	Promoting Comfort Bundle		Pre-Implementation	3 mo.	6mo	9mo	Post Implementation
		To answer, click on cell and a triangle appears, then click and choose yes or no from the drop down menu					
Number	**Readiness**	Clarification	Answer	Answer	Answer	Answer	Answer
1a	Do the midwifery care providers in your institution have policies/guidelines/statements that support a process of shared decision making ?	Shared decision making indicates responsiveness to women's needs and					
1b	Do the physician providers have policies/guidelines/statements that support a process of shared decision making ?						
2a	Does initial or annual unit based training for registered nurses contain content in **physical labor support**?						
2b	Does initial or annual unit based training contain content in **emotional labor support**?						
2c	Does initial or annual unit based training contain content in **advocacy** during labor support?						
2d	Does initial or annual unit based training contain content about **informational labor** support?						
3	Does the hospital have a policy, clinical protocol, or guideline about caring activities focused on support and comfort measures to assist a woman to cope with labor?	This should include mention of freedom of movement, hydrotherapy, nutrition and hydration in labor, and use of non-pharmacologic pain management techniques					
4	Does your hospital have a guideline promoting a provision of continuous 1 to 1 support during active labor?	This excludes 1:1 support from a family member; the intent is to have this support from a trained individual					
5	Does your unit have some or all of these items:						
5a		tub or pool					
5b		shower					
5c		adjustable lighting					
5d		birthing balls or peanut balls					
5e		TENS unit					
5f		ability for pts to play music (if they do not have their own)					
5g		healthy snacks in labor					
5h		support for squatting					
5i		rocking chair or lounge chair					
5j		heat or cold packs					
6a	*In practices who attend births in your unit:* Is information about **non-pharmacologic** pain measures discussed during the prenatal period with clients and documented in the chart?						
6b	*In practices who attend births in your unit:* Is information about **pharmacologic** pain measures discussed during the prenatal period with clients and documented in the chart?						
	Risk and Appropriateness Assessment						
7a	Does every woman in labor receive information about non-pharmacologic pain management and assistance with comfort and coping?						
7b	Are you utilizing a coping scale to assess women in labor for coping with labor?						
7c	Are women in labor assessed for preferences and engaged in shared decision making related to comfort and coping, including intended use of nonuse of pharmacologic pain management	Shared decision making indicates responsiveness to women's needs and preferences					
	Reliable Delivery of Appropriate Care						
8	*Does every woman whose current intention is to labor without pharmacologic pain management have access to some or all of these items:*						
8a		tub or pool					
8b		shower					
8c		adjustable lighting					
8d		birthing balls					
8e		TENS unit					
8f		ability for pts to play music (if they do not have their own)					
8g		healthy snacks in labor					
8h		support for squatting					
8i		heat or cold packs					
8j		rocking chair or lounge chair					
9	Does every woman in labor receive encouragement to remain upright during labor and ambulate and change positions wihtout restrictions during labor?						
10	Does every woman in labor receive clear communication that includes her parter and family in the process of shared decision making?						
	Recognition and Response						
11	For women in labor who are not able to cope with non-pharmacological support, are care and comfort options utilized until the woman receives pharmacologic pain management?						
	Reporting/Systems Learning						
12	Do registered nurses, physicians and midwives receive training in labor support within 60-90 days of hire?						
13	Does the unit document annual training updates about non-pharmacologic labor support?						

Intermittent Auscultation Bundle

			Pre-Implementation	3 mo.	6mo	9mo	Post Implementation-mentation
		To answer, click on cell and a triangle appears, then click and choose yes or no from the drop					
Number	**Readiness**	**Clarification**	Answer	Answer	Answer	Answer	Answer
1a	Does the unit leadership provide **initial** training for all **maternity care professionals** on evidence- based approaches to fetal heart rate (FHR) assessment, including intermittent auscultation (IA) and associated standardized documentation.	Maternity care professionals include all physicians, nurses and midwives					
1b	Doe the unit leadership provide **ongoing** training for all maternity care professionals on evidence- based approaches to fetal heart rate (FHR) assessment, including intermittent auscultation (IA) and associated standardized documentation.	Maternity care professionals include all physicians, nurses and midwives					
3	Is the unit culture one that supports the evidence-based use of IA as the preferred method of FHR monitoring for women at no a priori risk for developing fetal acidemia during labor and/or are at low risk for extraplacental insufficiency.						
4	Are there evidence based policies/guidelines that delineate inclusion and exclusion criteria for IA and the transition from one type of fetal monitoring to another?	Includes sufficient telemetry units so that women can have freedom of movement in labor.					
5	Does the unit ensure sufficient staffing to maintain adherence to evidence-based unit protocol for IA for all appropriate candidates.						
6	Does the unit provide electronic FHR equipment for when transition to continuous monitoring is indicated.						
7	Does the unit have the necessary equipment (hand held doppler) for each qualified candidate for IA?						
8	Does the unit have promote shared decision making, including having consumer education materials that include evidence-based approaches to FHR assessment during labor.						
	Risk and Appropriateness Assessment						
9	Is each woman who presents in labor assessed for eligibility for IA?						
10	Does each woman in labor receive ongoing assessment of fetal well-being consistent with the evidence-based unit policy?						
	Reliable Delivery of Appropriate Care						
11	Is every woman eligible for IA assessed in adherence with an evidence-based unit IA policy that includes established criteria for converting to continuous EFM?						
12	Is every woman assessed for IA regularly informed of overall FHR assessment throughout labor and provided with necessary information about these assessments?						
	Recognition and Response						
13	Is every woman who is eligible for IA transitioned to CEFM as indicated by to established criteria?						
14	Is every woman who is has been transitioned to CEFM resumed for IA if fetal monitoring indicates the fetus is at low risk for fetal acidemia according to established criteria?						
15	Is every woman who is eligible for IA involved in decision making about the method of FHR assessement if the maternal or fetal status changes?						
	Reporting/Systems Learning						
16	Does the unit keep a record of competency training for professionals in IA?						
17	Does the unit monitor how many eligible women receive IA?						
18	Is there a multidisciplinary system to support peer review of significant events related to FHR assessment?						
19	Does the unit administer patient satisfaction surveys that address: decision-making, comfort, education and process related to EFM? Does the unit evaluate these surveys?						

	Promoting Spontaneous Progress in Labor Bundle		Pre-Implementation	3 mo.	6mo	9mo	Post Implementation-mentation
		To answer, click on cell and a triangle appears, then click and choose from the drop down menu.					
Number	**Readiness**	**Clarification**	Answer	Answer	Answer	Answer	Answer
1a	Do you have a unit policy that provides a plan of care for early/latent labor?						
1b	Is there space to enable women in latent labor to receive comfort measures and support?						
1c	Are there safety criteria for return home prior to active labor admission?						
2	Is there initial training and skill development for all maternity care professionals (MD, CNM, RN) about evidence based care practices that support maternal choice and promote spontaneous labor?	e.g., mobility, upright positioning, continuous labor support, passive second stage descent, and physiologic pushing					
3	Is there ongoing training for all maternity care professionals (MD, CNM, RN) about evidence based care practices that support maternal choice and promote spontaneous labor?						
4	Is there access to equipment that promote spontaneous labor progress?	Are there: areas for walking during labor, showers, labor tubs, music, birthing balls, birth bars, squat bars?					
5a	Is there an established interprofessional policy for labor care that specifies: a) evidence based criteria for diagnosing active labor?	The policy should include all 3 elements.					
5b	b) describes the system of communication to signal physiologic parameters of labor duration have been exceeded?						
5c	c) triggers a protocol for intervention consideration?						
	Risk and Appropriateness Assessment						
6	Do women in labor have access to supportive care and information about comfort measures that can be used during latent labor?	e.g., early labor lounge, home-based doula support					
7	Are women engaged in shared decision making about the timing of admission to the birth unit?						
8	Are women assessed for active labor using common objective criteria and informed of their stage of labor?						
	Reliable Delivery of Appropriate Care						
9	Is the clinical team using objective criteria to assess a woman's stage of labor?						
10	Is every woman assessed for progress in active labor using contemporary physiologic parameters?						
	Recognition and Response						
11	Are women informed of their stage in labor?						
12	Are women engaged in shared decision making about any interventions aimed at speeding labor?						
	Reporting/Systems Learning						
13	Is there documentation of the maternity care professional training and skill development regarding use of evidence-based care practices that promote the progress of spontaneous labor.						
14	Does the ob department track and publically report rates of physiologic childbirth?						
15	Is there a policy for routine, interdisciplinary review of all operative births performed for the indication of labor progress disorders?						

Term	Definition	Notes
NTSV Cesarean Rate	The rate of cesarean sections in women who are nulliparous (first birth), at term (> 37 weeks gestational age), with a single fetus in the vertex position.	Patients with ICD-10-CM Principal Diagnosis Code or Other Diagnosis Codes for multiple gestations and other presentations are excluded. • The patient age in years is equal to the Admission Date minus the Birthdate. Patients less than 8 years of age or greater or equal to 65 years of age are excluded. • Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is greater than 120 days, the patient is excluded. • Patients are excluded if "Yes" is selected for Clinical Trial. • Patients with a Gestational Age less than 37 weeks or UTD are excluded from the measure.
SPONTANEOUS LABOR AND BIRTH	Initiation of labor without the use of pharmacological and/or mechanical interventions, resulting in a non-operative vaginal birth Does not apply if any of the following are used or performed: · Cervical ripening agents, mechanical dilators, or induction of labor · Forceps or vacuum assistance · Cesarean birth Still applies if any of the following are used or performed: · Augmentation of labor · Episiotomy · Regional anesthesia	
CESAREAN BIRTH	Birth of the fetus(es) from the uterus through an abdominal incision Does not apply if any of the following occur: · Abdominal pregnancy · Ectopic Pregnancy	
PARITY	The number of pregnancies reaching 20 weeks and 0 days of gestation or beyond, regardless of the number of fetuses or outcomes	In cases of multiple pregnancies, parity is only increased with birth of the last fetus
LABOR RELATED DEFINITIONS		

SPONTANEOUS ONSET OF LABOR	Labor without the use of pharmacological and/or mechanical interventions to initiate labor Does not apply if the following is performed: · Artificial rupture of membranes before the onset of labor	May occur at any gestational age
INDUCTION OF LABOR	The use of pharmacological and/or mechanical methods to initiate labor Examples of methods include but are not limited to: artificial rupture of membranes, balloons, oxytocin, prostaglandin, laminaria, or other cervical ripening agents Still applies even if any of the following are performed: · Unsuccessful attempts at initiating labor · Initiation of labor following spontaneous ruptured membranes without contractions	
TERM RELATED DEFINITIONS		
PRETERM	Less than 37 weeks and 0 days Late Preterm is 34 weeks and 0 days through 36 weeks and 6 days	
TERM	Greater than or equal to 37 weeks and 0 days using best EDD. It is divided into the following categories: Early Term - 37 weeks and 0 days through 38 weeks and 6 days Full Term - 39 weeks and 0 days through 40 weeks and 6 days Late Term - 41 weeks and 0 days through 41 weeks and 6 days Post Term - Greater than or equal to 42 weeks and 0 days	
MIDWIFERY CARE RELATED DEFINITIONS		
Any Midwifery Care in Labor	Any labor assessment and/or management performed by a midwife during the intrapartum care period resulting in a birth. -Does not include first assist at cesarean. -Includes midwifery triage assessment if the assessment results in intrapartum admission.	
Other Definitions		

Continuous Support in Labor	The term "continuous labor support" refers to non-medical care of the laboring woman throughout labor and birth by a trained person. - Supportive care during labour may involve physical support emotional support, comfort measures, information and advocacy. Caring activities should focus on support and comfort measures to assist a woman to cope with labor, e.g., freedom of movement, hydrotherapy, nutrition and hydration in labor, and use of non-pharmacologic pain management techniques.3,4	
Intermittant Auscultaion	Intermittent auscultation is the auditory technique for sampling and counting the fetal heart rate at particular intervals with the human ear. It is often practised by listening and counting the fetal heart sounds through the mother's abdominal wall for at least 15 seconds and then multiplied by four. Other practices and recommendation for the length of listening to the fetal heart range from15 to 30 to 60 seconds, as well as the recommendation to listen to the fetal heart during and after a contraction in second stage	
Low Risk of Fetal Acidemia- if none = eligible for IA	**Risk Factors:** Maternal –Antenatal Hypertensive disorders of pregnancy-on meds Pre-existing diabetes mellitus/gestational diabetes-on meds Antepartum hemorrhage Maternal medical disease Previous C/S Multiple pregnancy Maternal MVA/Trauma in last month Morbid obesity BMI > 40 presently Breech presentation	From Alberta Health Services Antenatal Form

	Fetal – Antenatal intrauterine growth restriction by U/S Decrease fetal activity Prematurity < 37 weeks Isoimmunization Oligohydramnios by U/S Intrapartum Intrauterine infection/chorioamnionitis Prolonged rupture of membranes (>24 hours at term) Meconium staining of the amniotic fluid Induced labour with oxytocin Augmented labour with oxytocin Hypertonic uterus Preterm labour < 37 weeks gestation Post-term pregnancy (>42 weeks) Vaginal bleeding in labour Abnormal FHR on auscultation	
Definitons of Variables		
Predominant method of fetal monitoring used in the first stage of labor.	A "common sense" decision rule is used. E.g., if IA was ordered, carried out for 7 of 10 hours of labors but intermittent EFM was used when the RN had breaks, then IA is the predominant method. If intermittent EFM was ordered but continueous was used for 6 of 12 hours of labor, then continuous is the predominant method.	
Predominant method of fetal monitoring used at the time of birth	This refers to predominant method used in second stage. For example if IA is used throughout second stage but not in the last 10 minues, then continous is used in the last 10 minutes, then IA is the predominant method.	
1:1 continuous labor support	1:1 is the provision of non-medical care of the laboring woman throughout labor and birth by a trained person. This requires that someone (not necessarily the same individual) is consistently available to the woman for labor support activites.	Providers, nurses and doulas can share the labor support role for a given woman. Family members, unless specifically trained in labor support, cannot fullfill this role.