Maternity Services

Internal Audit Clinical Tool (MAT IACT)

June 2017

IACT Background

The IACT was developed in a project with East Grampians Health Service and the Victorian Managed Insurance Authority (VMIA).

MAT IACT Content

The MAT IACT is for use in Victorian public hospital maternity services and is presented in the following four sections:

1. Quality Systems Evaluation – a review of the implementation of the main quality systems that underpin service delivery in the maternity service.
2. Clinical Documentation Evaluation - a review of the documents that support clinical processes in the maternity service
3. Clinical Data Review – a review of the type of patient related maternity and neonatal data that is monitored and analysed by the organisation for quality improvement purposes
4. Patient Record Review – a review of patient medical records for general clinical processes occurring in all stages of maternity care. The patient files used will comprise a mixture of randomly selected files and files representing women and neonates with complex outcomes of care (for details of staff assistance, sampling and recording see Part 4)

Using the MAT IACT

The MAT IACT is used by the internal auditor with an independent clinical expert in obstetrics. The complete tool can be used for a comprehensive review or selected criteria may be used to focus in on areas of significant risk (e.g. intrapartum care). The scope of the audit, the number of criteria and the patient groups is agreed by the team before starting

The MAT IACT columns are as follows

* *Criteria*: the definition of what is being measured objectively through the internal audit process
* *Desired processes to address criteria*: Lists the various processes that are examined to provide evidence of meeting the criterion
* *Evidence to support processes*: Lists the possible sources of evidence that may be used to determine if the process for each criterion are present (note additional evidence may be sought by the internal audit team)
* *Method of data collection*: Lists possible methods of collecting evidence related to each process such as staff interview or document review
* *Phase* – Provides suggestions as to whether the evidence could be reviewed onsite or offsite. This may help planning the requirements for pre audit offsite documentation and documentation required onsite
* *IA+/-CE expert* –provides suggestions for who may be involved with each phase of evidence collection the internal auditor (IA) or the (clinical expert)

Recording the results

This tool is used to record the information from the audit. The ‘Evidence to Support Process’ column is populated with the evidence for each criterion.

Part 4: The patient file data for Part 4 is documented on the separate data collection sheets and the cumulative score is recorded in the evidence columns.

The cumulative score for each criterion enables re-audit after recommendations have been implemented.

Criteria rating

Each organisation will have their own system of rating of controls and the priority of recommendations. In part 4 of the tool the clinical expert rates the aggregate findings in terms of severity (as described below). This allocation of rating, by the clinical experts allows the internal auditor to incorporate clinical findings and recommendations from Part 4 into the final audit report.

Scoping the Tool

The scope of the audit is finalised by discussion by the internal auditor with the organisation.

\*Note: the numbering of criterion is consistent across the tool and data collection templates so any amendment of the tool to reflect the new scope should not alter the numbering.

This first part of the internal audit tool aims to evaluate the implementation and effectiveness of organisation wide quality structures and systems that support quality care and control risk in the maternity service.

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| CRITERIA | DESIRED PROCESSES TO ADDRESS CRITERIA | EVIDENCE TO SUPPORT PROCESSES  (record evidence sighted) | METHOD OF DATA COLLECTION | PHASE | IA and or CE |
| **POLICIES AND GUIDELINES** | | | | | |
| 1. Current maternity service policies and procedures are available to staff | * 1. Policies, procedures and protocols are regularly reviewed/updated (minimum 3 yearly) | *Clear process documented for regular review of policies, procedures and protocols*  *Sample of policies and procedures have last review date and next review date documented* | Document review | *Offsite* | IA |
| * 1. Periodic monitoring of compliance with maternity service policies and procedures, protocols occurs through audit or other evaluation processes? | *Audits and Clinical audit schedules and reports*  *e.g. Documentation schedules and individual audit reports* | Staff Interview,  Document Review | *Offsite/Onsite* | IA |
| * 1. A clear process exists by which maternity service policies and procedures are distributed to, accessible and understood by employees. | *Clear process documented for distribution and staff acknowledgement including*   * *Access for visiting staff and locum staff* * *May include employee acknowledgment of* *their receipt of the information and /or confirmation that they have read and understand* | Staff interview  Document review | *Onsite* | IA |
| **WORKFORCE** | | | | | |
| 1. New staff receive appropriate orientation to the maternity service | * 1. The maternity service has orientation guidelines, procedures, checklists and logs to ensure comprehensive orientation for the clinical workforce (including locum staff) in key areas identified through a risk based approach | *Maternity service* *orientation procedures, guidelines, checklists*  *Sample of staff have orientation to the maternity service recorded in appropriate documentation/log* | Staff interview  Document review | Offsite/Onsite | IA |
| 1. New staff have appropriate skills and knowledge of maternity services | * 1. New medical and midwifery staff undergo initial credentialling [[1]](#footnote-1)reviewed to ensure skills and knowledge are current and approriate to the individual scope of practice | *Credentialling policy/procedure*  *Audit of new staff personnel files for initial credentialling including:*   * professional credentials in midwifery and obstetrics or GP credentials (Diploma of the RANZCOG or Dip RANZCOG Advanced) * registration and any restrictions of scope * review of practice * review of current organisation mandatory training requirement which may include:   *- Neonatal resusIACTion (NNR)*  *- Adult Basic Life Support (Adult BLS)*  *- Fetal Surveillance Education Program (FSEP)*  *- Obstetric emergency training (MSEP or PROMPT)*  *-Other mandatory training requirements* | Document review | Onsite | IA &CE |
| 1. Existing staff are competant to undertake their defined scope of practice | * 1. Periodic re credentialling of staff occurs to ensure skills and experience are appropriate to deliver a defined scope of practice | Audit of staff personnel files/log/records for re-credentialling including:   * registration status and any restrictions of scope of practice * review of recent practice * review of current organisaton mandatory training which may include :   *- Neonatal resusIACTion (NNR)*  *- Adult Basic Life Support (Adult BLS)*  *- Fetal Surveillance Education Program (FSEP)*  *- Obstetric emergency training (MSEP or PROMPT)*  *-Other mandatory training requirements*  *Clear evidence of restriction of scope of practice if organisation mandatory training requirements are not met* | Document review | IAIA |  |
| 1. Staff undertake professional development relevant to the maternity service and their individual scope of practice | * 1. The maternity service has a documented education plan for medical and nursing staff based on: * type and frequency of competency based requirements for maternity skills * needs analysis of staff * consideration of key maternity risks | *Maternity Services Education Plan which addresses education to be provided by the organisation and the frequency required (e.g. annual) and may include:*   * *Organisation Mandatory competency requirements( with specified frequency):*   *-Neonatal resuscitation (NNR)*  *- Adult Basic Life Support (Adult BLS)*  *- Fetal Surveillance Education Program (FSEP)*  *- Obstetric emergency training (MSEP or PROMPT)*  *-Other mandatory areas e.g. medication, ultrasound*   * *Other education identified in relation to risks and service model* | Document review  staff interview | Offsite/ Onsite | IA |
|  | * 1. The education program is periodically evaluated for effectiveness | *Documentation of education program evaluation*   * *analysis of attendance, outcomes* * *recommendations* * *Frequency of evaluation* | Document review | Off |  |
|  | * 1. Individual professional development requirements for maternity service staff are identified through annual performance appraisals, and then planned and implemented. | *Audit of Personnel files to see individual professional development*  *This may include mentoring in the workplace e.g. RANZCOG FSEP Practitioner level guidelines to guide the mentoring of less experienced staff in fetal surveillance see* (Fetal Surveillance Education Program) |  |  |  |
|  | * 1. Clinical review meetings are regularly held to review cases e.g. cases that required transfer or review of intervention triggered by CTG (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014 3rd edition) | *Schedule of clinical review meetings and attending staff* | Document review | Onsite | IA &CE |
| 1. Individual scope of practice is defined and periodically reviewed | * 1. The scope of practice of individual staff in the maternity service is documented | *Log of scope of practice or addendum to position description documenting approved scope of practice such as:*   * *Ability to administer anaesthetic* * *Ability to perform planned/emergency caesarian section* * *Ability to perform ultrasound* |  |  |  |
| * 1. Review of scope of practice occurs in relation to the implementation of new procedures or equipment | *Evidence of training for new equipment or amendment to scope of practice* | Document review  Staff interview | Onsite | IA +CE |
| 1. Appropriate levels of staffing in the maternity service | * 1. The rosters demonstrate staffing in the maternity service is appropriate | *Roster consistent with staffing requirements (medical, nursing, administrative and other personnel) according to the level of maternity service as defined in the DHHS capability framework* (Department of Health, 2010) *(see table 2: workforce )* | Document review  Staff interview | Onsite | IA +CE |
| 1. Appropriate access to specialist consultation | * 1. Appropriate access to specialist consultation is demonstrated | *Access to specialist consultation consistent with the level of the maternity service (see workforce table 2) is evident through:*   * *the staff rosters* * *access through telehealth consultations* * *Through consultation , and referral or transfer of care agreements between other health services of higher level consistent with the level of the maternity service* | Document review  Staff interview | Onsite | IA +CE |
| 1. Appropriate access to support services | * 1. Appropriate access to support services such as allied health, interpreters, incontinence and lactation consultants through rosters and referral arrangements ( as guided by the capability framework (see workforce table x)) | *Access to support services consistent with the level of the maternity service (see table 2:workforce) is evident through:*   * *the staff rosters* * *access through telehealth consultations*   *-Through consultation , and referral or transfer of care agreements between other health services of higher level consistent with the level of the maternity service (see table 2:workforce)* | Document review | Onsite | IA +ED |
| 1. Staff culture in the maternity service is at an acceptable level | * 1. Workforce culture in the maternity service is regularly assessed, analysed and responded to. | *Workforce culture evaluation and analysis may include :*   * *staff satisfaction surveys* * *review of turnover rates* * *review of sick leave rates* | Document review  Staff interview. | Offsite/Onsite | IA |
| **RISK MANAGEMENT** | | | | | |
| 1. Risk identification and assessment occurrs regularly | * 1. The maternity service identifies and manages maternity services risks (including clinical) | *Current risk profile or register for maternity service* which *includes clinical risks* | Review risk register | Onsite | IA |
| * 1. A risk based methodology is applied to the approval of new procedures and equipment, within the maternity service | *Applications for use of new equipment/procedures with evidence that a risk assessment has been undertaken* | Document review  Staff interview. | Onsite | IA |
| 1. Monitoring of maternity service risk occurs regularly | * 1. Risks that have been identified as requiring action have assoIACTed action plans with strategies for risk reduction, timelines and clear responsibilities (risk owners) | *Review risk register for maternity service risk action plans* | Document review | Onsite | IA |
|  | * 1. Maternity service risks are escalated in line with the organisation’s risk management framework | *Evidence of risk escalation to appropriate level* | Document review | Onsite | IA |
| 1. Controls put in place to manage key risks are monitored for effectiveness | * 1. Contols to mitigate key risks (procedures, clinical guidelines compliance) are tested through periodic audit or other means | *Audit occurs against known high risks* | Document review | Onsite | IA |
| 1. Risk reporting and communication is effective | * 1. The risk profile of the maternity service is reviewed at the relevant meeting/committee | *Periodic risk profiling and reporting* | Document review | Offsite | IA |
| 14.2 Communication to staff occurs regarding key maternity service risks and emerging risks and management strategies (minutes, agendas, bulletins) | *Evidence in minutes, agendas, bulletin* | Document review  Staff interview, | Onsite | IA |
| 1. All incidents and near misses are reported, appropriately documentated and managed | 15.1 Maternity service incidents, adverse events and near misses are recorded in the incident system | *Review of incident database* | Incident database review  Staff interview, | Onsite | IA and CE |
| 15.2 Management are able to track the incident trends in the maternity service and there is evidence of action taken | *Incident reporting e.g. rates, trends data over 3yr period* | Report review | Onsite | IA and CE |
|  | 15.3 Root casue analysis or in depth case review of serious incidents or adverse events is undertaken in the maternity service | *Review incident database (DHHS requiement for all sentinel events and incident severity rating 1 to have root cause analysis*) | Incident database review  Staff interview, |  |  |
| 15.4 Maternity service staff are familiar with the open disclosure process | *Open Disclosure Policy/procedure*  *Evidence staff familiar with process* | Document review  Staff interview | Onsite | IA +CE |
| **QUALITY IMPROVEMENT** | | | | | |
| 1. Responsibility for quality improvement is clearly assigned in the maternity service | 16.1 Clear responsbilities for monitoring and responding to quality issue have been allocated in the maternity service and individuals understand and enact their responsbilities in relation to quality | *Management and staff Position descriptions document e.g. Responsibilities for*   * *quality plan oversight and implementation* * *Audits and Clinical audits* * *Monitoring and reporting on quality* * *Development and review of clinical pathways* * *Sentinel event monitoring and incident investigation* * *Complaint investigation and resolution* | *Position descriptions Staff interview* | *Offsite/ onsite* | IA |
| 1. The accountability and reporting mechanisms for quality of care in the maternity service are documented and followed | 17.1 Clear accountabilities for the maternity service quality of care are reflected through regular metrics/reports provided in line with a reporting framework, relevant quality committees and management and the board | *Evidence of scheduled reports or reporting framework with specification of reporting frequency, accountability and responsibility. Data reported may include:*   * *DHHS maternity indicators* * *Organisation generated maternity data* | Document review | Onsite | IA+CE |
| 17.2 There is a process in place and regular meetings to feedback results of any monitoring or audits and any action arising to maternity service staff | *Reports and minutes , newsletter demonstrate communication to staff in relation to monitoring and related quality improvement actions* | Document review  Staff interview | Onsite | IA +CE |
| 1. Quality improvement is a planned coordinated activity | 18.1 There is a quality improvement plan in place for the maternity service | *Quality plan demonstrating:*   * *clear links to whole of hospital strategic quality initiatives* * *timeframes, responsibilities, evaluation measures* | Document review  Staff interview | Onsite | ED |
| 18.2 The evaluation of improvement initiatives are undertaken through analysis of data | *Evidence of the use of data in monitoring over time in evaluation of improvement initiatives* | Document review  Staff interview | Onsite | IA +CE |
| **PATIENT EXPERIENCE** | | | | | |
| 1. Maternity service Patient experience is periodically evaluated with appropriate tools | The analysis of patient experience/satisfaction in maternity service is undertaken and analysed periodically to improve quality of care | *Evidence of recommendations from patient experience analysis implemented and evaluated e.g.* | Document review | Onsite | IA+CE |
| 1. Appropriate resolution of maternity service complaints | 20.1 The analysis of complaints in maternity service is undertaken and analysed periodically to improve quality of care including the assessment of: | *Complaints policy and procedure*  *Analysis of complaints process*   * *Types of complaints* * *Timely response to complaints* * *The percentage of complaints resolved* | Document review | Onsite | IA |
| **INFRASTRUCTURE** | | | | | |
| 1. IT systems support recording and reporting on key data | A functional electronic patient information management system that enables data reporting and monitoring in the maternity service | *A safe effective data system that allows:*   * *Timely reporting of maternity data* * *Data presented in a format that enables analysis e.g. trends* * *Secure system with password protection and timeout* | Staff Interview | Onsite | IA and CE |
| 1. Appropriate management of maternity service financial resources | A departmental budget is linked to the organisations operational plan (which aligns with the organisation’s strategic plan) | *Maternity Services budget with links to unit operational plan and organisational strategy* | Document review  Staff interview | Onsite | IA |
| 1. The infrastructure resources of the maternity service are managed appropriately | 23.1 There is an equipment maintenance register that is current | *Equipment register covers maternity equipment* | Document review | Onsite | IA |
| 23.2 Equipment appropriate to the maternity service is available when needed | *Equipment as defined in the Department of Health cabability Framework for Victorian maternity and newboard services* (Department of Health, 2010)*.( see table 3: Equipment)* | Document review  Facilities inspection | Onsite | IA |
| 23.3 There is an effective system for restocking essential items |  | Staff interview | Onsite | IA and CE |

This second part of the internal audit tool aims to evaluate the appropriateness of documents (policies, procedures and guidelines) that support clinical processes that control risk in the maternity service. Many of these documents may be reviewed offsite prior to the onsite visit.

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| CRITERIA | DESIRED PROCESSES TO ADDRESS CRITERIA | EVIDENCE TO SUPPORT PROCESSES  (record evidence sighted) | METHOD OF DATA COLLECTION | PHASE | IA and or CE |
| **GENERAL** | | | | | |
| 1. Maternity and neonatal services are integrated and coordinated at a regional level | Consultation, referral and transfer processes are established and documented | *Documented processes exist between health services with different levels of maternity and newborn care within the region (refer table 1) and include:*   * *agreed level of registered medical personnel, or other specialist clinicians who can initiate coordinating processes* * *agreed clinical criteria for referral and transfer of women to and from services* * *agreed clinical criteria for referral and transfer of neonates to and from services* * *agreed referral pathways for access and referral to specialist clinicians* * *referral and transfer processes* * *trigger mechanisms for local emergency health interventions* * *agreed process for organising emergency retrieval* | Document review | Offsite | CE |
| 1. All maternity service procedures and protocols are evidence based and reviewed periodically | Maternity service clinical procedures/protocols reference current clinical standards and guidelines. | *Documents cite current clincial standards and guidelines. This is supported by a system to make readily available clinical standards, decision support tools and guidelines e.g. up to date, RANZCOG guidelines, RWH guidelines etc* | Document  Evidence database review | Offsite/onsite | CE |
| **ANTENATAL CARE** | | | | | |
| 1. Appropriate antenatal care is provided at a suitable level of maternity service | There is a current procedure/protocol understood by staff which outlines which women will receive antenatal care at the organisations maternity service and the conditions under which women will be referred for specialist consultation or whose care will be transferred to another maternity services | *Document which articulates*   * *clinical criteria for antenatal care at the organisation according to the level of service defined in the framework (see table 1: maternal and neonate complexity).* * *conditions under which specific women receving antenatal care at the organisations maternity service will be referred for specialist consultation or whose care will be transferred to another maternity services and reflect the levels of maternal complexity in the framework* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Comprehensive antenatal care of women occurs on their first visit in a timely manner | There is a current procedure/protocol understood by staff which outlines the initial assessment and information provision to women | *The document outlines the initial assessment and information provision to women and includes* (Sinni, 2011)(The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2015)(Australian Health Ministers’ Advisory Council, 2012)(3centrescollaboration, 2012)*:*   * *Determination of gestational age and due date* * *Medical, family, pyschosocial history* * *Lifestyle factors - Smoking status, alcohol, medicines and nutritional supplements* * *Clinical examination – BMI, BP and Proteinuria* * *Discussion and ordering of first trimester tests including – FBE, Blood group, rubella, syphilis, MSU, Hep B, Hep C, pap smear, genetic testing (Maternal serum screening and Ultrasound)* * *Vaccination advice (flu, pertussis)* * *General pregnancy advice –potential teratogens, exercise, nutrition* * *Antenatal education options* * *Identification of complication and risk factors* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Access to the appropriate model of antenatal care is available | There is a currentprocedure/protocol understood by staff to ensure that information is provided on the appropriate model of care for women | *The document outlines the appropriate model of care for women and includes:*   * *models of care available locally e.g. shared care* * *the suitability of these services for the individual woman after consideration of any risk factors* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Subsequent appropriate antenatal care of women is provided | There is a current procedure/protocol understood by staff which guides the appropriate subsequent antenatal monitoring, screening and information provision to the woman | *The document outlines the subsequent antenatal monitoring, screening and information provision including* (Sinni, 2011)(3centrescollaboration, 2012)(The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2015)*:*   * *Subjective maternal wellbeing* * *BMI, BP and Proteinuria and fetal movement assessment at every visit,* * *Symphysis-fundal height (SFH) assessed at every visit after 20/40* * *Abdominal palpation assessed at every visit after 30/40* * *Discussion and ordering of screening tests including*   *– 18-20 week ultrasound,*  *- Glucose Screening test at 24-28 weeks,*  *- Group B strep testing (either universal or risk based screening approach)*   * *General advice re admission, labour and going home and Vitamin K* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Appropriate management of common conditions in pregnancy | There are current procedures/protocols understood by staff outlining the organsiations approach to managmet of common condition s in pregnancy | *Documents that can be accessed by staff that outline:*   * *the management of common conditions in pregnancy e.g. pre eclampsia, gestational diabetes management, drug and alcohol use, rhesus negative* * *Routine procedures and indications for pre natal screening* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Appropriate arrangements are made for booking of intrapartum care | There is a current procedure understood by staff which outlines the booking process for intrapartum care | *The document outlines:*   * *suitability for birth at designated level of maternity service through clear clinical criteria* * *formal transfer criteria for women whose suitability for giving birth at the service changes upon identification of risk factors later in antenatal care* |  |  |  |
| **INTRAPARTUM CARE** | | | | | |
| 1. Access to telephone triage and advice | There is a current procedure/protocol understood by staff which outlines the approach to telephone advice for women commencing labour and triage and documentation of that advice | *The document outlines the approach to triage and documentation of advice* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. An appropriate initial assessment of the woman and fetus is undertaken on presentation | There is a current procedure/protocol understood by staff for initial assessment of the woman and fetus: | *The document outlines the initial assessment of the woman and fetus :*   * *Processes for identification of patients (uses at least three patient identifiers)* * *Acessing previous patient files /antental files for review* * *Key maternal and fetal observations to be recorded* (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014 3rd edition) * *Timeframes for initial assessment to be undertaken* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Periodic assessment monitoring of maternal status | There is a current procedure/protocol understood by staff for monitoring and documentation of maternal clinical status | *The document outlines monitoring and documentation of maternal clinical status with:*   * *requirements for recording of clinical observations* * *Clear clinical deterioration escalation triggers* * *Clear requirements for use of emergency codes* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Appropriate fetal surveillance is undertaken | There is a current procedure/protocol understood by staff that outlines the aproach to fetal surveillance | *The document outlines the aproach to fetal surveillance in labour including* (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014 3rd edition)*:*   * *methods of fetal surveillance* * *frequency of assessment* * *frequency and method of recording interpretation* * *escalation triggers and action required in relation to abnormal results* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Effective communication between midwifery and medical staff | There is a current procedure/protocol understood by staff outlining communication protocols | *The document outlines communication protocols including:*   * *handover protocols including use of communication tools such as ISBAR* * *protocols for communication of deterioration to senior staff and specialists* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Induction of labour is appropriately administered | There is a current procedure/protocol understood by staff outlining the approach to inductions in the maternity service | *The document outlines induction protocols including:*   * *The indications for induction* * *The contraindication for induction* * *The methods of induction available in the service* * *The clinical monitoring requirements assoIACTed with induction* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Appropriate management of routine labour | There is a current procedures/ understood by staff outlining the approach to routine labour | *Document exists that outlines the management of first, second and third stage labour* |  |  |  |
| 1. Appropriate management of common conditions and complications in labour | There are current procedures/protocols which are documented and are understood by staff | *Documents exist that outline protocols in relation to common conditions and complications in labour including that outline:*   * *the management of common conditions in labour e.g breech births, birth after previous caesarian section* * *routine procedures and indications for their use e.g. instrumental births, fetal blood sampling, cord sampling* * *the management of common complications e.g. pre and eclampsia, delayed progress, shoulder dystocia, cord prolapse, GBS, post partum haemorrhage, perineal tears* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. Patient informed consent for intervention has been obtained | There is a current procedure for patient informed consent in the maternity service | *The document outlines the informed consent procedure that includes:*   * *Reference to relevant legislative requirements* * *Procedure for assessing competence* * *Information provided to patients must address purpose, importance, benefits, options and risks of care provided in the maternity service and possible costs assoIACTed with proposed investigations, referrals or treatments to be borne by the patient.* * *Information must be provided in a manner appropriate for the patient’s cultural, language and educational background* | Document review | Offsite/onsite | IA +CE |
| 1. The referral or transfer of at risk women and fetus in a timely manner | There is a current procedure/protocol that is understood by staff for referral of care to more senior staff or for facililating transfer to other maternity services including*:* | *The document outlines the processes for maternal referral and transfer including:*   * *Maternal and fetal clinical criteria for referral of care to more senior staff or transfer* * *authority for initiating transfer* * *The method of consultation with transfer services regarding suitability and risks of transfer* * *The method and timing of transfer* |  |  |  |
| **POST NATAL CARE** | | | | | |
| 1. The appropriate immediate post-natal care of the woman | There is a current procedure/protocol understood by staff outlining the routine assessment and management of women in the birth suite | *The document outlines the post natal maternal procedure including:*   * *Maternal clinical observation type and frequency and action required in relation to abnormal observations* * *Facilitating skin to skin contact* * *Facilitating first infant feed* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. The appropriate immediate care of the neonate | There is a current procedure/protocol understood by staff outlining the routine assessment and management of neonates in the birth unit | *The document outlines the post natal neonatal procedure including:*   * *Clinical observation type and frequency and action required (e.g. APGAR scores and required action)* * *Approach to cord clamping (immediate or delayed)* * *Vitamin K administration* * *Observations in the first four hours post partum* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| 1. The referral and transfer of ‘at risk’ neonate | There is a current procedure/protocal understood by staff outlining and processes for neonatal transfer | *The document outlines the processes for neonatal transfer including:*   * *clinical criteria for transfer* * *authority for initiating transfer* * *The method of consultation with transfer services (PIPER) regarding suitability of transfer* * *The method and timing of transfer*   newborn stabilisation prioir to transfer |  |  |  |
| 1. The appropriate care of the woman and neonate once transferred from birth suite to the ward | There is a current procedure/protocol understood by staff outlining the assessment and management of women and noenates in the ward | *The document outlines the post natal care of the mother and neonte in the ward procedure including:*   * *Clinical observation frequency and action required for both mother and neonate in routine labour* * *post-operative analgesia* * *Support for infant feeding* * *Appropriate instruction re care of infant* * *Full assessment of neonate prior to discharge* | Document review  Staff Interview | Offsite/onsite | IA +CE |
| **DISCHARGE** | | | | | |
| 1. A comprehensive timely discharge plan is provided to the mother, and other providers involved in their care. | There is a current procedure/protocol for discharge from the maternity service | *The document outlines the discharge requirements from the maternity ward and includes:*   1. *Documented discharge plan* 2. *Discharge communication to primary care providers, maternal and child health nurse and other relevant providers* 3. *Medication instruction* 4. *Any follow up appointments* | Document review  Staff Interview | Offsite/onsite | IA +CE |

This third part of the internal tool is used to evaluate the data that is collected and analysed in the maternity service. The data is separated in to demand, process and outcome data. The audit does not collect and verify the raw data but looks at the units own approach to collection and analysis of this data.

**Note:** All data is reviewed onsite with the Clinical Expert

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| CRITERIA | DESIRED DATA TO ADDRESS CRITERIA | EVIDENCE TO SUPPORT DATA USE |
| **DEMAND DATA** | | |
| 1. Admission/demand data is collected and analysed in the maternity service | Total admissions  Admission by date of week and hour of day | Can include maternity service or quality reports and quality improvement initiatives |
| **PROCESS DATA** | | |
| 1. Women with 1st antenatal visit before 12 wks is collected and analysed |  |  |
| 1. No. of antenatal visits for routine pregnancy is collected and analysed |  |  |
| 1. Smoking rates in pregnancy are collected and analysed | Maternal smoking at less than 20 weeks  Maternal smoking at >- 20 weeks |  |
| 1. Rates of induction in standard primiparae is collected and analysed |  |  |
| 1. Rate of caesarean section in standard primiparae is collected and analysed |  |  |
| 1. Decision to delivery interval for emergency caesarean section is collected and analysed |  |  |
| 1. Instrumental vaginal birth for women giving birth for the first time is collected and analysed |  |  |
| 1. Referral to postnatal domiciliary care or hospital in the home is collected and analysed |  |  |
| **GENERAL OUTCOME DATA** | | |
| 1. Complaints data is collected and analysed in the maternity service | e.g. Number and type of complaints /10,000admissions and trend  over time |  |
| 1. Incident data is collected and analysed in the maternity service | e.g. Number and type of incidents /10,000 admission and trend  over time |  |
| 1. Maternal average length of stay data is collected and analysed |  |  |
| 1. Neonatal length of stay is collected and analysed |  |  |
| 1. Unplanned re-admissions data is collected and analysed | e.g. Percentage of maternity patients who have unplanned  re admissions within 48 hours of discharge |  |
| **MATERNAL OUTCOMES** | | |
| 1. Rates of 3rd and 4th degree perineal tear is collected and analysed |  |  |
| 1. Post partum haemorrhage (> than 1000ml) is collected and analysed |  |  |
| 1. Mortality data is collected and analysed in the maternity service | Evidence of analysis and benchmarking of mortality data  Evidence of mortality data analysis used to inform action |  |
| 1. Rate of blood transfusion is collected and analysed in the maternity service |  |  |
| **NEONATAL OUTCOMES** | | |
| 1. Low 5 minute APGAR score (less than 7) for at term neonates is collected and analysed |  |  |
| 1. Severe fetal growth restriction at term is collected and analysed |  |  |
| 1. Perinatal mortality rates is collected and analysed | * Total perinatal mortality ratio * Perinatal mortality ratio for babies born at 32 weeks or more |  |
| **WORKFORCE** | | |
| 1. Percentage of staff with FSEP training |  |  |
| 1. Percentage of staff with NNR training |  |  |
| 1. Percentage of staff with Emergency obstetric care training |  |  |

This fourth part of the MATIACT is used to evaluate the individual medical records for evidence of appropriate clinical processes that control risk in the maternity service. This section is divided up into main areas addressing antenatal, intrapartum and postnatal care. This part of the tool is designed to be undertaken with the assistance of a member of staff (eligible to be rostered on in maternity services) to assist with file navigation at all times during the patient file review.

Sampling

The internal audit sample comprises 5-10 files randomly selected maternity files and a minimum of 5 purposively sampled files from specified subpopulations reflecting complications with outcomes with admissions in the last 12 months. The randomly selected files should represent a range of shifts at the hospital (am pm and nights)The related neonate files will be needed if criterion 191 is included in the scope of the audit. The subpopulations to be included are agreed in the process of scoping of the internal audit. All general criteria would be examined on these files An additional consideration in the selection of files is ensuring files cover different shifts in the clinical area, for example some files randomly selected from the evening/night shift.

Patient files need to be checked for suitability prior to the internal audit and there needs also to be provision made for additional files if needed at the onsite visit.

The subpopulation groups that may be included are:

1. Apgar score <7 at 5 minutes
2. Neonatal admissions to PICU/NICU or other services (PIPER specialised transfer services)
3. Maternal ICU/HDU admissions or transfer to other services
4. Prolonged length of stay of mother
5. Prolonged length of stay of baby
6. Post partum haemorrhage ( blood loss over 1500ml)
7. Maternal Blood transfusion

How to document data

The patient file data from individual patient files for Part 4 are documented on the separate data collection sheets for the general and sub populations. The aggregate data from all the patient records is recorded in the evidence columns in this document. In most cases the aggregate data required to be entered in this document is an indication of the total number of files that demonstrate the criterion (the numerator) over the total number of files examined (the denominator).

Assessment of Severity Rating

For each of the aggregate criterion results demonstrating a significant omission of care the clinical expert (with the assistance the internal auditor if required) needs to make a severity rating in terms of therisk, the omissions in care or documentation, represent to the organisation and the urgency with which it is required to be addressed

The rating scale used needs to be confirmed by the internal auditor but would generally follow the form of *high, medium* and *low* ratings based on consideration of the following criteria:

* likelihood of the error to potentially cause signiﬁcant harm
* the likelihood to expose the health service to successful litigation
* urgency with which it needs to be addressed by the organisation

Recommendations

For each of the criterion with a severity rating the clinician should provide a brief recommendation to improve practice.

Antenatal Care

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| # | ANTENATAL CARE CRITERION | Total No. of patients who meet criteria (Numerator) | Total No. of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Assessment of severity rating  (high, medium and low) and Recommendations |
| **FIRST ANTENATAL ASSESSMENT** | | | | | |
| 71 | Date of first visit documented |  |  |  |  |
| 72 | Interpreter required documented |  |  |  |  |
| 73 | Age at first visit documented |  |  |  |  |
| 74 | Estimated due date (EDD) documented |  |  |  |  |
| 75 | Method of EDD estimation documented |  |  |  |  |
| 76 | Gestational age at first visit documented |  |  |  |  |
| 77 | First visit occurred before 12 weeks gestation? |  |  |  |  |
| 78 | Medical history documented |  |  |  |  |
| 79 | Family history documented |  |  |  |  |
| 80 | Social history documented |  |  |  |  |
| 81 | Mental health history documented |  |  |  |  |
| 82 | Smoking history documented |  |  |  |  |
| 83 | Alcohol history documented |  |  |  |  |
| 84 | Drug history documented |  |  |  |  |
| 85 | Nutritional supplements history documented (e.g. folic acid, , vitamins) |  |  |  |  |
| 86 | Pap smear history documented |  |  |  |  |
| 87 | BP documented (Australian Health Ministers’ Advisory Council, 2012) |  |  |  |  |
| 88 | Proteinuria tested and documented (Australian Health Ministers’ Advisory Council, 2012) |  |  |  |  |
| 89 | BMI calculated and documented |  |  |  |  |
| 90 | Maternal risk factors identified and documented? |  |  |  |  |
| 91 | Model of care documented? |  |  |  |  |
| 92 | Appropriateness for model of care (with consideration of risk factors) |  |  |  |  |
| **INITIAL ANTENATAL SCREENING (AT FIRST AND/OR SECOND VISIT)** | | | | | |
| 93 | Blood group and rhesus D status |  |  |  |  |
| 94 | Full Blood examination undertaken |  |  |  |  |
| 95 | Syhillis screening undertaken |  |  |  |  |
| 96 | Hep B screening undertaken |  |  |  |  |
| 97 | Hep C screening undertaken (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2015) |  |  |  |  |
| 98 | Rubella Screening undertaken |  |  |  |  |
| 99 | HIV screening undertaken (Australian Health Ministers’ Advisory Council, 2012) |  |  |  |  |
| 100 | Mid stream urine (MSU) for bacteriuria undertaken |  |  |  |  |
| 101 | Maternal serum screen (MSS) in first trimester undertaken |  |  |  |  |
| 102 | USS before 14/40 undertaken |  |  |  |  |
| **SUBSEQUENT ANTENATAL VISITS** | | |  |  |  |
| 103 | Blood Pressure documented at every visit |  |  |  |  |
| 104 | Urinalysis is documented ( if indicated by hypertension) (3centrescollaboration, 2012) |  |  |  |  |
| 105 | Fetal movement assessment every visit is documented |  |  |  |  |
| 106 | Symphysis-fundal height (SFH) assessed at every visit after 20/40 is documented |  |  |  |  |
| 107 | Abdominal palpation assessed at every visit after 30/40 is documented |  |  |  |  |
| **SUBSEQUENT SCREENING TESTS** | |  |  |  |  |
| 108 | Glucose Challenge test undertaken |  |  |  |  |
| 109 | Ultrasound 18-20 weeks undertaken |  |  |  |  |
| 110 | Group B streptococcus (GBS) undertaken if universal approach to screening at service or if woman high risk |  |  |  |  |
| 111 | FBE at 28 weeks undertaken |  |  |  |  |
| 112 | Syphilis, Hepatitis B, Hepatitis C, HIV repeat screening at 28 weeks in high-risk populations undertaken |  |  |  |  |
| 113 | Identification of risk factors in subsequent antenatal visits |  |  |  |  |
| 114 | Total number of antenatal visits for low risk pregnancy |  |  |  |  |

Intrapartum Care

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| # | INTRAPARTUM CARE CRITERION | Total No. of patients who meet criteria (Numerator) | Total No. of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Assessment of severity rating  (high, medium and low) and Recommendations |
| **INITIAL ASSESSMENT** | | | | | |
| 115 | Time of initial assessment/clinical observations commenced documented |  |  |  |  |
| 116 | Gestational age documented |  |  |  |  |
| 117 | Documentation of pregnancy complicatons |  |  |  |  |
| 118 | Documentation of antenatal investigation results (Ultrasounds, GBS status, Blood Group & ab screen, FBE & Hb, GTT, infectious disease screen) |  |  |  |  |
| 119 | Length strength and frequency of contractions is documented |  |  |  |  |
| 120 | Vaginal loss is documented |  |  |  |  |
| 121 | Pulse is documented |  |  |  |  |
| 122 | BP is documented |  |  |  |  |
| 123 | Temperature is documented |  |  |  |  |
| 124 | Respiratory rate is documented |  |  |  |  |
| 125 | Urinalysis undertaken and recorded |  |  |  |  |
| 126 | Palpation of the abdomen is documented |  |  |  |  |
| 127 | Vaginal examination if the woman in established labour is documented |  |  |  |  |
| 128 | Method of fetal surveillance documented |  |  |  |  |
| 129 | Appropriate method of fetal surveillance for initial assessment with consideration of antenatal risks? |  |  |  |  |
| 130 | Results of fetal surveillance documented |  |  |  |  |
| 131 | Risk factors that may lead to transfer to obstetric lead care identified and documented? |  |  |  |  |
| 132 | Determination of suitability of midwifery led care? |  |  |  |  |
| INDUCTION OF LABOUR | | | | | |
| 133 | BISHOP score documented |  |  |  |  |
| 134 | Method of induction documented |  |  |  |  |
| 135 | CTG undertaken and documented pre induction and until active labour established |  |  |  |  |
| 136 | Induction appropriate to consideration of indications and risk factors? |  |  |  |  |
| MONITORING OF FIRST STAGE LABOUR | | | | | |
| 137 | Time first stage commenced documented |  |  |  |  |
| 138 | Pulse documented (every half hour) (3centrescollaboration, 2012) |  |  |  |  |
| 139 | Respiratory rate |  |  |  |  |
| 140 | BP documented (every two hours) (3centrescollaboration, 2012) |  |  |  |  |
| 141 | Temperature documented (every four hours) (3centrescollaboration, 2012) |  |  |  |  |
| 142 | Analgesia administration documented |  |  |  |  |
| 143 | Palpation of the abdomen documented |  |  |  |  |
| 144 | If fetal surveillence was undertaken primarily through auscultation, was this undertaken every 15-30 minutes in the first stage of labour and documented (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014 3rd edition) |  |  |  |  |
| 145 | If fetal surveillence was undertaken through CTG (as appropriate to fetal condition) was there evidence of review every of 15-30 minutes (clinican digital and written signature), interpretations recorded (at least hourly) and appropriate action taken (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014 3rd edition) (The Royal Womens Hospital, 2014) |  |  |  |  |
| 146 | Appropriate method of fetal surveillence with consideration of intrapartum risk factors? |  |  |  |  |
| 147 | Vaginal Examination documented (approx every four hours) (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014) |  |  |  |  |
| 148 | Maternal fluids documented |  |  |  |  |
| 149 | Partogram documented labour progress |  |  |  |  |
| 150 | Adequate progress in first stage labour? |  |  |  |  |
| 151 | Appropriate response to delayed progress in first stage labour? |  |  |  |  |
| MONITORING OF SECOND STAGE LABOUR | | | | | |
| 152 | Time second stage commenced documented |  |  |  |  |
| 153 | Pulse documented (every hour) (3centrescollaboration, 2012) |  |  |  |  |
| 154 | BP documented (every hour) (3centrescollaboration, 2012) |  |  |  |  |
| 155 | Temperature documented (every four hours) (3centrescollaboration, 2012) |  |  |  |  |
| 156 | Maternal fluids documented |  |  |  |  |
| 157 | If fetal surveillence was undertaken primarily through auscultation were results recorded after each contraction or at least every five minutes in the active second stage of labour (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014 3rd edition) (The Royal Womens Hospital, 2014) |  |  |  |  |
| 158 | If fetal surveillence was undertaken through CTG was there of evidence review at least every 5 minutes or after each contraction (clinican digital and written signature), and appropriate action taken (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014 3rd edition) (The Royal Womens Hospital, 2014) |  |  |  |  |
| 159 | Appropriate method of fetal surveillence? |  |  |  |  |
| 160 | Was the obstetric team notified of suspected delayed progress for primiparous at 1 hour of active second stage or for multiparous at 30 minutes (Monash Health, 2014) |  |  |  |  |
| 161 | Was referral of care to obstetric team for operative birth made for primiparous at 2 hrs and multiparous at 1 hr (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014) |  |  |  |  |
| 162 | What was the average decision to delivery interval for emergency caesarean section? |  |  |  |  |
| 163 | If Fetal Blood Sampling was (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2016) available in service and indicated was this undertaken and recorded |  |  |  |  |
| MONITORING OF THIRD STAGE LABOUR | | | | | |
| 164 | Maternal general condition recorded |  |  |  |  |
| 165 | Time of cord clamping recorded |  |  |  |  |
| 166 | Vaginal blood loss documented |  |  |  |  |
| 167 | Use of a uterotonic agent documented |  |  |  |  |
| 168 | Appropriate uterotonic agent administration? |  |  |  |  |
| 169 | Application of controlled cord traction documented (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2016) |  |  |  |  |
| 170 | Time, condition, structure, cord vessels and completeness of delivery of placenta is recorded |  |  |  |  |
| 171 | If paired cord blood sampling was indicated (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014 3rd edition) during labour was this undertaken? |  |  |  |  |
| REFERRAL AND TRANSFER | | | | | |
| 171 | Was escalation of care and referral to a more experienced practitioner indicated at any stage of labour? |  |  |  |  |
| 172 | If yes, was the decision to escalate made in a timely way? |  |  |  |  |
| 173 | If yes, was the woman reviewed in a timely way? |  |  |  |  |
| 174 | Was the transfer of care to another maternity facility indicated at any stage of labour? |  |  |  |  |
| 175 | If yes, was the decision to transfer made in a timely way? |  |  |  |  |
| 176 | If yes, was the woman transferred in a timely way? |  |  |  |  |

Postnatal Care

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| # | POSTNATAL CARE CRITERION | Total No. of patients who meet criteria (Numerator) | Total No. of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Assessment of severity rating  (high, medium and low) and Recommendations |
| **INITIAL POST NATAL MATERNAL ASSESSMENT** | | | | | |
| 178 | Temperature documented (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014) |  |  |  |  |
| 179 | Pulse documented (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014) |  |  |  |  |
| 180 | Blood pressure documented (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014) |  |  |  |  |
| 181 | Abdominal palpation for position of uterus is recorded (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014) |  |  |  |  |
| 182 | Volume of urine passed documented |  |  |  |  |
| 183 | Recording of perineal assessment and management (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014) |  |  |  |  |
| 184 | Maternal emotional health documented |  |  |  |  |
| 185 | Feeding of baby recorded |  |  |  |  |
| INITIAL NEONATAL CARE | | | | | |
| 186 | Apgar score at 1 minute (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014) |  |  |  |  |
| 187 | Apgar score at 5 minute (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014) |  |  |  |  |
| 188 | Vit K adminstered and documented |  |  |  |  |
| 189 | Hourly temperature, Respiratory rate, pulses rate, colour,tone and cord check for first 4 hours documented for uncomplicated birth and as appropriate for birth complications (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014) (Monash Health, 2014) |  |  |  |  |
| MATERNITY WARD POSTNATAL CARE | | | | | |
| 190 | Periodic (change of shift, ward round) maternal health assessment documented for normal labour (wellbeing, major systems review, feeding, wound status, vaginal loss, urinary voiding) |  |  |  |  |
| 191 | Neonatal 4 hourly temp, heart rate respiratory rate for 24 hours documented for normal labour and birth (Monash Health, 2014) |  |  |  |  |
| 192 | Copy of discharge plan/letter in records |  |  |  |  |
| 193 | Date and time of discharge documented |  |  |  |  |
| 194 | Record of follow up appointment date and time in discharge plan |  |  |  |  |
| 195 | Record of medication prescribed in discharge plan |  |  |  |  |
| 196 | Interventions provided in maternity service recorded in discharge plan |  |  |  |  |
| 197 | Key contacts recorded in discharge plan |  |  |  |  |
| 198 | Self management strategy recorded in discharge plan |  |  |  |  |

This next section of Part 4 of the patient record review examines criteria in specific sub populations. The subpopulation included in the audit and the sample size would be confirmed in the planning process and scoping of the internal audit.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| # | POPULATION : POST PARTUM HAEMORRHAGE | Total No. of patients who meet criteria (Numerator) | Total No. of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Assessment of severity rating (high, medium and low) and Recommendations |
| 199 | Post-partum haemorrhage risk was identified antenatally |  |  |  |  |
| 200 | Method of assessment of blood loss documented |  |  |  |  |
| 201 | Estimate of volume of blood loss documented |  |  |  |  |
| 202 | Oxygen saturation documented (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2016) |  |  |  |  |
| 203 | Pulse recorded (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2016) |  |  |  |  |
| 204 | Respiratory rate documented |  |  |  |  |
| 205 | Urinary output (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2016) |  |  |  |  |
| 206 | If rapid blood loss was timely assistance for escalation of care documented |  |  |  |  |
| 207 | IV access established in a timely manner |  |  |  |  |
| 208 | Was oxygen administered and documented |  |  |  |  |
| 209 | Were appropriate resuscitation protocols administered |  |  |  |  |
| 210 | Management of PPH appropriate to the cause (repeat ueterotonic agent, uterine massage etc), |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| POPULATION:  ADDITIONAL SPECIFIC POPULATION AGREED WITH ORGANISATON | Total No. of patients who meet criteria (Numerator) | Total No. of patient files examined  (Denominator) | The Percentage  (Numerator/ Denominator  x 100) | Assessment of severity rating ( high , medium and low) and Recommendations |
| Agreed criteria for population |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Level | Maternal complexity | Newborn Complexity |
| 1 | * Ante and post natal support and emergency births. * Low risk shared care in assoIACTion with identified facility | * Postnatal domiciliary management of newborns born at 37 weeks gestation or more without complications. |
| 2 | * Management of normal risk pregnancies including management of labour, birth and puerperium (6 weeks) at 37 weeks gestation or more. * Depending on local facilities and personnel, option for planned, booked elective caesarean sections according to RANZCOG statement.10 | * Postnatal in-patient and domiciliary management of newborns at 37 weeks gestation or more without complications. * Minor conditions not requiring additional nursing or specialist medical care, e.g. short term transient mild respiratory distress, minor feeding difficulties. * Depending on local facilities and personnel, option for phototherapy for jaundice without significant pathological cause, with advice from specialist paediatrician. |
| 3 | * Normal risk pregnancies including management of labour, birth and puerperium at 37 weeks gestation or more including elective and emergency caesarean section. | * Postnatal in-patient and domiciliary management of newborns at 37 weeks gestation or more without complications. * Minor conditions not requiring additional nursing or specialist medical care, e.g. short term transient mild respiratory distress, minor feeding difficulties. * Depending on local facilities and personnel, option for phototherapy for jaundice without significant pathological cause, with advice from specialist paediatrician. |
| 4 | * Management of low and moderate risk pregnancies including management of labour, birth and puerperium at 34 weeks gestation or more | * As per *Neonatal Services Guidelines*6 Level 2 Low dependency: * Uncomplicated infants of 34 weeks gestation or more, birthweight at least 2,000 grams(including growing preterm and convalescing infants). * Infants requiring incubator care for short term transition problems or mild complications, including: oxygen requirement less than 40 per cent, apnoea monitoring, blood glucose * monitoring, short term intravenous therapy, phototherapy, gavage feeding. |
| 5 | * Management of moderate and selected high risk pregnancies including management of labour, birth and puerperium at 32 weeks gestation or more. | * As per *Neonatal Services Guidelines*6 Level 2 High dependency. * Uncomplicated 32 weeks gestation or more, or birth weight at least 1300 grams: includes growing preterm and convalescing infants. * Incubator care for infants who are sick or preterm, requiring oxygen less than 60 per cent, cardiorespiratory monitoring, short term intra-arterial blood pressure monitoring, close observation – for example Neonatal Abstinence Syndrome. * Short term ventilator care pending transfer (less than 6 hours). * Depending on local facilities and personnel, option for nasal CPAP within NSAC guidelines, exchange transfusion. |
| 6 | * Specialising in high risk pregnancy care for women from across the state. * Provides pregnancy care for normal, low and moderate risk pregnancies from local geographic area. * Specialist services include but are not restricted to Fetal Management Unit (FMU), Multiple Pregnancy Service, Diabetes Service, Alcohol and Drug Service. | * Comprehensive care for all neonates, within a multidisciplinary management model. * May provide Level 2–5 services (previously Level 1 and 2) . * Full range of respiratory support available. * May provide or have links to neonatal surgery and care for complex congenital and metabolic diseases of the newborn. * Provide or have links to a broad range of sub-speciality consultative and paramedical services as per *Neonatal services guidelines*.6 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Level 1 | Level 2 | Level 3 | | Level 4 | | Level 5 | Level 6 |
| **NURSING/MIDWIFERY** | | | | | | | | |
| Registered midwives |  |  |  |  | |  | |  |
| 24 hour on call midwives |  |  |  |  | |  | |  |
| Designated Midwife Educator |  |  |  |  | |  | | full time |
| A minimum of one nurse educator with NIC qualifications and post graduate in education. |  |  |  |  | |  | |  |
| Equipment nurse with NIC training. |  |  |  |  | |  | |  |
| Midwife in charge with postgraduate qualification |  |  |  |  | |  | |  |
| Nurse coordinator to manage high risk neonates |  |  |  |  | |  | |  |
| Nurse in charge of nursery with 3 yrs midwifery/neonatal and Level 2 high dependency experience and qualification |  |  |  |  | |  | |  |
| Nurses in nursery with neonatal high dependency experience and/or level 2 course |  |  |  |  | |  | |  |
| At least one registered nurse division 1/midwife with NIC certification on duty at all times. |  |  |  |  | |  | |  |
| A designated senior nurse/midwife with neonatal experience and managerial responsibility. |  |  |  |  | |  | |  |
| A designated nurse/midwife responsible for further education and training, including in-service experience in resuscitation of neonates. |  |  |  |  | |  | |  |
| **MEDICAL STAFF** | | | | | | | | |
| GP's credentialed for shared care |  |  |  |  | |  | |  |
| Accredited share care program |  |  |  |  | |  | |  |
| GPs credentialed for obstetric care. |  |  |  |  | |  | |  |
| Specialist obstetrician, general surgeon or GP credentialled to perform caesarean section |  | elective only |  24 hrs/day |  | |  | |  |
| GP anaesthetists credentialled for provision of appropriate obstetric anaesthesia and analgesia, including spinal anaesthetic. |  |  | on call 24 hrs/day | 24 hrs/day or specialist anaesthetists | |  | |  |
| Consultation and referral pathways to specialist obstetrician |  |  |  |  | |  | |  |
| Specialist Obstetrician on staff to advise on obstetrics service |  |  |  |  | |  | |  |
| on call 24 hrs a day by GP obstetrician credentialed for advanced obstetric care (including caesar) or specialist obstetrician |  |  |  |  | |  | |  |
| Obstetrician 24 hour on call and able to attend within 30 minutes of decision to delivery |  |  |  |  | |  | |  |
| Designated Obstetric registrar on site 24 hrs a day |  |  |  |  | | and/or HMO | |  |
| Onsite specialist registrar with authority to open theatre and experience to at a minimum  commence operating without direct supervision while awaiting consultant presence. |  |  |  |  | |  | |  |
| A specialist obstetric consultant appointed as clinical head of service. |  |  |  |  | |  | |  |
| Specialist anaesthetists on call 24 hours a day (to perform spinal and general) |  |  |  | Or GP anaesthetist | |  | |  |
| anaesthetic registrar onsite 24 hrs a day |  |  |  |  | |  | |  |
| Consultation and referral pathways to specialist paediatrician |  |  |  |  | |  | |  |
| Paediatrician on call 24 hours a day; availability within a time consistent with the health service’s risk management protocol. |  |  | or GP with paediatric skills/ neonatal ALS | or GP with paediatric skills/ neonatal ALS | |  | |  |
| paediatric registrar and/Or HMO's on site 24 hours a day |  |  |  |  | |  | |  |
| paediatrician on staff to advise on neonatal service and clinical care |  |  |  |  | |  | |  |
| Established referral pathway to sub specialist paediatric medical and surgical services. |  |  |  |  | |  | |  |
| RMO available for special care nursery |  |  |  |  | |  | |  |
| An appointed specialist neonatology consultant appointed as head of unit. |  |  |  |  | |  | |  |
| Specialist neonatal consultant staff available 24 hours a day. At least one consultant should be predominantly present during working hours and exclusively rostered to be available |  |  |  |  | |  | |  |
| Junior/registrar staff undertaking basic or advanced training in perinatal/neonatal medicine. |  |  |  |  | |  | |  |
| At least one doctor on site 24 hours a day who is experienced to deal with all emergencies. |  |  |  |  | |  | |  |
| 24 hour resident cover by an appropriately trained doctor who should be available for the intensive care unit at all times and not be required to cover any other service. |  |  |  |  | |  | |  |
| Access to obstetric medical/specialist physician services. |  |  |  |  | |  | |  |
| Established referral pathway for surgical consultation/referral. |  |  |  |  | |  | |  |
| **ALLIED HEALTH** | | | | | | | | |
| referral pathways to Allied health (physio, SW, interpreters, continence and dietician) |  |  |  |  | |  | |  |
| lactation consultant |  |  |  | experience in | |  | |  |
| On site access to Allied health ( physio, SW, interpreters, continence advisor and dietician) |  |  |  |  | |  | |  |
| On site or established referral pathway to: paediatric allied heath including dietician, physiotherapy, social work, OT, speech pathology, audiology, child protection |  |  |  |  | |  | |  |
| Pastoral care - minimum Monday–Friday, plus on call 24 hour roster. |  |  |  |  | |  | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 | Level 6 |
| **BIRTH ROOM** | | | | | | |
| Equipment to support imminent birth\* |  |  |  |  |  |  |
| Equipment to support labour, birth and puerperium |  |  |  |  |  |  |
| Fetal monitoring equipment |  |  |  |  |  |  |
| Neonatal resuscitation equipment |  |  |  |  |  |  |
| Adult resuscitation equipment |  |  |  |  |  |  |
| Portable ultrasound operated by trained staff |  |  |  |  |  |  |
| Adult cardiac monitoring, I-A pressure monitoring |  |  |  |  |  |  |
| Fetal acid/base balance and lactate equipment |  |  |  |  |  |  |
| **NURSERY** | | | | | | |
| Neonatal resuscitation equipment |  |  |  |  |  |  |
| Infant stabilisation facilities prior to transfer |  |  |  |  |  |  |
| Isolation facilities |  |  |  |  |  |  |
| **NEONATAL EQUIPMENT (references levels in 2015 Neonatal framework) \*\*** | | | | | | |
| incubator |  |  |  |  |  |  |
| phototherapy |  |  |  |  |  |  |
| gavage feeding |  |  |  |  |  |  |
| apnoea monitoring |  |  |  |  |  |  |
| continuous cardiorespiratory/pulse oximetry |  |  |  |  |  |  |
| CPAP/nasal cannulae |  |  |  |  |  |  |
| Blood gas monitoring |  |  |  |  |  |  |
| Non-invasive BP |  |  |  |  |  |  |
| Ventilator care |  |  |  |  |  |  |
| Central venous catheters |  |  |  |  |  |  |
| Parenteral nutrition |  |  |  |  |  |  |
| **OPERATING ROOMS** | | | | | | |
| equipment for caesarean section |  | optional |  |  |  |  |
| Neonatal resuscitation equipment |  | optional |  |  |  |  |
| Close to birth suite with ability to perform caesar within 30 minutes |  |  |  |  |  |  |
| HIGH DEPENDENCY UNIT (HDU) or ICU |  |  |  | HDU | HDU/ICU | ICU |

\*(2 clamps, scissors, ID label, placenta container, syntocinon 10 units) \*\* in accordance Australasian health facility guidelines: intensive care – neonatal/ special-care nursery

1. **Fetal Surveillance Education Program.** *Scoring and Reporting of the RANZCOG FSEP Assessment.* s.l. : Royal Australian and New Zealand College of Obstetricians and Gynaecologist.

2. **The Royal Australian and New Zealand College of Obstetricians and Gynaecologists.** *Intrapartum Fetal Surveillance : Clinical guideline.* 2014 3rd edition.

3. **Department of Health.** *Capability framework for Victorian maternity and newborn services.* melbourne : State Government of Victoria, 2010.

4. *Designing a clinical audit tool to measure processes of pregnancy care.* **Sinni, Suzanne, Wendy Cross, and Euan Wallace.** s.l. : Nursing: Research and Reviews , 2011, Vol. E1.

5. **The Royal Australian and New Zealand College of Obstetricians and Gynaecologists.** *Routine Antenatal Assessment in the Absence of Pregnancy Complications. College Statement C\_obs 3 (b).* 2015.

6. **Australian Health Ministers’ Advisory Council.** *Clinical Practice Guidelines: Antenatal Care – Module 1.* Canberra : Australian Government Department of Health and Ageing, 2012.

7. **3centrescollaboration.** *Labour and Birth Clinical Practice Guidelines.* 2012.

8. **The Royal Womens Hospital.** *Cardiotocograph (CTG) Interpretation and response.* 2014.

9. **The Royal Australian and New Zealand College of Obstetricians and Gynaecologists.** *Provision of Routine intrapartum care in the abscence of pregnancy complications C-Obs 31.* 2014.

10. **Monash Health.** *Midwifery primary carer referral to obstetric care criteria procedure.* 2014.

11. **The Royal Australian and New Zealand College of Obstetricians and Gynaecologists.** *Management of Postpartum Haemorrhage.* 2016.

12. **Monash Health.** *Observations (neonatal) babies in maternity procedure.* 2014.

13. **The Royal Australian and New Zealand College of Obstetricians and Gynaecologists.** *Standards of Maternity Care Maternity Care in Australia and New Zealand .* 2014.

14. **Australian Health Ministers’ Advisory Council.** *Clinical Practice Guidelines: Antenatal Care – Module 2. .* Canberra : Australian Government Department of Health and Ageing, 2014

15. **National Institute for Clinical Excellence.** *Antenatal care for uncomplicated pregnancies: clinical guideline.* 2008.

16. **Australian College of Midwives.** *National Midwifery Guidelines for Consultation and Referral. Edition 3 Issue 2.* 2014.

17. **National Institute for Heatlh and Care Excellence.** *Inducing labour: clinical guideline (CG70).* 2008.

18. **Department of health and Human Services.** *Defining levels of care for Victorian newborn services.* s.l. : State of Victoria, 2015.

1. Credentialling refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments. [↑](#footnote-ref-1)