Interprofessional Collaboration

TITLE: "Child-bearing Interprofessional Practice across the Continuum of Care: Caring for Clients with Substance Use Disorder during Labor and Birth"

Case Overview

Rosie Jenkins is a 25 y.o. gravida 2 parity1001 at 39 5/7 weeks gestation who presents to the hospital in labor. She is currently participating in a methadone maintenance program, resulting from a past medical history of opioid use disorder. This occurred following a serious motor vehicle accident a few years ago in which she sustained multiple fractures, surgery and a prolonged period of pain which was treated by her physicians with opioids. Mrs. Jenkins is now in the triage room alone, waiting to see the Certified Nurse Midwife (CNM). The nurse has already introduced himself to Mrs. Jenkins and assessed her. He reports the following:

- HPI:
  - Denies bleeding, rupture of membranes, bleeding; fetal movement is "good". Patient is having regular contractions every 4-5 minutes for the past five hours, with contractions getting stronger
  - Allergies: None.
  - Medicines: PNV, Methadone 30 mg po every day for the past year to manage pain and "get through each day"; nicotine patches
- Current pregnancy: no complications, regular prenatal care beginning in first trimester
- OB Hx: Spontaneous Vaginal Delivery (SVD) following spontaneous labor 2 years ago of a full-term female child living with her at home.
- PMH: substance use disorder (SUD), hx of multiple fractures; hx of sexual abuse as a child by family friend, history of tobacco use

Module Objectives

By the end of this simulation, the learner will be able to:

1. Advocate for patients in a manner that contributes to evidence-based care.
2. Demonstrate proficiency in communication as a member of the health care team.
3. Be aware of the influence of unconscious bias and social determinants of health on care and health outcomes for childbearing clients.
4. Recognize roles of all members of the health care team in collaborating as a member of an interprofessional team.
5. Address the specific clinical objectives pertaining to each scene of this IPE clinical simulation.
6. Address the identified **Core Competencies for Interprofessional Collaborative Practice (2016)** which are specific to this IPE clinical simulation.

Core Competencies for Interprofessional Collaborative Practice:

Competency 1: Values/Ethics

VE1. Work with individuals of other professions to maintain a climate of mutual respect and shared values.

VE2. Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.

VE5. Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services and programs.

VE6: Develop a trusting relationship with patients, families, and other team members.
VE7. Demonstrate high standards of ethical conduct and quality of care in contributions to team-based care.
VE9. Act with honesty and integrity in relationships with patients, families, communities, and other team members.

Competency 2: Roles/Responsibilities

RR1: Communicate one's roles and responsibilities clearly to patients, families, community members, and other professionals.
RR2: Recognize one's limitations in skills, knowledge, and abilities
RR3. Engage diverse professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific health and healthcare needs of patients and populations.
RR4. Explain the roles and responsibilities of other providers and how the team works together to provide care, promote health and prevent disease.
RR5. Use the full scope of knowledge, skills, and abilities of professionals from health and other fields to provide care that is safe, timely, efficient, effective and equitable.
RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.
RR9: Use unique and complementary abilities of all members of the team to optimize health and patient care.

Competency 3: Interprofessional Communication

CC2: Communicate information with patients, families, community members, and health team members in a form that is understandable, avoiding discipline-specific terminology when possible.
CC3. Express one's knowledge and opinions to team members involved in patient care and population health improvement with confidence, clarity and respect, working to ensure common understanding of information, treatment, care decisions, and population health programs and policies.
CC6: Use respectful language appropriate for a given difficult situation, crucial conversation, or conflict.
CC7. Recognize how one's own uniqueness (experience level, expertise, culture, power, and hierarchy within the health team) contributes to effective communication, conflict resolution and positive interprofessional working relationships.
CC8. Communicate the importance of teamwork in patient-centered care and population health programs and policies.

Competency 4: Teams and Teamwork

TT2. Develop consensus on the ethical principles to guide all aspects of team work.
TT3. Engage health and other professionals in shared patient-centered and population-focused problem-solving.
TT4: Integrate the knowledge and experience of health and other professions to inform health and care decisions, while respecting patient and community values and priorities/preferences for care.
TT8. Reflect on individual and team performance for individual, as well as team, performance improvement.
TT10: Use available evidence to inform effective teamwork and team-based practices.
TT11: Perform effectively on teams and in different team roles in a variety of settings

<u>Scene 1:</u> (Triage)

Brief Summary for Instructors:

Purpose: Demonstrate anticipatory guidance of laboring parents.

Summary: The patient is in the triage area and fetal monitors are being placed on the patient while the nurse completes the assessment. In addition to labor symptoms, the assessment includes the patient's learning needs and provides information regarding the patient's expectation for pain management.

Clinical Learning Objectives:

1. Demonstrate anticipatory guidance for a person in labor.

2. Recognize key patient factors that may affect labor.
3. Identify the patient's preferences for the labor and birth process (birth-plan).

Scene 2: (Labor)

Brief Summary for Instructors:

Purpose: The purpose is to demonstrate shared-decision making for a person with opioid use disorder who is in labor, while respecting labor preferences, and incorporating trauma-informed care strategies with laboring persons. The collaboration of the patient, doula, nurse, midwife, and CRNA provide an exemplar of how patient can remain patient-centered if all contributions are respected. Learners will have an opportunity to review labor management in early labor and best-practices for pain management of persons with a substance-use disorder (SUD).

Summary: The patient is in her labor room after just moving from triage. Her Doula has arrived and the nurse is applying external monitors to assess fetal well-being. She had been taken off of the monitors while walking. The three of them discuss intermittent versus continuous monitoring. The nurse acknowledges and validates the patient's wishes for intermittent monitoring and provides anticipatory counseling regarding pain management. The nurse also acknowledges options appropriate for a woman with Substance Use Disorder (SUD) and validates the patient's fear about receiving opioids, including an epidural. When the nurse leaves the room to check on the patient's methadone dose, the doula and patient reflect on the nurse's collaborative approach, and the patient expresses how grateful she is that the nurse did not make her provide a rationale for all of her choices, which would be re-traumatizing for her.

At the providers' workstation, the nurse consults with the attending Certified Nurse Mid-wife (CNM), Certified Registered Nurse Anesthetist (CRNA), and pharmacist. The attending physician initially dismisses the idea of intermittent monitoring but acknowledges that it is evidence-based. The CRNA indicates that they have already met the patient during an antepartum pain management discussion. The pharmacist confirms that they will prepare a solution with a higher concentration of local anesthetic versus narcotic, as appropriate for a patient with SUD

Clinical Learning Objectives:

By the end of this simulation, the learner will be able to:

1. Recognize best practice recommendations for women with SUD receiving intrapartum care, including trauma informed care shared-decision making (related to pain management and other interventions).
2. Discuss the role of the doula in pregnancy, labor and delivery.
3. Recognize how implicit bias and stigma can impact care.

Scene 3 (Delivery)

Brief Summary for Instructors

Purpose: The purpose is to demonstrate the role of the RN, doula, mid-wife, pharmacist, obstetrician and other team members during labor and a complex delivery of a pregnant patient with a history of substance use disorder.

Summary: Rosie is a 25 y.o. Gravida2/Parity1001 at 39 5/7 weeks gestation in labor. She is now fully dilated and has been pushing for 3 hours with slow progress. The fetal heart rate has been reassuring throughout the second stage. A shoulder dystocia occurs at delivery and is resolved following a well-coordinated team effort. Present in the room are the labor RN, the baby RN, and the CNM. The MD, NICU staff, and CRNA arrive later in the scene.

Clinical Learning Objectives:

By the end of this simulation, the learner will be able to:

1. Apply the nursing process to provide evidence-based care for a person during active labor.
2. Demonstrate proficiency in communication as a member of the health care team
3. Use best evidence to guide care of a birthing parent and fetus.

4. Identify the pathophysiology of and therapeutic interventions associated with common pregnancy complications.

Scene 4 (Breastfeeding)

Brief Summary for Instructors

Purpose: The purpose is to **r**eview the basic principles of breastfeeding including ideal positioning, characteristics of a good latch; review the safety of breastfeeding in the context of methadone use and anticipatory guidance for parents of an infant who may experience withdrawal.

Summary: In this scenario, the patient is attempting to establish breastfeeding. The charge nurse and lactation specialist both become involved at various points. The RN must manage her own discomfort and lack of familiarity with a patient on methadone and engage the patient in decision-making. The lactation consultant provides guidance for breastfeeding in the context of substance use disorder. When the RN re-enters the room, the TV is on and/or music playing. The patient is holding the baby, wrapped tightly in blankets, and trying to get the baby to positioned to feed. She's struggling due to lack of confidence.

Clinical Learning Objectives:

By the end of this simulation, the learner will be able to:

1. Apply evidence-based strategies to promote breastfeeding in the early postpartum period.
2. Recognize the best practice recommendations for breastfeeding and women with SUD.
3. Discuss how implicit bias and stigma can impact care
4. Apply strategies to respond to implicit bias and stigma in health care teams

Required Readings:

Silbert-Flagg, J, Pilliterri, A. (2018). Maternal and Child Health Nursing (8th edition) Philadelphia: PA: Wolters Kluwer.

Intrapartum

Chapter 15, "Nursing Care of a Family During labor and Birth" pp.347 - 372 (Includes EFM pages)
Silbert-Flagg, J, Pilliterri, A. (2018). Maternal and Child Health Nursing (8th edition) Philadelphia: PA: Wolters Kluwer. (or equivalent reading in a maternal/child nursing text)

Pain Management

Chapter 16, "The Nursing Role in Providing Comfort during Labor and Birth" pp. 373-395
Silbert-Flagg, J, Pilliterri, A. (2018). Maternal and Child Health Nursing (8th edition) Philadelphia: PA: Wolters Kluwer. (or equivalent reading in a maternal/child nursing text)

Processes and Stages of Labor

Chapter 15, "Nursing Care of a Family During Labor and Birth" pp. 326-345, pp.
Chapter 11, "Nursing Care Related to Assessment of a Pregnant Family" pp. 245-249; 278-279 (The Pelvis, Preparation for Labor) (or equivalent reading in a maternal/child nursing text)

Suggested Reading:

Simpson, K.R. & Creehan, P.A. (2014). Perinatal Nursing (4th ed.). Philadelphia: PA: Wolters Kluwer/Lippincott Williams & Wilkins.

Intrapartum and Postpartum

Chapter 14 - pp. 350 - 373) (or equivalent reading in a maternal/child nursing text)

Pain Management

Chapter 16, "Pain in Labor: Non-pharmacologic and Pharmacologic Management" (or equivalent reading in a maternal/child nursing text)

Key Teaching/Debriefing Points:

Scene 1: Triage

Key teaching/debriefing points:

- Respectful communication between the nurse and patient, nurse to nurse, and provider to patient.
- How to address a colleague when a disrespectful or judgmental comment has been made.
- Teaching/support needed by clients during labor.
- Women with SUD have a right to pain relief.

Clinical Scenario Debriefing Questions:

1. What is this scene about? (Patient is in early labor; patient is in a methadone treatment program; patient is scared of pain; stigma attached to people who have used drugs.)
2. What actions/statements did the nurse make?
3. Was this sufficient to address the situation?
4. What other methods could be used?
5. As the nurse, how would you handle this situation?
6. What teaching could be done with this client?
7. What did you learn from this scenario?

Scene 2: Labor

Key teaching/debriefing points:

- Trauma informed care: shared-decision making, avoiding re-traumatizing, engaging a doula as 'tool' to facilitate shared-decision making
- General IP considerations
  - Care may be re-traumatizing for women
  - Methadone dose will stay the same during L&D; same or slightly decreased PP. Watch for over sedation (UTD)
  - 1:1 care
- Pain relief principles
  - **Anesthesia consult** (same person she saw prenatally) – continuity of care
  - Neuraxial anesthesia is best option – discuss why IV not ideal; recommendation for high local concentration solution
  - Adjunct: nictoine patch
- Review Anticipatory guidance re: newborn p (after comfortable on epidural)
  - Extended LOS, preparation for that.
  - Screening procedures (need to discuss state reporting guidelines)
- Role of implicit bias and stigma

Clinical Scenario Debriefing Questions:

1. To what extent do you think that this care was trauma-informed. Can you give examples?
2. How was care individualized for Rosie, given her disorder?
3. How was care individualized for Rosie's baby, given that she was on methadone?
4. How did implicit bias and stigma factor into Rosie's care?

Scene 3: Delivery

Key teaching/debriefing points:

- Discuss the role of each team member in shoulder dystocia recognition, resolution, and documentation
- Discuss the implications of shoulder dystocia for the parent and neonate.
- Discuss the importance of skills practice drills for teamwork and communication
- Discuss the concept of referral of care to a higher level when appropriate.

Clinical Scenario Debriefing Questions:

1. What is clinical complication of a shoulder dystocia?
2. What is the significance of a shoulder dystocia for a patient during delivery?
    a. Discuss the maternal and neonatal morbidity and mortality risks that could be experienced with this obstetric emergency.
3. What went well in this situation?
    a. Calm clear effective communication
    b. Assembly and collaboration among team members
    c. Effective resolution of a clinical complication
4. What is the definition of a third-degree laceration?
5. What is the significance of a third-degree laceration for the birthing parent?
6. What went well in this scene?
    a. Discuss appropriate communication and teamwork
    b. Discuss appropriate recognition of personal skill limitations
    c. Discuss the process of debriefing with a patient after an obstetric emergency
    d. Explain respectful team communication which occurred

Scene 4: Postpartum-Breastfeeding

Key teaching/debriefing points:

- Stigma and lack of knowledge related to women with SUD and breastfeeding which may have occurred
- Issues addressing colleagues when one is newer or lower on the 'hierarchy'.
- Strategies used here: offering non-judgmental evidence-based information, dealing with issues "in the moment' so that opportunities for learning are not lost.
- From a structural perspective, if a Lactation Consultant was routinely ordered for all women with a SUD, the RN would not have had to incorporated this step; it would have been routine
- The LATCH score is a way to assess breastfeeding [review LATCH].
- Methadone is considered safe in pregnancy.
- Breastfeeding may reduce the amount of withdrawal symptoms and length of stay for newborns.
- For a client experiencing SUD, medication changes should be made in collaboration with medical team.

Clinical Scenario Debriefing Questions:

1. What was happening in this scene?
2. What factors added to the difficulty of this situation?
3. What strategies did you see the RN use to address the situation?
4. Was she successful? How do you know?
5. What would a "next step" look like if the Charge Nurse had not been responsive?
6. What are some structural issues that could be changed to avoid this challenge?
7. What was working well? (RN understood breastfeeding was indicated and provided support. LC was knowledgeable. Good communication techniques.)
8. What basics of breastfeeding support did you see occur here?
    a. Assistance with position, confidence, setting expectations.
9. What are the signs of a good latch? What other information would you need?
    a. Review LATCH elements.
10. What are some special considerations for women with SUD who breastfeed? Give some examples of how these were addressed.
    a. Important safety of medicine, impact on withdrawal and LOS for infant, importance of infant weights.

Curricular Information: This module is appropriate for inclusion in a childbearing clinical course for pre-licensure students.

Persons addressing substance use disorder often experience stigma within the health care setting, including in the childbearing context (SAMHSA, 2018). Pregnant persons can be safely managed on methadone; this approach can dramatically reduce risks to untreated substance use disorder (SAMHSA, 2018). In labor, persons with SUD have a right to pain management like any other patient (Safley & Swietlikowski, 2017). Pain management strategies should be individualized and discussed during prenatal care as well as in labor (Illinois Perinatal Quality Collaborative, 2019).

There is substantial evidence to support the use of a doula for support during labor and birth. As a member of the interprofessional team including nurses, midwives, obstetricians, anesthesiologists and nurse anesthetists, the doula provides continuous emotional, informational, and physical support to the pregnant woman and family. The presence of a doula has been credited to help improve outcomes for both laboring women and infants. Some of the benefits that have been identified when a doula is present include: fewer interventions, shorter length of labor, less use of analgesics, less incidence of low Apgar scores, and higher maternal satisfaction scores (Lucas & Wright, 2019).

Shoulder dystocia is a serious obstetric emergency that can harm both the newborn and the birthing parent (Silbert-Flagg & Pilliterri, 2018). Like other emergencies, it requires a well-coordinated, evidence-based response by an interprofessional team (Grobman, 2017). Following a shoulder dystocia, the care team should discuss what occurred and rationales for the care that was provided with the patient.

New parents with SUD who are treated with methadone can breastfeed safely (Illinois Perinatal Quality Collaborative, 2020). Breastfeeding serves as both a strategy to promote optimal nutrition and a soothing strategy in the context of possible withdrawal (Pritham, 2013). Health care team members with expertise in breastfeeding can provide support to both frontline staff and new parents to answer questions about breastfeeding in the context of methadone or other pharmacologic treatment for opioid use disorder.

Reference Materials

Grobman, W. A. (2014, June). Shoulder dystocia: simulation and a team-centered protocol. In *Seminars in Perinatology* (Vol. 38, No. 4, pp. 205-209). WB Saunders. http://dx.doi.org/10.1053/j.semperi.2014.04.006

Illinois Perinatal Collaborative (2020). Opportunities to Promote Breastfeeding: Mother and Newborns affected by Opioids. https://ilpqc.org/ILPQC%202020%2B/MNO-Neonatal/MNO-Neo%20Opportunities%20to%20Support%20Breastfeeding_7.29.2020.pdf

Illinois Perinatal Quality Collaborative. (2019) Example Checklist for CNMs for Prenatal/ Intrapartum/ Postpartum Care of Pregnant Women with Substance Use Disorders. https://ilpqc.org/wp-content/docs/toolkits/MNO-OB/Example-Checklist-for-Care-of-Pregnant-Women-with-SUD.pdf

Lucas, L., & Wright, E. (2019). Obstetrical providers' attitudes towards doulas: A scoping review. *MCN: The American Journal of Maternal Child Nursing, 44*(1), 33-39. doi: 10.1097/NMC.0000000000000510

Northern New England Perinatal Quality Improvement Network. (2018) http://www.nnepqin.org/a-toolkit- for-the-perinatal-care-of-women-with-opioid-use-disorders/. VIA https://ilpqc.org/wp-content/docs/toolkits/MNO-OB/Breastfeeding-Guidelines-for-Women-with-SUD.pdf

Pritham, U. A. (2013). Breastfeeding promotion for management of neonatal abstinence syndrome. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *42*(5), 517-526. Doi: DOI: 10.1111/1552-6909.12242

Safley, R. R., & Swietlikowski, J. (2017). Pain management in the opioid-dependent pregnant woman. *The Journal of perinatal & neonatal nursing*, *31*(2), 118-125. doi: 10.1097/JPN.0000000000000244

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Sperlich, M., Seng, J. S., Li, Y., Taylor, J., & Bradbury-Jones, C. (2017). Integrating trauma-informed care into maternity care practice: Conceptual and practical issues. *Journal of midwifery & women's health*, *62*(6), 661-672. doi:10.1111/jmwh.12674

Substance Abuse and Mental Health Services Administration (SAMHSA). Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. (Factsheets #11 and #12) https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054