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Increasing Lactation Consultant Support on The Maternal Child Health Unit

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NURS 670: Internship

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Abstract

Problem: Breastfeeding is the most beneficial feeding choice for newborns and one of the best ways for mothers to bond with their newborns. In the current Maternal Child Health (MCH) unit, exclusive breastfeeding rates have fallen lower than the unit's goal of 82%.

Context: Exclusive breastfeeding, when a newborn consumes only human breastmilk, is not always an easy process to initiate immediately after birth and in the early postpartum period. On this specific unit, there is not enough lactation consultant support to provide all patients on the unit.

Interventions: This project considers adding additional lactation consultants to support the MCH unit around-the-clock. A plan-do-study-act cycle was conducted to obtain approval for hiring, training, implementing the proposed lactation consultants and for evaluating of the outcome measures being reviewed.

Measures: Lactation consultants will be added to the nursing staff and work alternate shifts to remain available around the clock for breastfeeding needs. Evaluation of the patient satisfaction will be conducted by rounding on the unit and tracking patient satisfaction scores.

Results: Bringing on the additional lactation consultants to the unit, both outcome measures assessed noted improvement, including increased exclusive breastfeeding rates and higher patient satisfaction scores.

Conclusions: After evaluating the results, the Clinical Nurse Leader made a clear presentation to leadership for the need to permanently implement 24-hour coverage of lactation consultants on the MCH unit to ensure the best optimal outcomes for couplets and for unit goals. Ensuring staff and patients feel supported, with certified lactation consultants available at all times, is the most beneficial environment for couplets and staff to thrive in.

Keywords: *breastfeeding, lactation consultant, patient satisfaction, hospital, postpartum*

Introduction

Background

The aim of this improvement project is to add a lactation consultant to the postpartum unit to increase availability for both evening and night shifts to support the needs of new mothers in a San Jose Community Hospital Maternal Child Health (SJO MCH) unit. The collective goal of the unit for mothers and babies has been to maintain exclusive breastfeeding for the first 6 months after birth. Breastfeeding provides both short-term and long-term benefits for mothers and their infants. These benefits are both physical and physiological and include decreased postpartum depression, increased breastmilk production, and maternal weight loss (Anstey et al., 2018). Lactation support is a recurring and crucial need to foster bonding between the postpartum couplet of mom and newborn, especially starting the process within the first hour of birth, also referred to as the *golden hour*. If not started within the golden hour, it is ideal to have assistance on the unit to support the start of the breastfeeding process within the first 48 hours of life. The SJO MCH unit attempts to meet this need currently using one lactation consultant on day shift 5 days a week from 7:00 a.m. to 3:00 p.m.; however, in recent patient care surveys and interviews, the results revealed that additional consultative support is needed around-the-clock and not just simply during the day shift.

Lactation consultants are trained professionals who support and educate and are in full backing of breastfeeding newborns and mothers with the goal of providing breastmilk to their babies. In the current microsystem, it is expected that the designated shift leader, or ideally the clinical nurse leader (CNL), performs daily rounding to check in with each patient and/or couplet on the unit regarding their care, hospital experience, and overall expectations before discharge. During the nurse leader rounding performed 3 days a week on the postpartum unit over 5

months, over 80% ($n = 253$) of postpartum mothers and their support persons verbalized a need for additional lactation support after giving birth. Quantitative and qualitative results have also been reported outside of the discussed microsystem, which reinforce that those mothers who receive early International Board-Certified Lactation Consultant (IBCLC) organized education and support groups in the early postpartum time period, achieve higher breastfeeding self-efficacy and elevate exclusive breastfeeding rates up to 8 weeks postpartum (Lee et al., 2019).

Role of the Lactation Consultant

A lactation consultant, formerly titled IBCLC, is a healthcare professional who may work in healthcare environments and have obtained special training in the clinical management of breastfeeding. The work of a lactation consultant has been known to improve breastfeeding rates, lower health costs, and improve consumer satisfaction and trust (Flynn, 2020). Breastfeeding can be a challenging process and can often become overwhelming for mothers due to its discomforts and scheduling challenges. On the postpartum unit, the lactation consultant's primary focus is to support and facilitate counseling, encouragement, and management of the lactation processes and interactions to meet the needs and goals of families who choose to breastfeed their newborn. Often, newborns are not in a regular routine, and feeding times cannot be anticipated or scheduled, making mothers particularly tired and sleep deprived, leading to exhaustion. In this exhausted state, without the support of an IBCLC readily available to them breastfeeding fallouts occur more often, and the maintenance of exclusive breastfeeding can be interrupted.

The purpose of this quality improvement initiative is to increase the availability of lactation consultant coverage on the unit from 8 hours during day shifts to both evening and night shifts to continuously support mothers on the postpartum unit around-the-clock. In this author's opinion, the problem of unpredictable breastfeeding cycles during the most intimate

bonding time after childbirth will require a review of best practices in the literature and a focused quality improvement project to justify increasing staffing to support a better patient care lactation experience, while also increasing the exclusive breastfeeding rates on the unit to the collective unit goal of above 82% from the current 76%.

Setting

A microsystem assessment using the 5Ps was undertaken in March 2021. The current MCH unit statistics include deliveries at an average of 195 healthy babies per month. Of these 195 births, in 2021, the shared goal of the unit is to achieve an overall breastfeeding score of 82%. In the last 3 months, the rate of breastfeeding was measured at 73.3% in February 2021, 71% in March 2021, and 76% in April 2021. Staff on the MCH unit represent the front lines of care and include three lactation consultants, 159 registered nurses (RNs), eight obstetric technicians, six unit assistants, 15 certified nurse midwives, and 12 obstetrics and gynecology physicians, along with numerous anesthesiologists and pediatricians who rotate within the entire hospital (see Appendix A). According to Godfrey et al. (2017), this team represents a microsystem, “The place where quality is made, and costs are incurred. The special knowledge, skills, and resources of the clinical staff can be used in the clinical microsystem to meet the special needs of an individual patient” (p. 75). As the leader on this busy MCH unit, the role of the CNL aims to ensure that staff are respected and treated as valuable employees with the relevant training and consultant support required to provide high-quality care, specifically, access to 24-hour lactation consultation. In this quality improvement project, the problem of perceived understaffing of lactation consultant coverage in this unit contributes to dissatisfied patients and suboptimal breast-feeding metrics.

Patient Population

The current patient population of the unit is between 15 years and 53 years of age. After delivery, mothers, their babies, and their support person become a couplet and are cared for by a postpartum nurse for the MCH team. Mother and baby are considered a couplet. Many of these couplets are comprised of a full-term newborn, born at older than 38 weeks and without any complications, and a recovering mother, also without any birthing complications. Some newborns are considered small gestational age or large for gestational age and require close glucose monitoring and a great need for colostrum and breastmilk consumption to maintain adequate glucose levels. Also, some mothers experience traumatic birth instances, such as emergency cesarean births, postpartum hemorrhages after giving birth, and assistive device deliveries. All these complications can cause traumatic emotions to linger, causing decreased milk production, or can require the use of medications that reduce pain, but that also cause lethargy and decrease attentiveness. This is known for making mothers less connected to their babies and the needs of their newborns and attempts to breastfeed. Thus, there is an increased need for a lactation consultant to teach either the mother or partner how to apply insights into the newborn's behaviors and signs. Creating a supportive environment for these patients within this microsystem requires the attention of primary care nurses, physicians, and certified nurse midwives, and more common than any other, the lactation consultants, who are now only available less than 8 hours of the 24-hour day. Overseen by the CNL, it has been noted that the support for lactation is missing in the care being provided; however, it is integral to ensure newborns are given the best opportunities to acquire 100% breast milk nutrition.

Problem Description

Newborns and their mothers bond and initiate the routines of exclusive breastfeeding immediately after birth on the labor unit and continue while on the postpartum unit. Although support is present on the unit during the day shift 7:00 a.m. to 3:00 p.m., breastfeeding has and will continue to be a 24-hour process that needs continuous support during the initial postpartum hours. Like many departments within patient care services (PCS), the MCH unit has unit-based goals that are monitored and assessed. For example, one goal is a measure of *breastfeeding fallouts*, which includes metrics related to when a mother who initially states she wants to exclusively breastfeed, subsequently requests formula for her newborn. This can occur for a multitude of reasons, including newborn latch challenges, lack of positioning knowledge, and newborn irritability or frustration with the feeding process. Although this metric is not being captured in this project, it occurs in about 15% of couplets on the postpartum unit, perhaps unnecessarily, if the availability of the lactation support were present. With these common challenges faced by new mothers, an available lactation consultant can provide the support needed to overcome these barriers.

During the March 2021 microsystem assessment (see Appendix A), it was noted that on a daily basis, the current lactation consultant who works the hours of 7:00 a.m. to 3:00 p.m. only sees and works with about seven to eight couplets during an 8-hour shift, which leaves between six to seven couplets unsupported with lactation for an entire 24-hour period. On average, that can leave almost half of the postpartum patient census unsupported by a lactation consultant. Although the lactation consultant on the MCH unit is not expected to be present for every newborn's feeding, it should be the collective goal that a couplet who stays the average 34 hours

on the unit should have at least one one-on-one interaction and feeding session with a certified consultant.

Currently, the regional goal of all medical centers within the organization for percentage by core for human milk is 70% (see Appendix B). Exceeding this goal was the average of all medical centers from October 2019 through February 2021, measuring at 80% among the Northern California regions. These data highlight all facilities and their current breastfeeding rates. Unfortunately, it also notes that the current microsystem being discussed has fallen below average and maintained an average of 76% for exclusive breastfeeding within the same time period. To improve these metrics, the ongoing plan for 2021 has been to follow the core values updated in 2013 of MCH units regionwide from the Kaiser Permanente Care Institute to focus on providing foundational education for outpatient and inpatient clinicians/providers, incorporate cultural humility huddle card messaging to address patient specific concerns, and initiate the use of motivational interviewing techniques to encourage shared decision making and goal setting to enhance exclusive breastfeeding self-efficacy and continuation post-discharge. With this in mind, it is in the best interest of the unit and the responsibility of the CNL to identify, advocate, and develop a plan to overcome the barriers of implementation and maintain an environment of best evidence-based practices (Dang & Dearholt, 2018).

Opportunity for Improvement

Ideally, breastfeeding is completed every 2-3 hours for a newborn learning to latch and bond with their mother. Breastfeeding is not a 7:00 a.m. to 3:00 p.m. process, and support is always needed during a 24-hour period, depending upon many factors intrinsic to mother and baby. The process that is currently in place at SJO MCH starts with mothers who are identified by the primary postpartum RN, then added to a list to be seen by a lactation consultant the next

day for a consultation. If there are no mothers or babies identified as needing to be prioritized for breastfeeding support, it is only then that the lactation consultant will see first time mothers and other couplets on the unit for a drop-in consultation. Unfortunately, this is not efficient and can cause many moms and their newborns to be left behind without support and leads to a decrease in exclusive breastfeeding rates (see Appendix C). Although there is no direct evidence on this specific unit, the barriers are often discussed among nursing staff, and it is the common knowledge that mothers who have had prolonged labors (multiple hours pushing during the second stage of labor) and women who have had cesarean deliveries also have a more difficult experience with breastfeeding. This patient subpopulation often leads to more difficulty for mothers to breastfeed due to exhaustion from labor and the side effects from anesthesia.

One intervention opportunity for improvement would be to support these couplets initially on the labor unit or immediately after transfer to the postpartum unit, in lieu of waiting for couplets to experience difficulties or issues with the breastfeeding process (see Appendix D). This currently is not a part of the process because the consultants are often too occupied on the postpartum unit seeing patients before they are discharged home or spread thinly among the current patient census already transferred to the postpartum unit. Adding additional lactation support would bring forth added support to the MCH patients, along with associated increases in patient satisfaction scores and care experience. According to Harris et al. (2018), “Both quantitative and qualitative research methods in order to effectively evaluate success are required” (pp. 232-233).

Study of the Intervention

Project Overview

The purpose of this project is to add an additional lactation consultant to both evening and night shifts to increase the current coverage present only on day shifts. By adding additional lactation consultant support on the unit, the CNL anticipates an increase of breastfeeding factor scores from the current 82.4% (see Appendix E) to 100%, an increase in patient satisfaction scores from 3.6 stars to 5.0 stars (see Appendix F), and to attain an exclusive breastfeeding rate of 82% (see Appendix G) by December of 2021 or within 6 months of the additional lactation consultant to the staffing core. Considering the implementation of adding lactation consultant hours, it is expected that all postpartum patients on the unit will always have access to this consultant during their hospital stay. The goal is to reach a rate of 82% of exclusive breastfeeding on the unit and provide as much support to all patients to help achieve this goal. As a baseline metric, 72% of the newborns on this unit were exclusively breastfed in 2020, and 28% of the newborns born in 2020 were receiving alternative nutrition, in this case, newborn formula instead of human breastmilk or colostrum.

Improving the rate of breastfeeding is an initiative that will take a consensus effort of all members of the MCH unit. The most important aspect to the project is to have the specialty-trained consultant of lactation for the best overall outcomes for the couplets. Increasing the availability of a lactation consultant to around-the-clock will also increase patient satisfaction scores, making the case of additional staff members beneficial for both the organization and the patient care experience overall.

The American Academy of Pediatrics (AAP), the World Health Organization, and the Institute of Medicine recommend that exclusive breastfeeding for 6 months and continuing for 1

year or more is best for both the mother and infant (AAP, 2012). The Centers for Disease Control and Prevention (CDC, 2020) state, “Comprehensive hospital practices and policies that support breastfeeding have been shown to reduce medically unnecessary formula supplementation, reduce disparities in breastfeeding, and help give infants the best start in life” (p. 2)

Improvement efforts to optimize lactation support and increase breastfeeding rates and related metrics is essential to increase the positive perception of overall care and quality of the hospital stay. Creating a reliable and patient-centered experience of support for lactation and breastfeeding could be the one dimension of service delivery that influences a patient’s choice regarding which hospital they choose to deliver in and to receive care from, as well as which source of healthcare or health plan coverage they choose in the future. As stated by Johnson and Sollecito (2020), “Quality is something that all healthcare providers favor, but it is not, as many would like to believe, something that happens without planning and conscientious effort” (p. 178).

Available Knowledge

PICOT Question

In postpartum patients (P), how does increasing the amount of lactation consultant support hours to 24 hours (I), compared to the current 8 hours (C), influence the rate of exclusive breastfeeding and patient satisfaction scores (O) over a 6-month timeframe (T).

Literature Review and Data Sources

A literature search and review were conducted in May and June 2021, using the CINAHL, Scopus, and PubMed databases (see Appendix H). Additional searches were performed on websites that included the AAP, USDA.org, and the CDC. The search strategy

used in the research was focused on breastfeeding, lactation consultant support, and rates of breastfeeding with and without support on the postpartum unit. Search items included: *breastfeeding, exclusive breastfeeding, lactation consultant, IBCLC, postpartum lactation support, lactation education, breastfeeding education, and rates of breastfeeding*. About 20 results appeared in most combinations of search attempts; therefore, a time period for these articles was limited to 2005-2021.

Cost Analysis

Reviewing the data, over one-quarter of the newborn population in the microsystem would have an increased cost of nutritional support due to the lack of consuming their mother's human milk, which has also been noted to increase the cost of healthcare as a result of this supplemental nutrition. According to the U.S. Department of Agriculture (2019), "Reductions in the incidence of various diseases due to increased breastfeeding among Women, Infants and Children (WIC) participants would have reduced health-related costs to WIC households or their private and Government health insurance providers" (para. 5). These healthcare costs can be caused by the higher incidence rate of lower respiratory disease, asthma, obesity, and necrotizing enterocolitis when infants do not consume human breastmilk, inadvertently costing over \$3 million in healthcare costs for the mother and child over a lifetime (CDC, 2020). In other words, the higher the breastfeeding rates, the lower the overall healthcare costs throughout the newborns lifespan.

Keeping in mind that adding additional staff comes with increased costs to the organization, a cost analysis was performed to determine the overall benefit to the unit. Based on current data published by Glassdoor (2021), the average base salary at Kaiser Permanente of a full-time lactation RN in San Jose is \$135,200 per year, which broken down per hour is \$65/hour

for 40 hours a week. If a non-RN lactation consultant, with no RN license but certified with the IBCLC, were employed, the average base pay is \$81,236 annual salary, or about \$40/hour.

Although there is a drastic difference in salary, it is the preference of the CNL on the unit to employ a licensed RN with IBCLC certification to ensure the care being provided to the couplet includes both the medical knowledge to identify potential issues or complications during the postpartum period, along with the lactation consultation.

In a clearer overview, the cost per year of adding four lactation RNs to the MCH unit is about \$400,000. This figure, compared to the estimated \$3 million increased healthcare costs over the span of a lifetime, in this case 82 years, the average life expectancy in San Jose, California, would be \$36,585 per year; then multiplied by the 30% of couplets on the postpartum unit not exclusively breastfeeding, would total \$26,341,200. Moreover, the organization would spend \$400,000 on increasing lactation support, but save the community and non-profit hospital organization about \$25 million a year (see Appendix G).

Implementing these additional lactation consultants to the MCH unit for an additional 16 hours per day can improve the exclusive breastfeeding metrics and allow for critical time for the bedside nurse to spend with their patients. The lactation consultant RN would not be included in the hours per patient day calculation and would be counted as a continuous permanent support for the unit. The lactation consultant would be expected to provide support for bedside consultation, feeding session assistance, answering questions, and troubleshooting breastfeeding challenge needs throughout the unit over the 24-hour day.

The healthcare system in the United States has become more focused on the need to improve staffing practices and create the best patient outcomes while reducing costs. With the initiation of the Affordable Care Act in 2010, many programs have been established to recognize

hospitals who meet their quality improvement goals and financial goals. Ideally, staffing models should be able to be adjusted in real time to meet the real-time needs of patients, especially with the value-based system that is now in place (American Nurses Association, 2018). Adding an additional resource can help improve the patient's perception of value and actual quality of care received and help support nursing staff without taking away from the staffing model already in place.

Timeline

Adding additional lactation consultants to the unit is a process that is currently being implemented and is the plan moving forward for the postpartum unit. Referring to Appendix J for the Gantt chart timeline, there are many steps in this process. Also included in this Gantt Chart are the rapid cycle testing steps of the plan, do, study, act (PDSA) model for improvement, which offers a systematic approach to quality improvement in practice. Although the CNL has provided all the research findings, evidence, and benefits to leadership, many challenges need to be overcome, including financial feasibility and willingness of the management team to invest the up-front costs for possible financial gain in the future. Overall, the continued support of lactation is necessary to provide the best patient-centered care, and it will be the ongoing role of the CNL on the unit to continually evaluate and refine the processes to better and more efficiently meet the needs of patients (King et al., 2019).

Rationale

Breastfeeding is the preferred method of feeding newborns and is an instinct to many mothers, but an unappreciated and complicated behavior to learn for others. According to the International Board of Lactation Consultant Examiners (2016), "The profession of lactation consulting is young, but as of 2016, there were more than 15,700 IBCLCs in the United States

and close to 29,000 internationally” (p. 52). Most professional organizations and hospital organizations agree that breastfeeding should be supported and encouraged for all mothers and newborns; therefore, lactation education is critical to the postpartum mother. Whether a lactation consultant conducts one-on-one sessions on the postpartum unit or peer group led educational opportunities, the primary concern of many IBCLCs is a commitment to evidence-based practices (Anstey et al., 2018) to ensure all mothers are being provided information on best breastfeeding practices.

Specific Project Aim

In the current MCH unit, by October 2021, the specific aim is to employ lactation consultants who are readily available to improve exclusive breastfeeding rates by at least 6% to obtain an 82% exclusive breastfeeding rate from the time of birth to the time of discharge. The process will begin with adding additional lactation consultants to the staff and then scheduling them to meet the needs of every patient around-the-clock, to include both evening and night shifts.

In working to obtain the best clinical outcomes for both mother and child, the aims of this initiative were based on a framework that could address all aspects of the unit’s needs. Donabedian’s framework is a theory that includes three dimensions of quality that measure structure, processes, and outcomes. As discussed in Sherwood (2017), it is expected that within this framework, structure will support a correct process, which will then acquire the best patient outcomes. According to Gardner and colleagues (2014), “Specific structure elements were shown to influence the quality-of-service processes further validating the framework and the interdependence of the Structure, Process and Outcome components” (p. 1). While many microsystems may not specifically follow the Donabedian framework for quality, according to

Sherwood and Gardner et al., the most successful and high functioning systems that are dedicated to continuous quality improvement are likely to adopt and utilize these principles. Therefore, the specific aim and value of adding staffing to the organizational infrastructure should not be underestimated.

Ethical Considerations

This quality improvement project was approved by the University of San Francisco as an evidence-based change in practice project. Hence, IRB approval was not required (see Appendix K).

Outcome Measure Results

In the hopes to meet all the needs of the patients on the unit, the initial goal was to fill positions to cover additional lactation coverage shifts of evening and night shift. Management approval of the project was granted during the proposal phase of the project start; however, staffing constraints and continued staffing crises within the hospital limited the project to only being able to fill partial coverage of evening shifts and no night shifts until staffing for the unit for nursing care improved. Unfortunately, with the ongoing novel coronavirus pandemic continuing into late 2021, coverage for this project has not yet been met. In the meantime, the CNL continues to evaluate the metrics with the addition of partial evening shift coverage and monitor for any increases in exclusive breastfeeding rates and improved patient satisfaction scores.

With the limited number of lactation consultants being brought onto the unit, changing the budget was also constituted and recalculated. Instead of planning for a budget of employing four additional lactation consultants, the cost analysis was changed and revised to employing only two additional lactation consultants (see Appendix L). This change appears to save the

facility even more; however, the results, based on the evidence, would not expect the same results as 24-hour coverage on the postpartum unit would.

Exclusive Breastfeeding Rates

The intended outcomes of the added lactation intervention were to directly impact the rates of exclusive breastfeeding and the satisfaction rates of patients towards the unit from a breastfeeding perspective. In the 90 days of the temporary position covering evening shifts, the rate for exclusive breastfeeding showed a slight improvement from the initial 76%, but not the intended 6%, as stated in the specific aim. Training was provided for the lactation consultant to include the unit goal for its lactation consultants to be readily available and provide the most support for moms and babies as possible. It was also discussed that within the MCH unit, we intend to maintain a more breastfeeding-friendly staff support system for patients whenever needed during their stay. During nurse leader patient rounding, feedback received was positive and appreciative. Verbatims received were: “We are grateful for ... [help with] breastfeeding and what to expect with the newborn for next few weeks. We couldn’t have asked for more,” and “They listened to all of my questions and provided so much assistance” (National Research Corporation, 2021). There were also suggestions that at previous hospital stays in alternate locations, the night shift lactation consultant was most helpful for the difficult times when a newborn could not get a proper latch. Real-time feedback received was relayed to the postpartum nurses during the shift, who then spent their time assisting the couplet during their shift. It could be said that because of the rounding specific to breastfeeding and lactation, rates improved along with patient satisfaction; however, it could not be excluded that the rates improved because of the additional lactation consultant coverage added to the evening shift either. Creating a sustainable and retainable plan for increasing lactation coverage is still the CNL’s goal to make

lactation consultant availability to MCH patients readily available for both the immediate *golden hour* and the entirety of the postpartum hospital stay.

Overall Patient Satisfaction Scores

Patient satisfaction scores have been assessed in real time, but official HCAHPS data are not yet available for the specific timeframe being observed for this project. As expected, couplets on the postpartum unit have revealed higher overall satisfaction scores since the implementation in August 2021 (see Appendix M). The rate of satisfaction increased from 2.9 to 4.9 stars, correlating with the increased lactation consultant coverage on the unit. It is expected that these scores will reflect in the official HCAHPS survey for these same 90 days, along with sustain the same rating if the increased coverage remains on the unit. Although there is no indication as to how many additional lactation consultants it will take to maintain the improved satisfaction ratings, there is evidence from this initiative that increasing the lactation consultant hours will result in improved satisfaction scores and improved breastfeeding rates.

Summary

Implications for Nursing Practice

Overall, the results of the project are limited because of the constraints made on the number of lactation consultants added to the staffing core on the unit. Although the project did not follow the Project Charter (see Appendix N) verbatim, the project progressed with little variation of the plan documented in the charter itself. If a unit of similar structure were to follow this initiative using the Project Charter created, similar results of improved exclusive breastfeeding rates could be duplicated. With the addition of the two lactation consultants on the unit, for a 90-day period, improvements were seen in both the postpartum exclusive breastfeeding rates and overall patient satisfaction. It is the goal of the unit, with support from

management, to implement additional lactation consultant coverage once budgets and staffing constraints allow. In the meantime, any additional nursing staff on the postpartum and labor units will be assigned to assist with lactation on all shifts and assist mothers with breastfeeding needs, questions, or concerns. Follow-up appointments in the outpatient clinic will also be made for couplets prior to discharge with the IBCLC trained lactation consultant in the clinic chosen by the postpartum mother to ensure post-discharge lactation needs are met, as well. With these implementations, the unit intends on reaching and maintain its goal of 82% exclusive breastfeeding by June of 2022, while also achieving a rate of 4.5-star patient satisfaction scores by December of 2022.

Conclusion

Creating the best outcomes is the goal of most units, and to obtain these outcomes, the quality of the processes must be closely monitored and measured to maintain the overall structure of not only the physical environment but also those care teams who sustain and staff each the unit. Improving the breastfeeding rates, outcomes, and patient satisfaction scores are best supported and attained with the necessary staff, education, and improved infrastructure and processes. In summary, this quality improvement project in MCH reinforced the need for supplementing additional lactation support. This author, a graduate student CNL, believes that the first step in justifying new staffing arrangements and support systems for MCH start and end with listening to the patients and advocating for their stated needs during the complex and exhaustive delivery processes.

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<https://doi.org/10.1177/0193945910380408>

Appendix A

Inpatient Unit Profile – Maternal Child Health

Inpatient Unit Profile						
A. Purpose:						
Why does your unit exist? To provide the members of this area access to safe and comprehensive perinatal, antepartum, and postpartum care.						
		Site Contact: Daniella McClendon		Date: March 15, 2021		
Administrative Director: Barbara Vaughn		Nurse Director: Sara Camperi		Medical Director: Faezeh Ghafarri, OB Chief		
B. Know Your Patients: Take a close look into your unit, create a "high-level" picture of the PATIENT POPULATION that you serve. Who are they? What resources do they use? How do the patients view the care they receive?						
Est. Age Distribution of Pts:	%	List Your Top 10 Diagnoses/Conditions		Patient Satisfaction Scores- See Appendices A-J	% Always	
19-50 years	99	1. Labor	6. Cholestasis	Nurses Appendix A	94.3%	
51-65 years	1	2. Post Dates Induction	7. Chorio	Breastfeeding Appendices B-F	89.9%	
66-75 years	-	3. Gestational DM	8. AMA	Newborn Caregiver Appendix G	94.4%	
76+ years	-	4. Gestational HTN	9.	Pain Management Appendices H-I	Postpartum 90.3% (+10.5)	L&D 88.2% (+7.6)
% Males	0	5. SR0M	10.	Overall Hospital Rating Appendix J	91.3%	
% Females	100			Pt Population Census: Do these numbers change by season?(Y/N)	Y/N	Yes.
Living Situation	%	Point of Entry		Pt Census by Hour	Average 6	
Married	40%	Admissions		Pt Census by Day	Average 20	
Domestic Partner	40%	Clinic		Pt Census by Week	Average 105	
Single	20%	ED		Pt Census by Year	Average 3500	
Live Alone	9%	Transfer		30 Day Readmit Rate	17%	

Live with Others		90%		Discharge Disposition	%	Our patients in Other Units	3%
Nursing Home/SNF		n/a		Home	99%	Off Service Patients on Our Unit	0%
Homeless		1%		Home with Visiting Nurse	-	Re-Direct Status	Unit on Re-direct Status 6 times throughout the last month for more than 8hours.
Patient Type	LOS avg.	Range		Skilled Nursing Facility	-	*Complete "Through the Eyes of Your Patient",pg 8	
Vaginal Birth	30 hours	24-36		Other Hospital	-		*Complete "Through the Eyes of Your Patient",pg 8
Cesarean	40	36-48		Rehab Facility	-		
Fetal Demise	4%			Transfer to ICU	1%		

C. Know Your Professionals:Use the following template to create a comprehensive picture of your unit. Who does what and when? Is the right person doing the right activity? Are roles being optimized? Are all roles who contribute to the patient experience listed?

Current Staff	Day FTEs	Evening FTEs	Night FTEs	Per Diem
MD Total	4	4	4	10
CNMs Total	4	4	4	6
Unit Leader Total	1.5	2.5	2	0
L&D RNs Total	20	22	26	26
Mother Baby RNs Total	12	12	10	6
NICU RNs Total	6	6	5	4
OB Technicians Total	2	2	1	1
Secretaries (UA) Total	2	2	3	4
Lactation Consultants	2	0	0	1

Do you use Per Diems? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> NO	Staff Satisfaction Scores		%
Do you use Travelers? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NO	How stressful is the unit?	% Not Satisfied	80%
Do you use On-Call Staff? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NO	Would you recommend it as a good place to work?	% Strongly Agree	40%



Do you use a Float Pool? _____ Yes _____X___NO			
*Each staff member should complete the Personal Skills Assessment and “The Activity Survey”, pgs 10 - 12			
D. Know Your Processes: How do things get done in the microsystem? Who does what? What are the step-by-step processes? How long does the care process take? Where are the delays? What are the “between” microsystems hand-offs?			
1. Create flow charts of routine processes.	Do you use/initiate any of the following?	Capacity	# Rooms _23_ # Beds _23_
a) Overall admission and treatment process	Check all that apply		
b) Admit to Inpatient Unit	<input type="checkbox"/> Standing Orders/Critical Pathways		
c) Usual Inpatient care	<input type="checkbox"/> Rapid Response Team		
d) Change of shift process	<input type="checkbox"/> Bed Management Rounds		
e) Discharge process	<input type="checkbox"/> Multidisciplinary/with Family Rounds		
f) Transfer to another facility process	<input checked="" type="checkbox"/> Nurse Leader Rounds		
g) Medication Administration	<input type="checkbox"/> Preceptor/Charge Role		
h) Adverse event	<input checked="" type="checkbox"/> Discharge Goals		
		Linking Microsystems (e.g. ER, ICU, Skilled Nursing Facility)	
		OB/GYN Outpatient Clinic and ER	
2. Complete the Core and Supporting Process Assessment Tool, pg 14			
E. Know Your Patterns: What patterns are present but not acknowledged in your microsystem? What is the leadership and social pattern? How often does the microsystem meet to discuss patient care? Are patients and families involved? What are your results and outcomes?			
<ul style="list-style-type: none"> Does every member of the unit meet regularly as a team? Yes. 	<ul style="list-style-type: none"> Do the members of the unit regularly review and discuss safety and reliability issues? No 	<ul style="list-style-type: none"> What have you successfully changed? Nothing, working on adding support. 	
<ul style="list-style-type: none"> How frequently? Monthly 		<ul style="list-style-type: none"> What are you most proud of? Being able to change staff dynamics. What is your financial picture? Declining number of deliveries cause for concern to budget. Staffing changes and adjusts frequently. 	
<ul style="list-style-type: none"> What is the most significant pattern of variation? 		Increased Cesarean surgeries, call for increased LOS and discharge back up, which leads to times when unit goes on a re-direct status.	

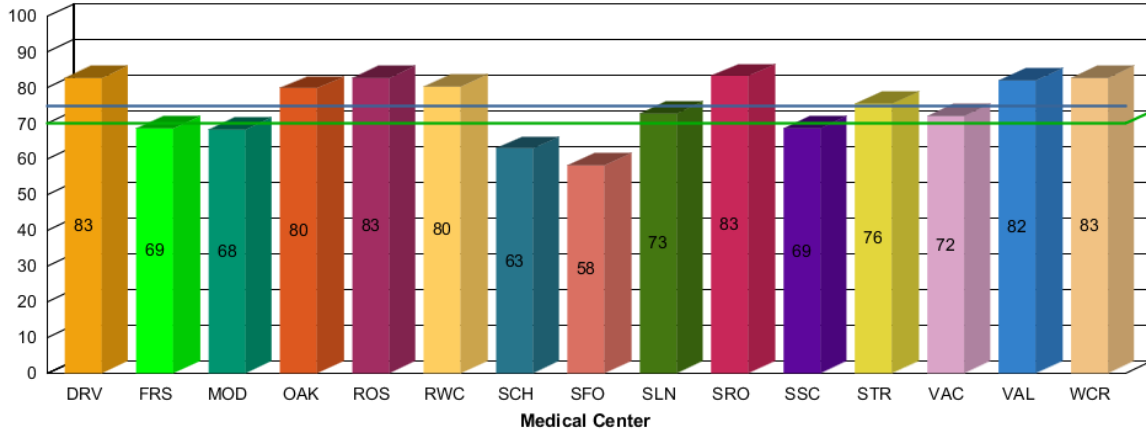
Appendix B

Breastfeeding Rates by Facility Within the Northern California Region

NCLDC0005 PC-05: Breast Feeding-TJC2015B1
 Medical Center: All Medical Centers
 Report Date Range: From 06/01/2021 To 06/30/2021



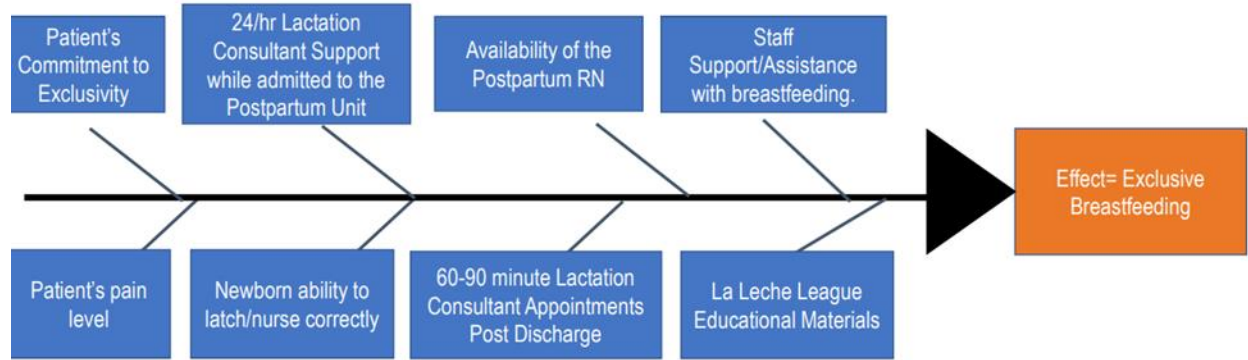
Percentage by Core Measure for Human Milk



* Green line represents the target % of Core Measure for the region. Blue line represents the average % of Core Measure for the region

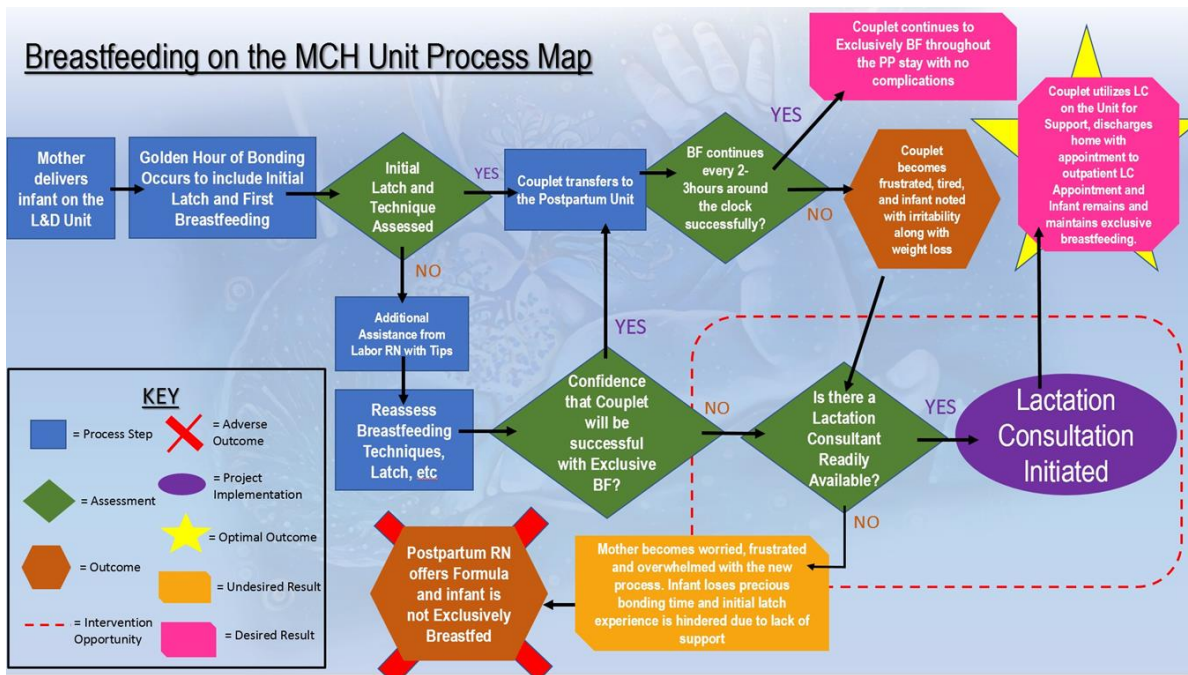
Appendix C

Effects of Exclusive Breastfeeding



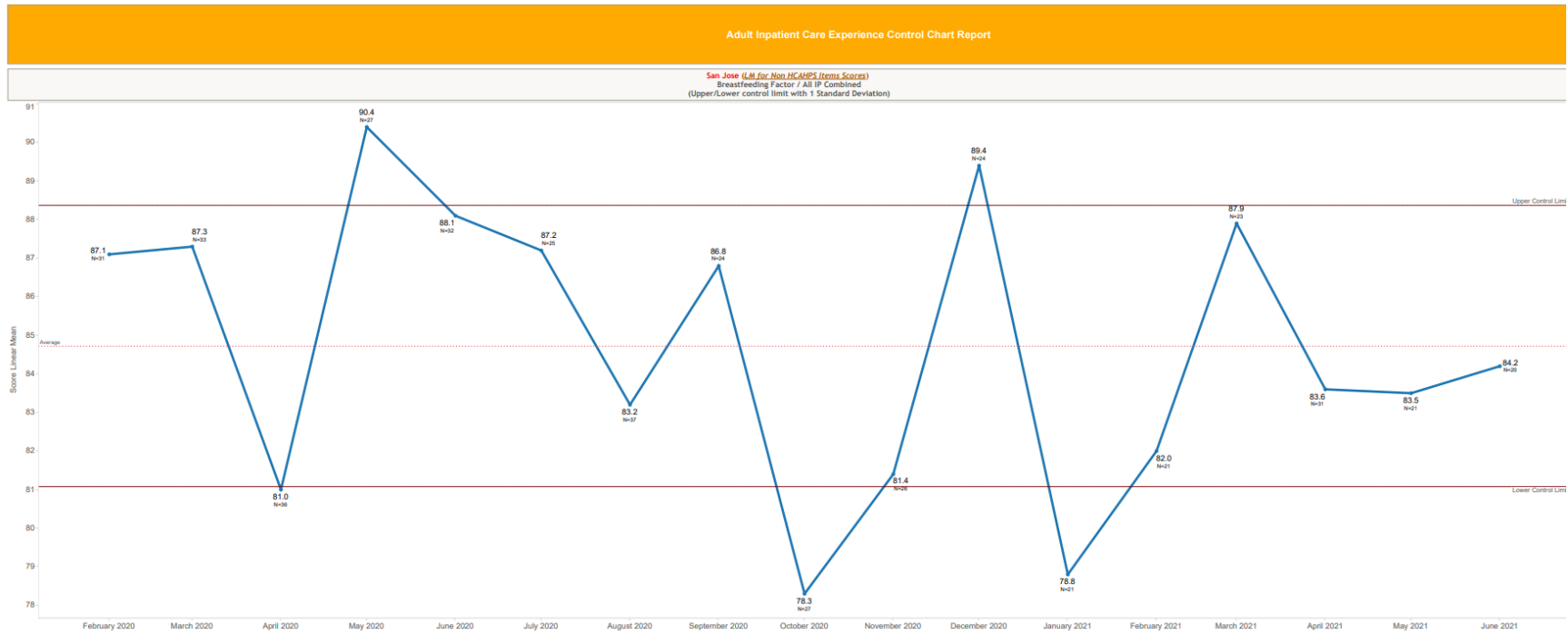
Appendix D

Breastfeeding on the Maternal Child Health Unit Process Map



Appendix E

HCAHPS Scores on Breastfeeding Factor on the Postpartum Unit



Kaiser Permanente-Adult Inpatient Care Experience Control Chart

Source: Kaiser Permanente Care Experience Tool

Appendix F

Overall San Jose Kaiser Permanente – Care Experience Rating – June 2021

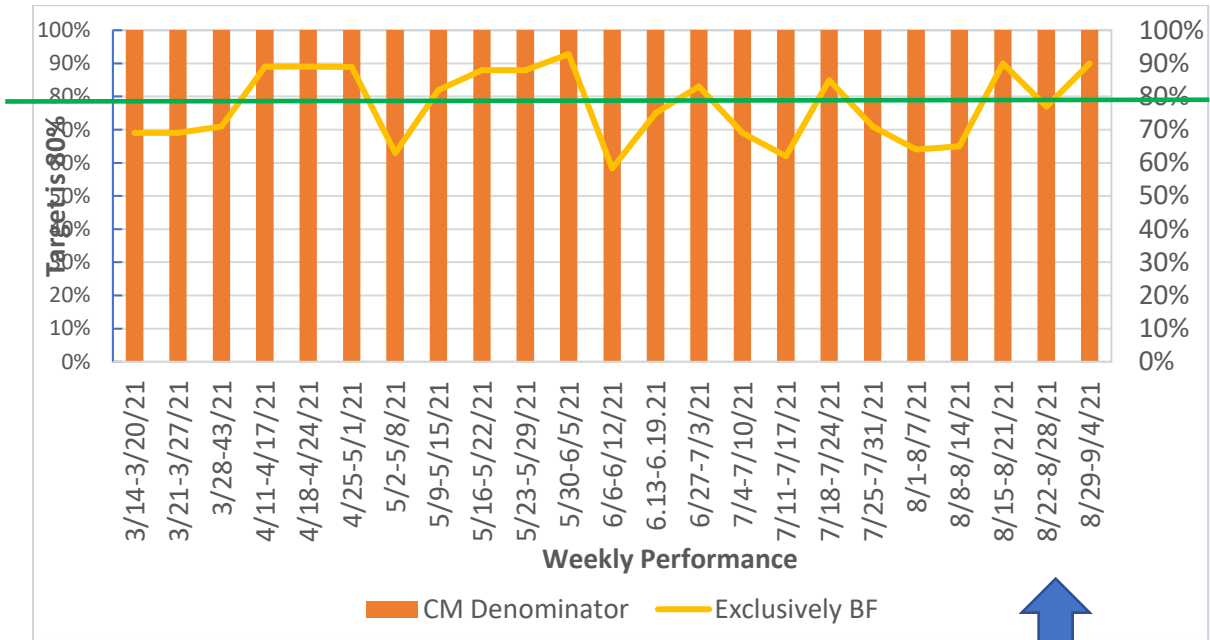


Kaiser Permanente-Adult Inpatient Care Experience Control Chart

Source: Kaiser Permanente Care Experience Tool

Appendix G

Exclusive Breastfeeding Rates from March 14, 2021 Through September 4, 2021



Notes:

Blue arrow represents the start of increased lactation consultants on the unit, August 1, 2021.

Green Line represents the goal of the unit of 80% exclusive breastfeeding.

Appendix H

Evaluation Table

PICOT Question: How does the additional support of a lactation consultant increased to (T) 24 hrs a day from 8 hrs a day (I) improve both the breastfeeding rates and patient satisfaction scores (O) on the Maternal Child Health unit (P)?

	Study	Design	Sample	Outcome/Feasibility	Evidence Rating
1	Anstey, E. H., Coulter, M., Jevitt, C. M., Perrin, K. M., Dabrow, S., Klasko-Foster, L. B., & Daley, E. M. (2018). Lactation consultants' perceived barriers to providing professional breastfeeding support. <i>Journal of Human Lactation</i> , 34(1), 51–67. https://doi.org/10.1177/0890334417726305	Retrospective study	30 IBCLCs practicing in Florida	Provides an insight from the provider perspective on the barriers to breastfeeding. Findings provide insight into the professional management issues of early breastfeeding problems faced by lactation consultants.	III A
2	Bonuck, K. A., Trombley, M., Freeman, K., & McKee, D. (2005). Randomized, controlled trial of a prenatal and postnatal lactation consultant intervention on duration and intensity of breastfeeding up to 12 months. <i>Pediatrics</i> , 116(6), 1413–1426. https://doi.org/10.1542/peds.2005-0435	RCT	304 women	To determine whether an individualized, prenatal, and postnatal lactation consultant intervention resulted in increased cumulative intensity of breastfeeding up to 52 weeks. The intervention combined several best-practice interventions; it offered professional, one-on-one, skills-based, prenatal, and postnatal education and support routinely. Intention to breastfeed at prenatal baseline was assessed in both groups.	I B

3	Cordell, A., & Elverson, C. (2021). Interventions to improve breastfeeding outcomes from six weeks to six months: A systematic review. <i>Western Journal of Nursing Research</i> , 43(6), 583–596. https://doi.org/10.1177/0193945920962118	Systematic review	21 articles	66% of studies significantly increased breastfeeding rates using at least one outcome measure. The most common components included interventions that targeted the breastfeeding women, the education and combination of education with social support, and using face-to-face or telephonic contacts over two separate time periods (one to include immediately postpartum).	III B
4	Haase, B., Brennan, E., & Wagner, C. L. (2019). Effectiveness of the IBCLC: Have we made an impact on the care of breastfeeding families over the past decade? <i>Journal of Human Lactation</i> , 35(3), 441–452. https://doi.org/10.1177/0890334419851805	Quantitative synthesis	119 records/ articles	A review on the effectiveness of IBCLCs and the role they have played in the last 10 years. Discusses the global access to IBCLCs for diverse populations and the influence of the care breastfeeding families need.	IV B
5	Lee, Y.-H., Chang, G.-L., & Chang, H.-Y. (2019). Effects of education and support groups organized by IBCLCs in early postpartum on breastfeeding. <i>Midwifery</i> , 75, 5–11. https://doi.org/10.1016/j.midw.2019.03.023	Quasi-experimental	214 postpartum women	Attending IBCLC organized breastfeeding education and support groups during early postpartum hospitalization may increase mothers breastfeeding self-efficacy and exclusive breastfeeding rates. This is demonstrated in both the self-efficacy percentage rates of the intervention group being higher than that of the control group; along with, the exclusive breastfeeding rates between the intervention group of 61% and control group at 39%, as well.	I A

6	Patel, S., & Patel, S. (2016). The effectiveness of lactation consultants and lactation counselors on breastfeeding outcomes. <i>Journal of Human Lactation</i> , 32(3), 530–541. https://doi.org/10.1177/0890334415618668	Meta synthesis of 16 studies with 5,084 participants identified for a systemic review of 44 full text reports	N/A	Of the studies, 15 were RCTs and 1 a cRCT. Overall findings that healthcare settings serving low-income populations should consider the use of lactation consultants and counselors in their education and support programs. Developing and improving intrapartum support programs that can be delivered face-to-face in the hospital, in the clinic, and at home or via telephone contact. Antenatal education can also improve maternal health outcomes.	II A
7	Van Dellen, S. A., Wisse, B., Mobach, M. P., & Dijkstra, A. (2019). The effect of a breastfeeding support programme on breastfeeding duration and exclusivity: A quasi-experiment. <i>BMC Public Health</i> , 19(1), N.PAG. https://doi.org/10.1186/s12889-019-7331-y	Quasi-experimental	158 participants	Breastfeeding support program is effective to delay cessation of any and exclusive breastfeeding cessation, therefore, increases breastfeeding duration and exclusivity.	III B
8	Wambach, K. A., Aaronson, L., Breedlove, G., Domian, E. W., Rojjanasrirat, W., & Yeh, H.-W. (2011). A randomized controlled trial of breastfeeding support and education for adolescent mothers. <i>Western Journal of Nursing Research</i> , 33(4), 486–505. https://doi.org/10.1177/0193945910380408	RCT	289 primiparous adolescent mothers, primarily of African American race or decent	Using in-home and telephonic lactation consultant interventions, including in-hospital postpartum and in-home, and telephone lactation consulting interventions improve breastfeeding duration. Also, using combinations of education, peer and professional support, have demonstrated effectiveness in increasing initiation and higher intensities of breastfeeding, but not exclusivity.	I B

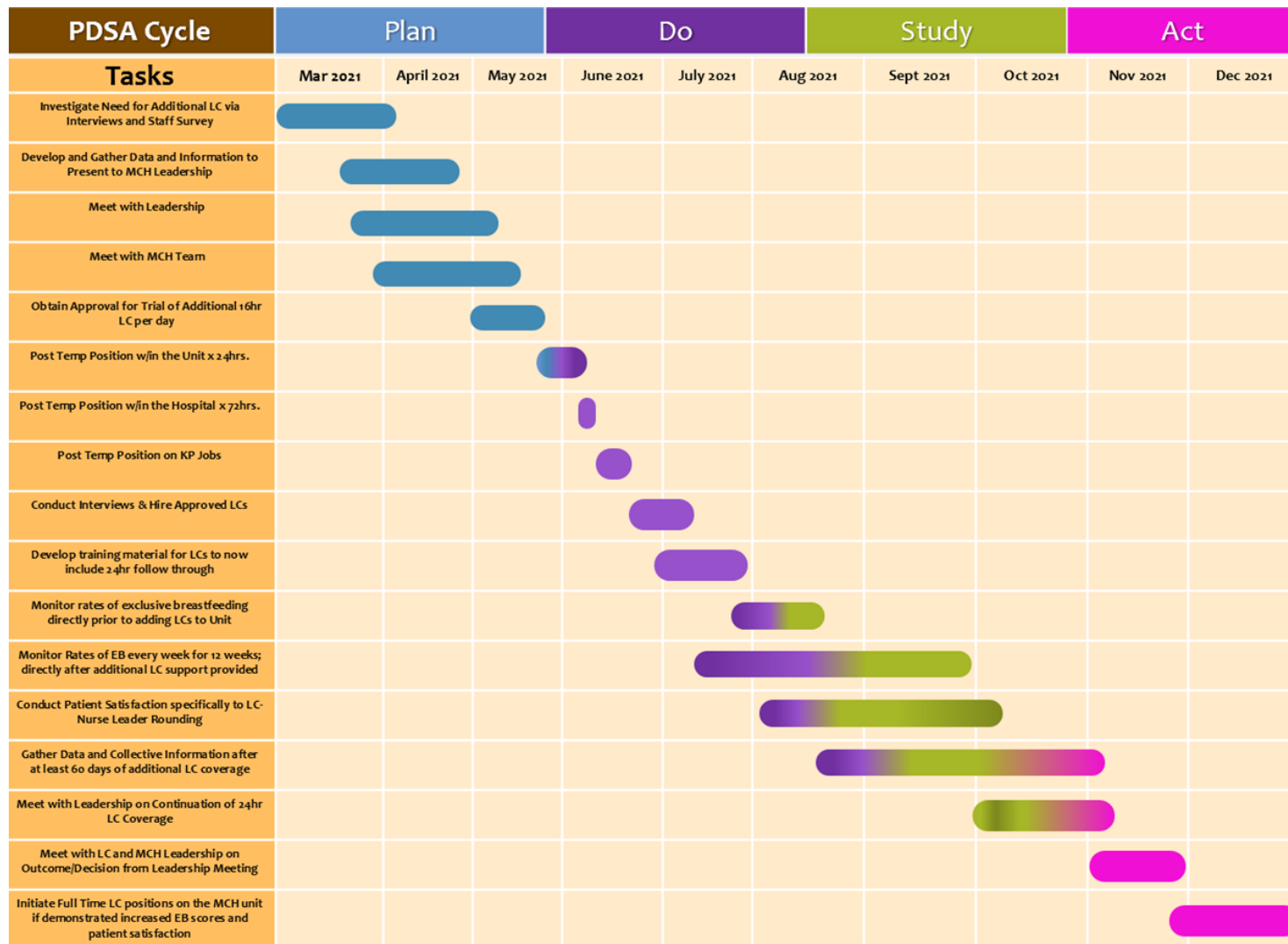
Appendix I

Projected Budget

Adding Additional Lactation Consultants to the MCH Unit	
EXPENSES	
Salaries and Wages (includes benefits at 35%)	
Lactation Consultant (0.8 FTE) [\$65 X 32HRS X 52 WEEKS]	\$108,160
Lactation Consultant (0.8 FTE)	\$108,160
Lactation Consultant (0.6 PTE) [\$65 X 24 HRS X 52 WEEKS]	\$81,120
Lactation Consultant (0.6 PTE)	\$81,120
Subtotal Salaries and Wages	\$378,560
Supplies Expenses (Shared computer, Desk, Supplies, etc.)	\$10,000
Subtotal Supplies	\$10,000
Total Expenses	\$388,560
SAVINGS	
Increased Lifetime Healthcare Costs Per Year [\$3,000,000 / 82 years]	\$36,585
	X
[Average total number of MCH deliveries per year 2,400 X Number of newborns not exclusively breastfeeding on the unit 30%]	720
Overall Healthcare Costs Per Year	\$26,341,200
Total Savings	\$25,952,640

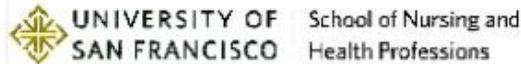
Appendix J

Gantt Chart



Appendix K

Statement of Non-Research Determination



CNL Project: Statement of Non-Research Determination Form

Student Name: Daniella McClendon

Title of Project: Adding Additional Lactation Support to the MCH Unit

Brief Description of Project:

A) Aim Statement: To improve the % of exclusively breastfeeding mothers on the postpartum unit to 82% from the baseline of 76% by adding an additional 16 hours of lactation consultant on the unit.

B) Description of Intervention: The purpose of this project is to add an additional lactation consultant to both evening and night shifts to increase the current coverage present only on day shifts. With adding additional lactation consultant support on the unit, the Clinical Nurse Leader on the unit will note an increase in patient satisfaction scores and attain an exclusive breastfeeding rate of 82% before this year's end or within 6 months of the added L.C. to the staffing core.

C) How will this intervention change practice? Considering the implementation of adding lactation consultants, it is expected that all postpartum patients on the unit and will always have access to this consultant during their hospital at any time.

D) Outcome measurements: The goal is to make lactation consultants readily available and provide the most supports for moms and babies as possible. We aim to improve exclusive breastfeeding rates by at least 6% to obtain an 82% exclusive breastfeeding rate, from the time of birth to the time of discharge by the end of 2021. The benefits are; better health outcomes for both mother and newborn, a more breastfeeding-friendly staff support system for patients and increased patient satisfaction scores on the overall postpartum unit.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:
(<http://answers.hhs.gov/ohrp/categories/1569>)

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UNIVERSITY OF SAN FRANCISCO | School of Nursing and Health Professions

- This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.
- This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

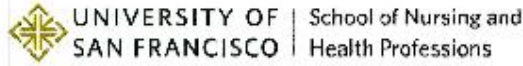
Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title: Increasing Lactation Consultant Support on The Maternal Child Health Unit.	YES	NO
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	✓	
The specific aim is to improve performance on a specific service or program and is a part of usual care. All participants will receive standard of care.	✓	
The project is NOT designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does NOT follow a protocol that overrides clinical decision-making.	✓	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards.	✓	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.	✓	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONIIP.	✓	
The project has NO funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	✓	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	✓	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: "This project was undertaken as an Evidence-based change of practice project at Kaiser Permanente-San Jose hospital or agency and as such was not formally supervised by the Institutional Review Board."	✓	

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ANSWER KEY: If the answer to ALL of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files. If the answer to ANY of these questions is NO, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Holmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print): Daniella McClendon

Signature of Student:

DATE 7/6/2021

SUPERVISING FACULTY MEMBER NAME (Please print):

Signature of Supervising Faculty Member

DATE _____

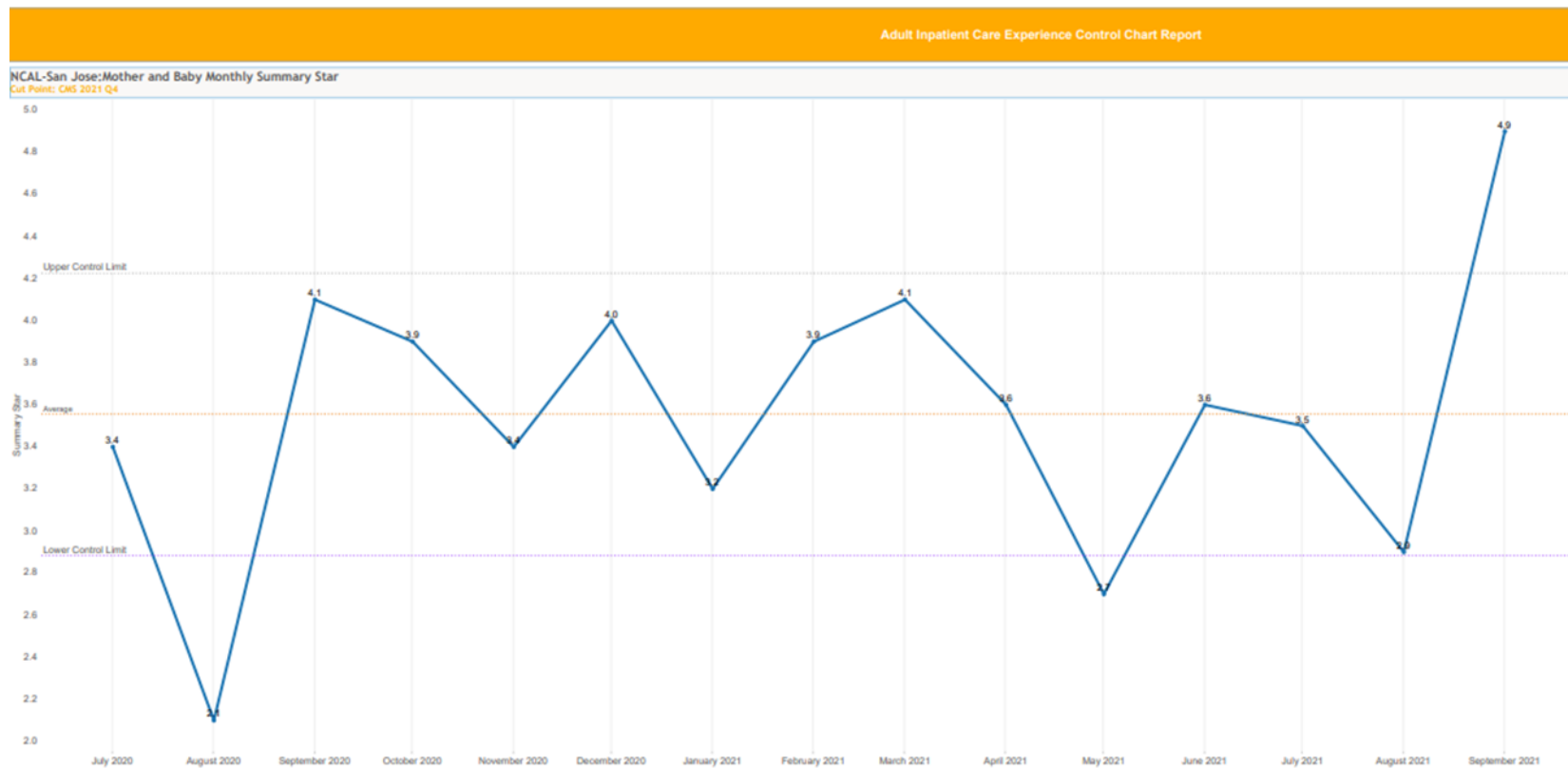
Appendix L

Adjusted Budget

Adding Additional Lactation Consultants to the MCH Unit-Revised Budget	
EXPENSES	
Salaries and Wages (includes benefits at 35%)	
Lactation Consultant (0.8 FTE) [\$65 X 32HRS X 52 WEEKS]	\$108,160
Lactation Consultant (0.6 FTE) [\$65 X 24 HRS X 52 WEEKS]	\$81,120
Subtotal Salaries and Wages	\$189,280
Supplies Expenses (Shared computer, Desk, Supplies, etc)	\$10,000
Subtotal Supplies	\$10,000
Total Expenses	\$199,280
SAVINGS	
Increased Lifetime Healthcare Costs Per Year [\$3,000,000 / 82 years]	\$36,585
	X
[Average total number of MCH deliveries per year 2400 X Number of newborns not exclusively breastfeeding 30%]	720
Overall Healthcare Costs Per Year	\$26,341,200
Total Savings	\$26,141,920

Appendix M

Overall San Jose Kaiser Permanente – Care Experience Rating – September 2021



Appendix N
Project Charter

Adding Additional Lactation Consultants to the MCH Unit-Project Charter

Daniella Grace McClendon

Practicum: Quality Improvement and Outcomes Management

Cathy Coleman, DNP, RN, CPHQ, PHN, CNL

Summer 2021

Project Title: Adding Additional Lactation Consultants to the MCH Unit

University/Organization Name: University of San Francisco in partnership with Kaiser

Permanente

Problem

Newborns and their mothers' bond and initiate the routines of exclusive breastfeeding while on the post-partum unit. Although support is present on the unit during the day shift, there is no support other than the primary nurse on both evening and night shifts. Breastfeeding has and will continue to be a twenty-four-hour process that needs continuous support during the initial post-partum hours.

Global Aim Statement: Increase availability of Lactation Support on the Postpartum Unit by 16 hours over the next 5 months.

Specific Aim Statement: To improve the % of exclusively breastfeeding mothers on the postpartum unit to 82% from the baseline of 76% by adding an additional 16 hours of lactation consultant on the unit.

Rationale

It is the recommendation of the American Academy of Pediatrics with mutual recommendation by the World Health Organization and the Institute of Medicine that exclusive breastfeeding for 6 months and continuing for 1 year or more is best for both the mother and infant (AAP,2012).

The purpose of this project is to add an additional lactation consultant to both evening and night shifts to increase the current coverage present only on day shifts. With adding additional lactation consultant support on the unit, the Clinical Nurse Leader on the unit will note an increase in patient satisfaction scores and attain an exclusive breastfeeding rate of 82% before this year's end or within 6 months of the added lactation consultant (LC) to the staffing core.

The Centers for Disease states that "Comprehensive hospital practices and policies that support breastfeeding have been shown to reduce medically unnecessary formula supplementation, reduce disparities in breastfeeding, and help give infants the best start in life." To improve these metrics, the plan for 2021 has been to "focus on providing foundational education for outpatient and inpatient clinicians/providers, incorporate cultural humility huddle card messaging to address patient specific concerns and initiate the use of motivational interviewing techniques to encourage shared decision making and goal setting to enhance exclusive breastfeeding self-efficacy and continuation post-discharge" (KPCI, 2013).

Considering the implementation of adding lactation consultants, it is expected that all postpartum patients on the unit will always have access to this consultant during their hospital stay. The goal is to reach a rate of 82% of exclusive breastfeeding on the unit and provide as much support to all patients to help achieve this goal.

As the CNL on the unit the goal is to maintain the integrity of the role and demonstrate leadership in guiding the department towards the stated initiatives. One of the competencies aimed in this project are described by King et al. to, "advocate for the value and role of the

professional nurse as member and leader of interprofessional healthcare teams. Understand other health professions' scopes of practice to maximize contributions within the healthcare team" (pp 17-18).

Goals: The goal is to make lactation consultants readily available and provide the most supports for moms and babies as possible. We aim to improve exclusive breastfeeding rates by at least 6% to obtain an 82% exclusive breastfeeding rate, from the time of birth to the time of discharge by the end of 2021. The benefits are:

- 1) Better health outcomes for both mother and newborn,
- 2) A more breastfeeding-friendly staff support system for patients
- 3) Increased patient satisfaction scores

How Will We Know a Change Is an Improvement?

Outcome (or Project) Measure(s)

Measure	Data Source	Target
Outcome		
% of exclusive breastfeeding couplets on the Postpartum Unit	Chart Review	82%
Number of hours per week Lactation Consultant Scheduled/Worked	Schedule Review	168 hours (24hrs x 7 days= 168hrs)
Process		
% of overall patient satisfaction scores	Kaiser Permanente Care Experience Tool	100%

HCHAPS Scores on Breastfeeding Factor on the Post-Partum Unit	Kaiser Permanente Care Experience Tool	100%
Percentage of Patients who Knew How to Obtain Lactation Assistance on the Post-Partum Unit	Kaiser Permanente Care Experience Tool	100%
Balancing		
Decrease of Patient Satisfaction Scores on the Postpartum Unit	Kaiser Permanente Care Experience Tool	<5%

Team:

MCH Director
Nurse Manager
Assistant Nurse Managers
Obstetrician
Pediatrician
Anesthesiologist
Midwife
Patient Representative
Postpartum RNs
Labor RNs
NICU RNs

References

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- Kaiser Permanente Care Institute (KPCI). (2013). *Improving hospital breastfeeding support implementation toolkit*. Kaiser Permanente Medical Care Program.
- King, C. R., Gerard, S. O., & Rapp, C. G. (2018). *Essential knowledge for CNL and APRN nurse leaders*. Springer Publishing Company.

Appendices

Appendix A

Measurement Strategy

Background (Global Aim): Increase availability of Lactation Support on the Postpartum Unit by 16 hours over the next 5 months.

Population Criteria: Mothers and infants (couplets) admitted to the post-partum unit of the Maternal Child Health Unit.

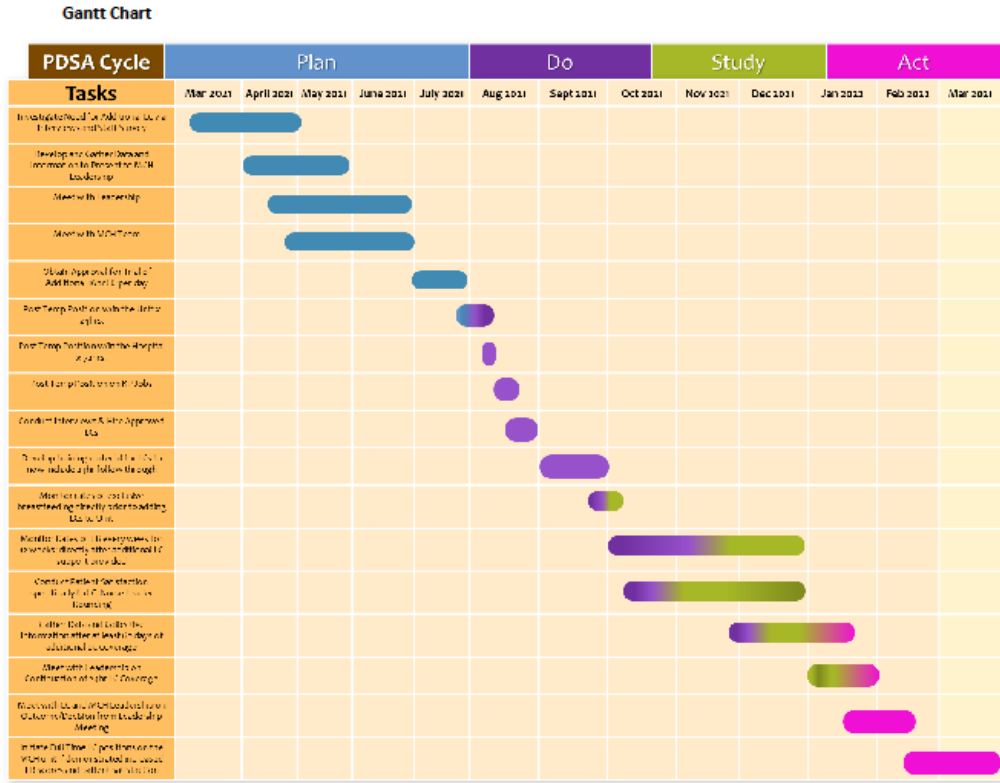
Data Collection: Data will be obtained via patient interviews and rounding on the postpartum unit, chart reviews and evaluating patient care experience tools to determine patient satisfaction scores. After the baseline data is collected immediately prior to the implementation of the additional lactation consultant hours, the same data will be tracked and followed over the course of 90 days and be reevaluated at the end of the trial period of the 90 days to determine if the implementation of additional LC hours in fact increased exclusive breastfeeding (EB) scores and patient satisfaction ratings.

Data Definitions:

Data Element	Definition
LC Hours Per Day	Number of hours per day/week Lactation Consultant Scheduled/Worked
EB Couplets	Number of exclusive breastfeeding couplets on the postpartum unit
Attended Feedings	Number of feedings lactation consultant assisted with
Nurse Leader Rounding Scores	Satisfaction/Dissatisfaction comments obtained via Nurse Leader Rounding

BF Factor HCHAPS Score	HCHAPS Scores on Breastfeeding Factor on the Post-Partum Unit- Obtained During Post Discharge Survey
Patient Knowledge of LC Availability Scores	Percentage of Patients who Knew How to Obtain Lactation Assistance on the Post-Partum Unit-Obtained During Post Discharge Survey
Overall Postpartum Patient Satisfaction Scores	Patient Care Experience Scores on the Post-Partum Unit-Obtained During Post Discharge Survey

Appendix B



Appendix C

CNL Competencies

Essentials	Description	CNL Competencies
Essential 2: Organizational and Systems Leadership	<ul style="list-style-type: none"> Apply leadership skills and decision making in the provision of culturally responsive, high-quality nursing care, healthcare team coordination, and the oversight and accountability for care delivery and outcomes. 	<ul style="list-style-type: none"> Evaluate the efficacy and utility of evidence-based care delivery approaches and their outcomes at the microsystem level. Collaborate with healthcare professionals, including physicians, advanced practice nurses, nurse managers and others, to plan, implement and evaluate an improvement opportunity.
Essential 6: Health Policy and Advocacy	<ul style="list-style-type: none"> Advocate for policies that improve the health of the public and the profession of nursing 	<ul style="list-style-type: none"> Advocate for policies that leverage social change, promote wellness, improve care outcomes, and reduce costs.
Essential 7: Interprofessional Collaboration for Improving Patient and Population Health Outcomes	<ul style="list-style-type: none"> Advocate for the value and role of the professional nurse as member and leader of interprofessional healthcare teams. Understand other health professions' scopes of practice to maximize contributions within the healthcare team. 	<ul style="list-style-type: none"> Facilitate collaborative, interprofessional approaches and strategies in the design, coordination, and evaluation of patient-centered care.
Essential 8: Clinical Prevention and Population Health for Improving Health	<ul style="list-style-type: none"> Synthesize broad ecological, global, and social determinants of health; principles of 	<ul style="list-style-type: none"> Monitor the outcomes of comprehensive plans of care that address the health

	<p>genetics and genomics; and epidemiologic data to design and deliver evidence based, culturally relevant clinical prevention interventions and strategies.</p>	<p>promotion and disease prevention needs of patient populations</p>
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