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CQI in Action: A Birth Center Postpartum Hemorrhage Process Improvement Project



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Birth Center of Denver (BCD) began 2 years ago as the first hospital-owned, freestanding birth center in the state of Colorado. The foundation for the birth center was the AABC Standards and CABC Indicators, with the goal of obtaining CABC accreditation by the end of our first year. We achieved that goal and were accredited by the CABC 12 months after seeing our first client.

The BCD Continuous Quality Improvement (CQI) Manual is expansive and encompasses the birth center model of care. It incorporates the elements necessary to support a hospital-owned, freestanding birth center model.

Shortly after opening, one of our CNMs chose “Postpartum Hemorrhage Prevention in a Birth Center” as her Doctorate of Nursing Practice (DNP) project. We studied, learned, and collected data. She presented her project at both the ACNM and the AABC annual meetings in 2020, as well as to our department leadership team.

Culture of Safety

A culture of safety is essential to the QI process. All team members must

feel empowered to speak up when they encounter an event that needs addressing. By design, our hierarchy at BCD is flat regarding safety and culture. Several of our team members come from a hospital setting or other birth centers where occurrence event reporting was viewed as blaming or negative. Root Cause Analysis (RCA), safety event reports, and/or event debriefs are

meant to further the overall culture of safety at BCD rather than focusing on individual issues. Our goal is to continue to build

an ongoing culture of quality, safety, support, and transparency.

Sentinel Events

The reporting of Sentinel Events, as defined by the CABC, is required once a birth center has applied for accreditation. Although a postpartum hemorrhage (PPH) is not defined as a sentinel event requiring reporting, a “maternal hemorrhage requiring D&C, blood products, hysterectomy or other surgical intervention” is reportable, as is an “emergent transfer of the mother or newborn – intrapartum, postpartum, or neonatal”. At BCD, a client who meets the criteria for PPH defined as

a blood loss \geq 1000cc, requires emergent transfer to the hospital via ambulance. With each PPH reviewed with CABC, we continued to examine our processes and how we could improve them. We discovered that our foundational

“The hallmark of any quality improvement project is the desire to improve the safety of the clients you serve.”



City Park Suite at Birth Center of Denver

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processes were sound and we continued to be open to suggestions and feedback from others based on their experiences. We have been able to adjust our processes and found ways to help our team feel more confident in their management of PPH. This also helped our team have more intentional conversations with our clients, so that they also felt safer if they needed to transfer from the birth center to the hospital.

Root Cause Analysis Process

We started by creating our own RCA form that was useful, but did not contain the details we needed to provide a comprehensive review of events. We moved to the RCA form provided by CABC and have found it to be beneficial since it contains more targeted questions that can be utilized universally for any type of event.

We worked on certain items related to the management of PPH and were able to improve based on our RCA process and sentinel event reporting (*see box on right*).

Chart Audits

We utilize formal chart audits to ensure that our processes are followed and updated, and to validate that client care is in alignment with both our Clinical Care Guidelines as well as evidence-based best practices.

Postpartum hemorrhage will be a continuous QI project at BCD based on our learnings over the last two years. We are currently working on adding the use of TXA this year, and will have even more data to evaluate following this addition to our PPH guidelines. We know that PPH is the biggest risk associated with community birth, and BCD is committed to reassessing and making changes to our processes whenever necessary. Many learnings and process improvements that have developed as a result of our CQI processes, and working with CABC, have been extremely valuable.

Critical Events Team Training (CETT)

- *Frequency:* twice per year and include both maternal and newborn drills.
- *Participants:* BCD staff and contracted ambulance crew.
- *Format:* run by hospital staff from labor and delivery and the NICU who are specifically trained to run CETT in the hospital, brought in to keep it as “real” as possible. It is beneficial to have them observe what we are able to achieve in the birth center with just two staff members (one CNM and one RN) when an event occurs on a weekend or middle of the night.

Ambulance response times

- BCD contracts with an ambulance company responsive to birth center requirements and will call 911 if they are not able to respond in a timely fashion.
- This has allowed us to pull the dispatch tapes and address any communication issues immediately following an event. These efforts led to standardization of the EMS process for the entire building.

Scripting for ambulance calls

- Developed laminated scripts for client transfer to help us use language EMS and hospital staff need to get our message across in a stressful situation. Team members give essential information without forgetting any vital details.

Large emergency response kit

- A large emergency kit is kept in the birth suite so no one has to leave the room to get supplies and medications to manage a PPH.
- All PPH medications are kept in an easily accessible secured kit.

Vital sign machines

- Staff have been trained how to cycle the machine to give readings at pre-determined intervals for retrieval during charting.

Peer review

- Ongoing peer review validates adherence to practice guidelines.




Data collection

- Provided ongoing evaluation of PPH processes and updating of guidelines as needed based on the RCA.

Suggestion boxes

- Allow for feedback from hospital staff members about interfacility transfers.

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