SESLHD POLICY COVER SHEET

NAME OF DOCUMENT	Maternity Services Clinical Escalation Policy
TYPE OF DOCUMENT	Policy
DOCUMENT NUMBER	SESLHDPD/273
DATE OF PUBLICATION	September 2016
RISK RATING	Medium
LEVEL OF EVIDENCE	NSQHS 1, 1.10 and 10.3
REVIEW DATE	September 2019
FORMER REFERENCE(S)	PD 290 'Maternity Services Escalation Policy'
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	A/Prof Danny Challis Director Women and Children's Clinical Stream
AUTHOR	Dee Sinclair CNC Maternity Clinical Risk Management
POSITION RESPONSIBLE FOR THE DOCUMENT	Dee Sinclair CNC Maternity Clinical Risk Management dee.sinclair@health.nsw.gov.au
KEY TERMS	Escalation, concern, inform, communication, maternity, clinical escalation
SUMMARY	The Policy is specific to Maternity Services and provides advice and clarity to clinical staff to escalate clinical situations of concern. The policy should be used in conjunction with NSW Ministry of Health Policy Directive PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating

Feedback about this document can be sent to seslhd-executiveservices@health.nsw.gov.au

1. POLICY STATEMENT

Maternity service users in South Eastern Sydney Local Health District (SESLHD) are entitled to safe, appropriate care. Staff members working in Maternity should voice their concerns about any clinical care and/or decision-making, which they perceive may adversely impact on safety. If necessary their concerns should be escalated to senior staff, in order to minimise the risks of adverse outcomes.

Midwives are autonomous practitioners in providing care for women with normal pregnancies. Midwives work collaboratively with obstetricians in order to identify deviations from the norm during pregnancy, birth and in the postnatal period, and refer deviations from the norm appropriately. The National Midwifery Guidelines for Consultation and Referral, published by The Australian College of Midwives (ACM) is a National Framework to provide individual midwives with an evidence based pathway for consultation and referral of care between midwives, doctors and other health care providers.

In recent years, a number of reports have been published by the Clinical Excellence Commission (CEC) and NSW Health identifying common themes which have resulted in adverse outcomes in Maternity Services. Recommendations to mitigate against such outcomes increasingly include escalation pathways and strategies.

1.2 EVIDENCE FOR ESCALATION

The NSW CEC focus report in 2013: *Fetal Monitoring: Are we getting it right,* made 11 recommendations for care. Recommendation 11 prompted services to *"Enhance the confidence of maternity staff confidence to escalate concerns through the provision of graded assertiveness training."*

Fetal wellbeing, Obstetric emergency, Neonatal resuscitation and Training Program (FONT) is Mandatory Training for all clinicians working in Maternity Services. The training provides multidisciplinary role play which also improves confidence in staff to escalate in situations of clinical concerns.

Misinterpretation of Electronic Fetal Heart Rate patterns is a common theme. The CEC report published in 2013 – *Fetal Monitoring: Are we getting it right?* cites numerous cases where inadequate monitoring and interpretation of clinical observations contributed to delays in diagnosis and treatment of fetal distress.

2. AIM

The overall aim of this policy is to ***ensure that escalation occurs in a timely manner to provide safe evidence based care for service users.***

Where a staff member is not satisfied with the response they receive from the midwife, doctor or nurse who has reviewed the patient, they are required to notify the next person in seniority and provide details of why they are dissatisfied with the initial woman or baby's review.

Possible scenarios are cited below:

- The duty obstetric team is asked not to enter a room where progress of labour varies from normal.
- A midwifery team leader perceives that the duty registrar has misinterpreted the baseline fetal heart rate, resulting in the incorrect categorisation of the overall fetal heart rate pattern.

- A midwife is asked to commence syntocinon at full dilatation by a consultant, when she/he interprets the fetal heart rate pattern as pathological.
- A team leader, during a busy shift, believes that the review of the woman by a registrar underestimates the clinical significance of a post-partum haemorrhage.
- A baby is 'grunting' for a prolonged period post birth, and the midwife is of the opinion that the baby should be admitted to Special Care Nursery for observation, but the duty neonatal/ paediatric resident medical officer does not agree.

3. TARGET AUDIENCE

- Departmental MUMs/ NUMs
- Registered Midwives/Nurses
- Medical Staff
- After hours Nurse/ Midwifery manager

4. IMPLEMENTATION

4.1 The clinician's concerns should be documented in the woman's and/or baby's medical record, as well as a description of their clinical condition at the time. Judgments in respect to an individual clinician's clinical practice must not be documented, only objective data regarding the patient's condition and management plan should be included.

4.2 As per NSW Ministry of Health Policy Directive PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating, the frequency of observations should be reviewed and increased as required, and maintained until a further review and plan of management has been made and documented in the medical record.

4.3 Where the situation remains unresolved, to the satisfaction of the staff member who is concerned, the consultant should be contacted and a clear request made for a further expert opinion and/or assistance as appropriate. This conversation and any subsequent clinical management plan should be clearly documented in the medical record.

4.4 If the nominated or on-call consultant responsible for the woman or baby cannot be contacted, the obstetric director of the specialty should be contacted directly. If there is any conflict in regards to treatment, the after hours Nurse/Midwifery Manager and/or the midwifery manager of the service should be contacted.

4.5 If at any time a staff member has difficulty contacting the next level of seniority, the Director of Clinical Services or Executive member on-call should be contacted directly. Appendix 1 details the Maternity Services Clinical Escalation Policy Flow Chart.

5. COMMUNICATION

The on-call consultant is frequently required to make decisions regarding clinical management. In making these decisions the consultant is dependent upon the accuracy of the information provided. For this reason, protocol language should always be used as per local policy, RCOG/RANZCOG/FONT guidelines. This is particularly relevant for discussion around fetal heart rate patterns. **Appendix 2** details the accepted terminology in NSW for the interpretation, escalation and referral of fetal heart rate patterns.

It is critical that communication is clear, concise and accurate between both parties. It is

recommended that ISBAR (Introduction, Situation, Background, Assessment and Request) is used in all interactions. Instructions received for ongoing management plans should be clear, have established timelines and documented in the medical record following the conversation using the same accepted protocol terminology.

6. DEFINITIONS

Fetal heart rate pattern definitions can be found at **Appendix 2**

7. DOCUMENTATION

Partogram, Antenatal and Intrapartum fetal heart rate pattern adhesive labels, clinical notes, Maternal postnatal pathways, neonatal care plan, standard maternity observation chart, standard neonatal observation chart, PACE forms/ stickers.

8. REFERENCES

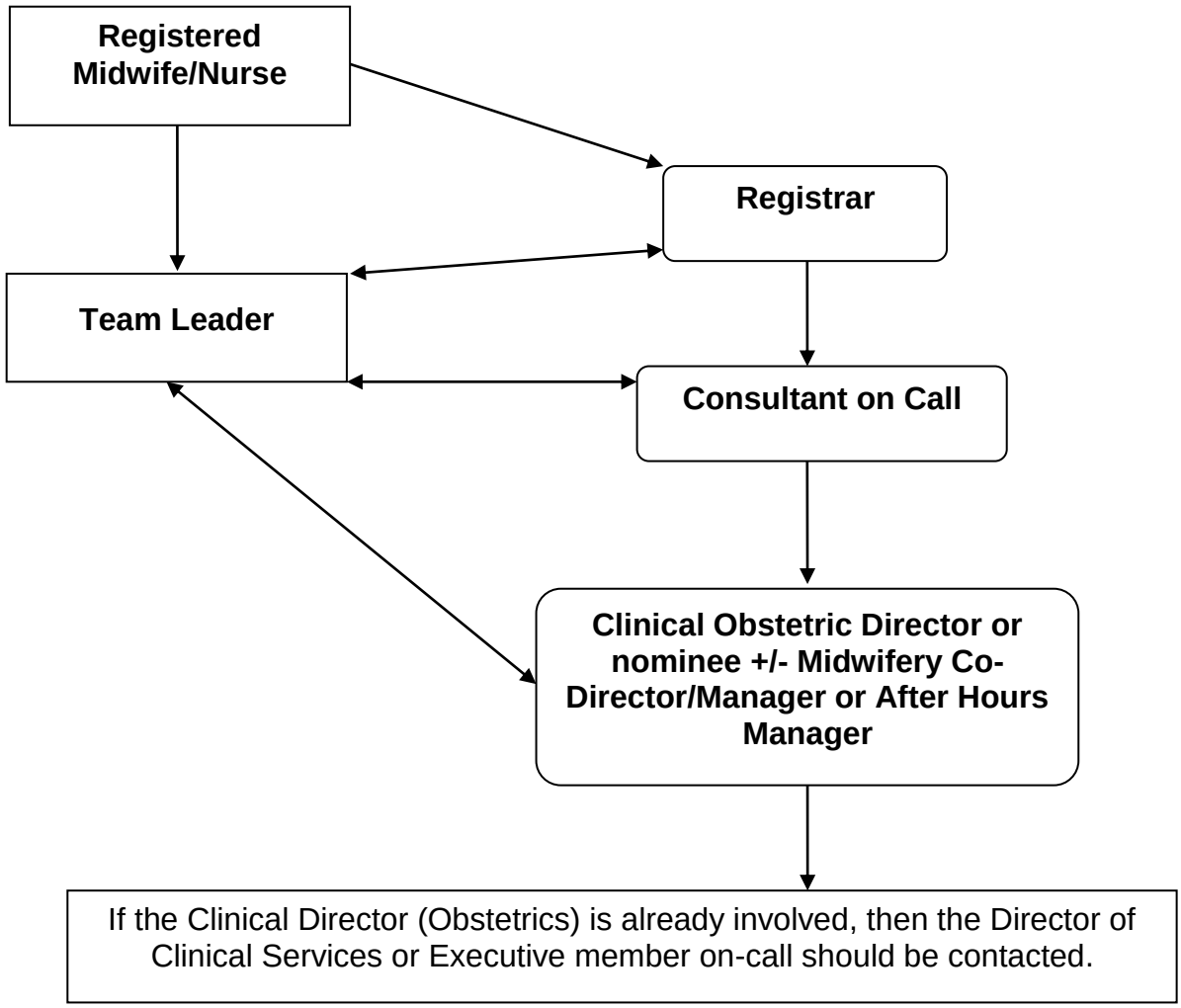
- Australian College of Midwives. 2013 National Midwifery Guidelines for Consultation and Referral 3rd Edition.
- NSW Ministry of Health Information Bulletin IB2008_002 Fetal Welfare, Obstetric Emergency, Neonatal Resuscitation Training
- Clinical Excellence Commission Partnering with Patients
- National Institute of Clinical Excellence (NICE), Clinical Guideline 90 Intrapartum care for Healthy Women and Babies, December 2014
- NSW Health Clinical Excellence Commission (CEC) Patient Safety Team Focus Report 2013 'Fetal Monitoring- Are we getting it right?'
- NSW Ministry of Health Policy Directive PD2009_060 Clinical Handover - Standard Key Principles
- NSW Ministry of Health Guideline GL2016_001 Maternity - Fetal Heart Rate Monitoring
- NSW Ministry of Health Policy Directive PD2013_049 Recognition and Management of Patients who are Clinically Deteriorating
- Royal College of Obstetricians and Gynaecologists. The Use of Electronic Fetal Monitoring Evidence-based Clinical Guideline Number 8, 2001.
- REACH is a 2015 CEC initiative; Recognise, Encourage, Act, Call, Help is on its way (REACH) developed from the CEC initiative Partnering with Patients; this encourages relatives to request that a PACE call is initiated if they have concerns in regards to their relatives/ baby's condition.

9. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
May 2014	3	Reviewed by Dee Sinclair, CMC Maternity Clinical Risk Management
July 2016	4	Reviewed by Expert Group, endorsed by Clinical Governance Committee
July 2016	4	Updates endorsed by Executive Sponsor
September 2016	4	Final draft submitted to Executive Services with associated paperwork

Appendix 1: Maternity Services Clinical Escalation Policy Flow Chart

- All health care professionals are duty bound to ENSURE that the best care is provided. It is not acceptable to collaborate with sub-optimal standards of care, because a staff member was *'obeying instructions'.*
- Concerns about clinical care and/or ethics by the on- call clinician, that do not appear to have been addressed appropriately by protocols, should be acted upon.
- This policy does not affect PACE calling criteria which must be adhered to.
- The correct pathway for escalation is demonstrated in the flow chart below. It outlines a process for addressing clinical concerns which will apply to most facilities.
- Professional judgment must be exercised when it is deemed that a more senior member of staff is required to review the situation.



Appendix 2: Antenatal Fetal Heart Rate Pattern Interpretation and Management Algorithm

Between the Flags
Keeping patients safe

Antenatal Fetal Heart Rate Pattern Interpretation and Management Algorithm

Identified Risk for Antenatal FHR Monitoring	Maternal	Any change in maternal condition where you consider there may be compromise to fetal welfare. Conditions may include those covered in PD2010_040 for example: • *Uncontrolled hypertension* • *APH* • *Preterm labour*
	Fetal	Where there is a suspicion that fetal welfare may be compromised. For example: • *Absent or decreased fetal movement* • *IUGR* • *Non-reassuring finding on auscultation*

Features	**Contractions**	**Baseline Rate** (bpm)	**Variability** (bpm)	**Reactivity** (Two accelerations present in 10 mins)	**Decelerations**
Reassuring	• Nil • Present >37/40	110–160	≥ 5	Present	• None • Single isolated
Non-reassuring	• Present <37/40	100-109 161-179	• < 5 for > 30 mins • >25 for >15mins	Absent >30mins	• Repetitive • Shallow • Prolonged < 3 mins
Abnormal	• Tonic >2min • ≥6:10	< 100 > 180	• < 5 > 40mins • Sinusoidal ≥ 10mins	Absent >60mins	• Prolonged > 3 mins

Management Plan - Clinical Response

Reassuring features	Cease monitoring. All features of the fetal heart rate pattern are reassuring, and /or there is no perceived risk of fetal compromise as the maternal condition stabilises, ie: bleeding placenta praevia
One or more non-reassuring features	Keep monitoring with ongoing assessment. Escalate to the midwife in charge (Team Leader) or medical officer for a clinical review within 30 mins (*do not give food or oral fluids*)
One or more abnormal features	Notify a medical officer for immediate review. Consider further fetal welfare assessment and/or consider expediting birth

*** A clinician may call for a clinical review at any time if they are concerned or unsure.**

Between the Flags
Keeping patients safe

Intrapartum Fetal Heart Rate Pattern Interpretation and Management Algorithm

DR = Determine Risk is *continuous* electronic fetal heart rate monitoring required?	Maternal	Any maternal condition or intervention where you consider there may be compromise to fetal welfare. These may include those covered in PD2010_040 for example: • *Pre-eclampsia* • *Syntocinon* • *Previous Uterine Surgery*
	Fetal	Where there is a suspicion that fetal welfare may be compromised. For example: • *Non-reassuring finding on auscultation* • *Suspicion of IUGR* • *Preterm labour* • *Meconium stained liquor*

	C	**BRa**	**V**	**A**	**D**
Features	**C**ontractions	**B**aseline **R**ate (bpm)	**V**ariability (bpm)	**A**ccelerations	**D**ecelerations
Reassuring	≤5 in 10 mins	110–160	≥ 5	Present	None or Early
Non-reassuring	6-7 in 10 mins	100–109 161–180	• < 5 for 40 mins • >25 for >15mins	The absence of accelerations with otherwise normal trace is of uncertain significance	• Typical variable decelerations with over 50% of contractions, occurring for > 90 mins • Atypical variable or late decelerations over 3 consecutive contractions • Single prolonged deceleration for up to 3 mins
Abnormal	• >7 in 10 mins • Tonic >2mins	< 100 > 180	• < 5 for 90 mins • Sinusoidal pattern ≥ 10 mins		• Either atypical variable decelerations with over 50% of contractions or late decelerations, both for >30 mins • Single prolonged deceleration for more than 3 mins

O = Overall Assessment

Classification	Definition
Normal	A pattern where all features are normal
Suspicious	A pattern where there is **1 Non-Reassuring** feature
Pathological	A Pattern where there are **2 or more Non-Reassuring** or **1 or more Abnormal** features

Fetal Blood Sampling

Interpretation	pH	Lactate
Normal	≥ 7.25	<4.2
Suspicious	7.21–7.24	4.3 -4.8
Abnormal	≤ 7.20	>4.8

Management Plan - Clinical Response

Normal	Keep monitoring if the maternal or fetal risks are unchanged. Consider intermittent electronic FHR monitoring if the woman needs to ambulate
Suspicious	Keep monitoring with ongoing assessment. Escalate to the midwife in charge/Team Leader or medical officer for clinical review within 30mins
Pathological	Notify medical officer for immediate review. Consider further fetal welfare assessment (fetal blood sampling) and/or consider expediting birth

(based on the RCOG and NICE Guidelines 2007)

*** A clinician may call for a clinical review at any time if they are concerned or unsure.**

Appendix 3: Neonatal Services Clinical Escalation Policy Flow Chart

- All health care professionals are duty bound to ENSURE that the best care is provided. It is not acceptable to collaborate with sub-optimal standards of care, because a staff member was *'obeying instructions'.*
- Concerns about clinical care and/or ethics by the on- call clinician, that do not appear to have been addressed appropriately by protocols, should be acted upon.
- This policy does not affect PACE calling criteria which must be adhered to.
- The correct pathway for escalation is demonstrated in the flow chart below. It outlines a process for addressing clinical concerns which will apply to most facilities.
- Professional judgment must be exercised when it is deemed that a more senior member of staff is required to review the situation.