The Labor & Delivery Unit at Children's Hospital Colorado is a specialty unit caring for pregnant women whose unborn babies require interventions and/or treatment immediately after delivery.

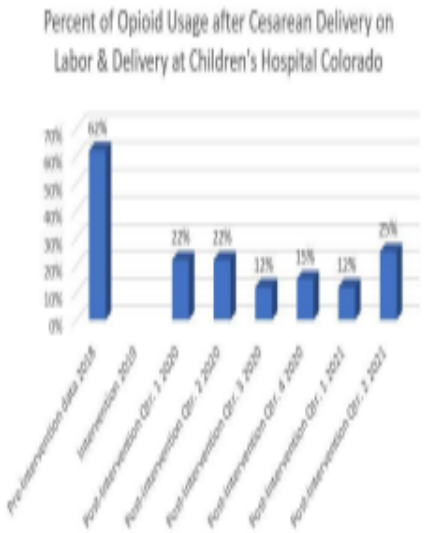
- Our Cesarean Section rate is 50%, which is attributed to the high-risk diagnoses of the specialty neonatal population who often are not candidates for a vaginal delivery due to inability to tolerate the stress of labor.
- As needed (PRN) non-opioid oral analgesics dosing can lead to ineffective pain management (ACOG 2018)
- Newborns are exposed to opioids given for pain relief through breast milk (ACOG 2018)
- Pain relief is important for maternal recovery. (SOAP 2019 & ACOG 2018)
- Rest will improve pain, fatigue, bonding, and decrease depression (SOAP 2019)
- The Society of Obstetric Anesthesia and Perinatology (SOAP) published recommendations to reduce opiate use in post-operative maternal patients in 2019.
- The American College of Gynecology and Obstetrics (ACOG), found that 1 in 300 opioid-naïve patients exposed to opioids after cesarean birth, will become persistent users of opioids.

METHODS

- Chart audits of all Cesarean delivery patients were conducted for baseline data in the year of 2018.
- In May 2019, Labor & Delivery implemented the Enhanced Recovery After Cesarean (ERAC) recommendations, which included:
  - A spinal or epidural dose of Duramorph prior to procedure.
  - A continuous wound infiltration device with local anesthetic placed during the procedure and maintained for 48 hours
  - IV Acetaminophen/NSAID administered immediately after delivery, then scheduled orally every six hours for 48 hours.
- In December 2019 postpartum care policy updated along with ongoing nursing education provided on ERAC guidelines.
- Pain medication administration data was collected from all Cesarean delivery patients who did not require general anesthesia during the first 48 hours postoperatively with ordered PRN oral narcotics.
- Data collected included:
  - Potential number of times patient could have oral narcotics according to provider order within the first 48 hours post-operatively.
  - Actual number of times patient received oral narcotics in the first 48 hours post-operatively.
  - Percentage between potential and actual usage.

RESULTS

Baseline data from the year 2018 showed a 62% usage of opioids. January 2020 to June 2021 (1.5 years) shows a decrease of more than 60 % quarterly of opioid usage in our cesarean delivery patients after implementing ERAC guidelines.



IMPLICATIONS

ERAC recommendations for effective pain management utilizing non-opioid multimodal therapies for post-operative cesarean delivery patients improves mobility and decreases opioid usage which will then decrease the risk of opioid exposure to high-risk infants.

CONCLUSIONS

Post-operative Cesarean delivery pain can be managed with the use of non-opioid multimodal therapies, decreasing opioid use by more than 50% in the first 48 hours postoperatively.

DISCLOSURES

None

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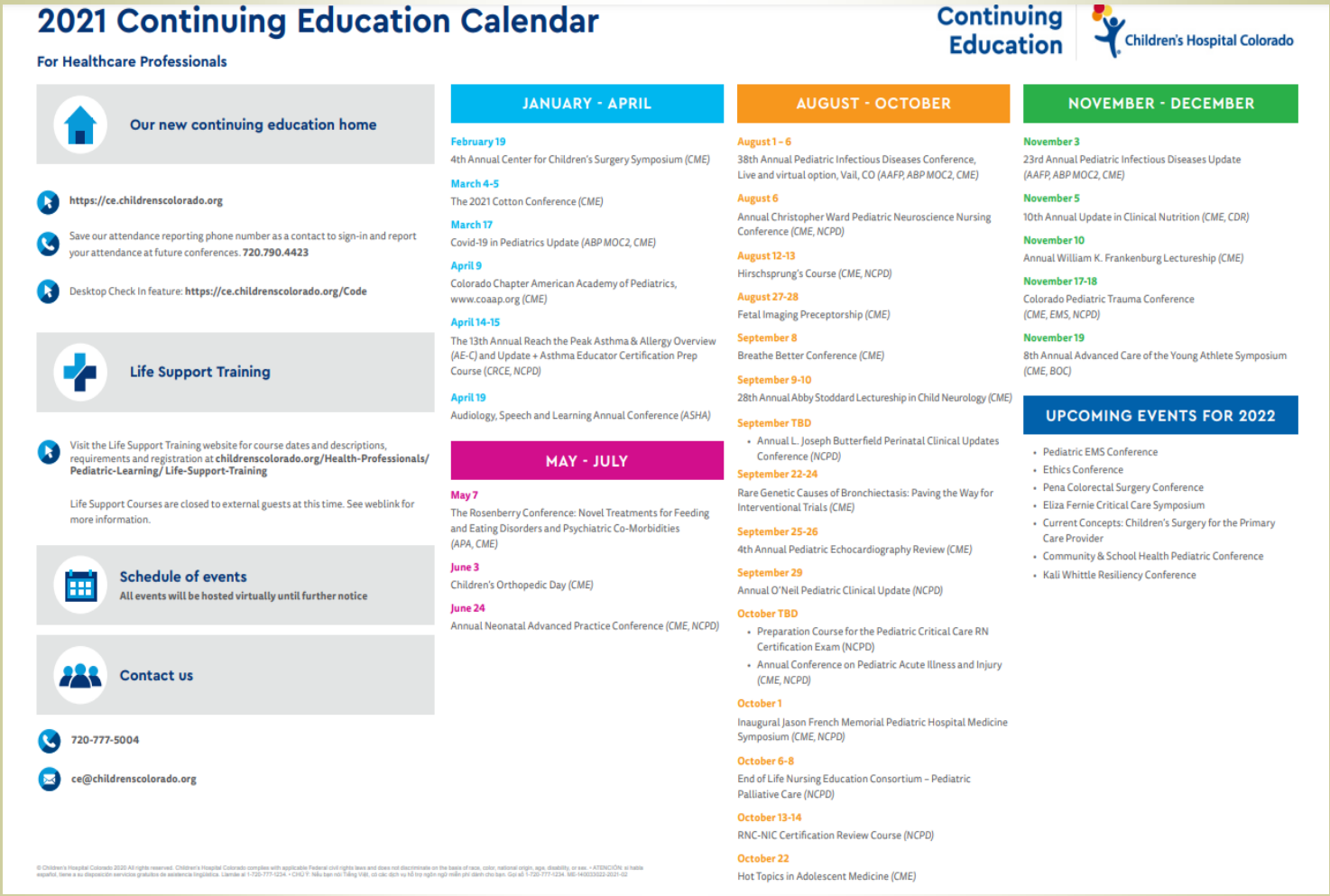

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JANUARY - APRIL

February 19
4th Annual Center for Children's Surgery Symposium *(CME)*

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March 17
Covid-19 in Pediatrics Update *(ABP MOC2, CME)*

April 9
Colorado Chapter American Academy of Pediatrics, www.coaap.org *(CME)*

April 14-15
The 13th Annual Reach the Peak Asthma & Allergy Overview *(AE-C)* and Update + Asthma Educator Certification Prep Course *(CRCE, NCPD)*

April 19
Audiology, Speech and Learning Annual Conference *(ASHA)*

MAY - JULY

May 7
The Rosenberry Conference: Novel Treatments for Feeding and Eating Disorders and Psychiatric Co-Morbidities *(APA, CME)*

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June 24
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AUGUST - OCTOBER

August 1 – 6
38th Annual Pediatric Infectious Diseases Conference, Live and virtual option, Vail, CO *(AAFP, ABP MOC2, CME)*

August 6
Annual Christopher Ward Pediatric Neuroscience Nursing Conference *(CME, NCPD)*

August 12-13
Hirschsprung's Course *(CME, NCPD)*

August 27-28
Fetal Imaging Preceptorship *(CME)*

September 8
Breathe Better Conference *(CME)*

September 9-10
28th Annual Abby Stoddard Lectureship in Child Neurology *(CME)*

September TBD
- Annual L. Joseph Butterfield Perinatal Clinical Updates Conference *(NCPD)*

September 22-24
Rare Genetic Causes of Bronchiectasis: Paving the Way for Interventional Trials *(CME)*

September 25-26
4th Annual Pediatric Echocardiography Review *(CME)*

September 29
Annual O'Neil Pediatric Clinical Update *(NCPD)*

October TBD
- Preparation Course for the Pediatric Critical Care RN Certification Exam (NCPD)
- Annual Conference on Pediatric Acute Illness and Injury *(CME, NCPD)*

October 1
Inaugural Jason French Memorial Pediatric Hospital Medicine Symposium *(CME, NCPD)*

October 6-8
End of Life Nursing Education Consortium – Pediatric Palliative Care *(NCPD)*

October 13-14
RNC-NIC Certification Review Course *(NCPD)*

October 22
Hot Topics in Adolescent Medicine *(CME)*

NOVEMBER - DECEMBER

November 3
23rd Annual Pediatric Infectious Diseases Update *(AAFP, ABP MOC2, CME)*

November 5
10th Annual Update in Clinical Nutrition *(CME, CDR)*

November 10
Annual William K. Frankenburg Lectureship *(CME)*

November 17-18
Colorado Pediatric Trauma Conference *(CME, EMS, NCPD)*

November 19
8th Annual Advanced Care of the Young Athlete Symposium *(CME, BOC)*

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- Ethics Conference
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