ARIADNE LABS

TEAMBIRTH

Thank you for your interest in TeamBirth!

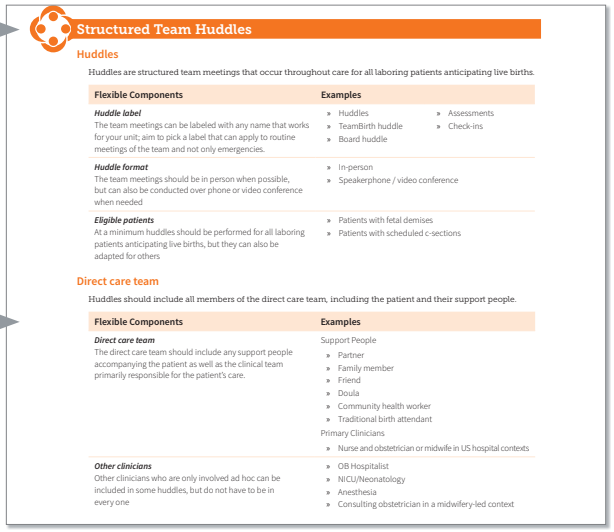
The purpose of this document is to help you navigate your components for TeamBirth. We break these components into core and flexible components and "add-ons" to help make implementation and adoption successful in your facility.

Core components are components that are critical to successful delivery of TeamBirth.*

TeamBirth core components are featured as section headers and subheadings on subsequent pages.

Flexible components are components of the solution which must be done, but that can be delivered in different ways depending on the needs of your context.

Flexible components are explained and examples, based on our experience implementing TeamBirth, are provided next to each flexible component.



Structured Team Huddles

Huddles

Huddles are structured team meetings that occur throughout care for all laboring patients anticipating live births.

Flexible Components	Examples
Huddle label The team meetings can be labeled with any name that works for your unit; aim to pick a label that can apply to routine meetings of the team and not only emergencies.	» Huddles » TeamBirth huddle » Board huddle » Assessments » Check-ins
Huddle format The team meetings should be in person when possible, but can also be conducted over phone or video conference when needed	» In-person » Speakerphone / video conference
Eligible patients At a minimum huddles should be performed for all laboring patients anticipating live births, but they can also be adapted for others	» Patients with fetal demises » Patients with scheduled c-sections

Direct care team

Huddles should include all members of the direct care team, including the patient and their support people.

Flexible Components	Examples
Direct care team The direct care team should include any support people accompanying the patient as well as the clinical team primarily responsible for the patient's care.	Support People » Partner » Family member » Friend » Doula » Community health worker » Traditional birth attendant Primary Clinicians » Nurse and obstetrician or midwife in US hospital contexts
Other clinicians Other clinicians who are only involved ad hoc can be included in some huddles, but do not have to be in every one	» OB Hospitalist » NICU/Neonatology » Anesthesia » Consulting obstetrician in a midwifery-led context

"Add-on" components are components, tools, and options that can be added to suit the local context. These additional components are based on our experience and that of our partners implementing TeamBirth.

Additional "Add-on" Components

Components which can be added to suit the local context

Discussion Guides & Decision Aids

- Admission discussion guide (patient- or clinician-facing version)
- Labor support guide
- Assisted delivery discussion aid (patient- or clinician-facing version)

Extensions Pre- and Post-Labor

- Prenatal care education / board socialization
- Post-delivery debriefs

Additional support and coaching from the Ariadne Labs team on how to adapt these components for your facility context can be accessed through higher tiers of service on Aria.

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* www.health.org.uk/blogs/collaborate-to-replicate-spread-and-scale-in-health-care

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Flexible Components and Examples

Components which must be done, but that could be delivered in different ways

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Team participation

Huddles should give all team members the opportunity to participate in the conversation.

Flexible Components	Examples
Huddle leader Any member of the team may call for a huddle and/or lead the conversation	» Designate a facilitator to prompt huddle, lead discussion, and ensure all team members have the opportunity to participate
Speaking order Members of the care team may participate in the huddle in any order as long as all members of the team have the opportunity to speak	

Huddle discussion topics

Huddles should discuss preferences, care plans (distinguishing plans for mom, baby, and labor progress), and expectations for the next huddle.

Flexible Components	Examples
Huddle topic order The order in which these discussion topics are covered during the huddles can be adapted to the patient, clinicians, and natural flow of conversation as long as all are covered	» In the order sections appear on the shared visual tool
Care plans Huddles should at least discuss current care plans, but can also discuss future plans and/or adjustments that may happen if conditions change between huddles	» Contingency plans for changes in condition over night

Huddle timing

Huddles should occur throughout labor at a minimum at admission, at decision points or changes in the plan of care, or at the request of any team member.

Flexible Components	Examples
Additional times Huddles may occur at any additional times throughout care that add value for the team	» Transfer of care » Change of shift » Tuck-in (before bed to plan for night-shift contingencies) » Unit-wide prioritization

Shared Labor & Delivery Planning Tool

Tool design

The Shared Labor & Delivery Planning Tool is a visual tool that structures communication and provides space to document discussions during huddles.

Flexible Components	Examples
Tool format We recommend a large (at least 2' x 3'), wall-hung dry erase board, but the shared planning tool format can be adapted if a dry erase board is not feasible in context; however, the adapted format must still be accessible to all direct care team members, including the patient	» Large (at least 2' x 3'), wall-hung dry erase board » Paper handout » Mobile app
Tool aesthetics The aesthetics of the shared planning tool can be adapted as long as it does not detract from the simplicity or usability of the tool	» Colors » Fonts » Branding » Pictures » Orientation (portrait or landscape)

Tool requirements

At a minimum, the tool includes the following sections:

1. The names of all team members,
2. The patient's preferences,
3. Care plans, distinguishing between plans for mom, baby, and labor progress, and
4. Expectations for the next huddle

Flexible Components	Examples
Tool organization The order and size of the sections on the shared planning tool can be adapted depending on the tool format and local context	» Evenly spaced » Larger space for care plans » Timeline labels evenly spaced » Timeline labels spaced based on average length of each phase of labor
Section labels The specific labels for the shared planning tool sections can be adapted as long as the intention and use of each section remains the same	» Adding roles for specific team members (e.g. Mom, Support, Nurse, Provider) » Labels for care plans (e.g. mom vs. maternal, baby vs. fetal) » Next assessment, huddle, or check-in
Additional sections Additional sections can be added to the shared planning tool, but aim to include only the minimum necessary information relevant to the full direct care team and do not include any private information that should not be read by anyone in the room	» Date » Room » Nurse phone number » Last huddle » GA » Medical background » Notes » Pain scale » Questions » Baby's name and stats

Shared, accessible, and relevant

All information included on the Shared Labor & Delivery Planning Tool must be shared, accessible, and relevant for the whole team. The tool should be present in all labor rooms and accessible for all team members throughout labor.

Flexible Components	Examples
Location The shared planning tool can be located anywhere that is accessible to all team members, including the patient from their bed	» Dry erase board on the wall next to or across from the patient's bed
Translation The shared planning tool should be adapted to be accessible to patients and clinicians based on their preferred language and literacy level	» Tools available in alternate languages » Stick-on labels in alternate languages » Icons for low literacy patients and/or support
Adding information Any members of the care team can add information to the shared planning tool	» Support the patient to write their own preferences » Encourage family notes and drawings on the dry erase board

Implementation

Structured quality improvement

Following an intentional structured quality improvement process is critical for the success of TeamBirth, including testing and adapting the solution for your context and providing ongoing coaching, monitoring and evaluation, and feedback to frontline clinicians.

Flexible Components	Examples
Quality improvement process Implementation teams may use any quality improvement process that provides structure and methods for implementation	» Rollout checklist and timeline for the implementation process » Ariadne Implementation Guide
Implementation team While there should be a dedicated team to lead the implementation of TeamBirth, the size and composition of the implementation team can vary based on local context	» Multidisciplinary implementation team » Designated project manager
Testing and adaptation methods Methods for testing and adapting tools and process of TeamBirth for local context, workflow, and practices	» Plan-Do-Study-Act (PDSA) cycles
Coaching and feedback methods Methods for observing and encouraging behaviors and providing respectful, constructive feedback to promote continuous improvement for teams and individuals	» "Office hours" with the implementation team » In-the-moment advice » Prompts / reminder for huddles » Management support for working with late adopters » Targeting positive and negative deviants
Monitoring methods Methods for evaluating fidelity of TeamBirth and capturing feedback (e.g. patient experiences) to motivate teams and measure progress	» Direct observation » L&D or postpartum rounding

Training and onboarding

Since teams come together randomly in labor, all clinicians that are a part of the direct care team in your unit should be trained in TeamBirth processes, including onboarding for new clinicians joining your unit.

Flexible Components	Examples
Training location Training locations can be adapted to meet clinicians where they are in order to reach everyone who is part of direct care teams in your unit	» In unit » In physician offices
Tool rollout order If additional "bolt-on" tools are implemented along with the shared visual tool, the rollout process can be adapted to local context.	» All at once » Shared visual tool and huddles first before bolt-on tools
Socialization methods Methods for engaging with all clinicians, communicating the value of TeamBirth, and inviting their participation in the initiative	» Unit champions who can reach all staff members (e.g. all shifts, all groups) » Multimodal communication methods » TeamBirth bulletin board » Share changes in experience with doctors not regularly on the unit to observe in person » Positive reinforcement » Launch celebration
Training content Training content can be adapted based on your existing approach to quality improvement or competency building on your unit and the key training opportunities to close the gaps between your current practices and TeamBirth	» Education on completing each board quadrant » Standard starting plans for mom, baby, and labor progress (e.g. pain management, intermittent monitoring, and expectant management for low risk moms) » Education on how to have a "productive" huddle » Training on writing in patient-friendly language
Training tools The training content can be supported by different tools to teach, model, or prompt practice	» Videos of good huddles » Script / checklist for huddles » Script for introducing tools to patients and their support » Board practice sheets and examples » Simulations
Additional clinicians trained In addition to members of the direct care team, consider extending training to other clinicians who may participate in huddles ad hoc when their specialties are needed.	» Anesthesia » NICU » Neonatology

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Extensions Pre- and Post-Labor

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- Antepartum huddles / board
- Triage huddles / board
- Post-delivery debriefs
- Postpartum huddles / board

Implementation

- Business plan / data (e.g. financial or patient satisfaction) to build case for leadership
- Predicted investment needed to implement (time, resources, etc.)
- Financial incentives for nurses and physicians
- Media / communications strategy

Community

- Knowledge sharing with other participating hospitals (e.g. ARIA discussion forum)
- Current sites as coaches or "buddies" for new sites

Measurement

Objectives \ Method	Direct observation	L&D rounding	Postpartum rounding	Debriefs	Patient surveys	Patient interviews	Clinician surveys	Clinician interviews	EMR documentation	EMR or administrative data
Fidelity of tool use	■	■	■	■	■	■	■	■	■	
Fidelity of huddle conversations	■	■	■	■	■	■	■	■	■	
Feasibility	■	■	■	■	■	■	■	■	■	
Patient acceptability/experience		■	■	■	■	■				
Clinician acceptability/experience		■	■	■			■	■		
Cesarean delivery rates										■
Maternal and neonatal outcomes										■