SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

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FUNCTIONAL GROUP(S)	Clinical Governance Women's and Babies Health
KEY TERMS	Deteriorating, maternity woman, escalation, gestation Clinical Emergency Response Systems (CERS), Between the Flags (BTF), Clinical Review, Rapid Response, Code Blue
SUMMARY	This document outlines the specific measures to be implemented across South Eastern Sydney Local Health District to allow the standardised approach to recognising and managing the deteriorating maternity woman from 20 weeks gestation to 6 weeks postpartum.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Management of the deteriorating MATERNITY woman

SESLHDPR/705

1. POLICY STATEMENT

Early recognition of the deteriorating maternity woman and the provision of a prompt and appropriate response are essential components of safe quality care.

South Eastern Sydney Local Health District (SESLHD) facilities will utilise a standardised clinical emergency response system (CERS) to facilitate early recognition and respond to women with signs of clinical deterioration. The agreed CERS system is the Clinical Excellence Commissions (CEC) and the Between the Flags (BTF) program.

This procedure shall be read in conjunction with NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating.

For pregnant and postnatal women who are less than 20 weeks gestation or more than 6 weeks postnatal refer to the SESLHD Procedure SESLHDPR/697 - Management of the Deteriorating ADULT inpatient (excluding maternity).

For paediatric patients refer to SESLHD Procedure SESLHDPR/284 - Management of the Deteriorating PAEDIATRIC Inpatient.

For neonates in special care nurseries, post-natal wards or within the maternity unit refer to SESLHD Procedure SESLHDPR/340 - Management of the Deteriorating NEONATAL inpatient.

NSW Ministry of Health Guideline GL2018_025 - Maternity Fetal Heart Rate Monitoring Guideline.

2. BACKGROUND

Failure to recognise, respond and appropriately manage a maternity woman's deterioration in physical and mental state is a known contributing factor to adverse outcomes.

This SESLHD procedure will outline specific measures to be implemented across the district to allow a standardised approach to recognising and managing the deteriorating maternity woman.

3. RESPONSIBILITIES

Clinical Nurse /Midwifery Consultant's and Educators will:

- Provide leadership and management of recognising and responding to the deteriorating maternity woman via the SESLHD Deteriorating Patient Programs (DPP) Committee and the Women's and Children's Clinical Stream (WCCS)
- Provide local guidance and directives on the Clinical Emergency Response System (CERS) to ensure consistency across all local sites occurs
- Provide education guided by the NSW Health Deteriorating Patient Education Strategy.

Medical, Midwifery and Nursing staff will:

- Complete mandatory Maternity and Fetal Safety Education Program and adhere to local guidelines and directives.

Maternity Manager's will:

- Support staff education
- Provide guidance on reporting requirements for each facility.

Clinical Governance Units will:

- Communicate with stakeholders, including maternity women, families, clinicians and the Clinical Excellence Commission (CEC), to provide feedback on the performance and effectiveness of the Deteriorating Patient Safety Net System.

4. ASSESSMENT OF DETERIORATION

4.1 Assessment

- A baseline systematic assessment (A-G or agreed equivalent A-I) is to be performed and documented in the maternity woman's health care record and be inclusive of a fetal wellbeing and mental state assessment. The assessment needs to include input from the maternity woman and her family/carer in changes to physical and mental state where appropriate.

4.2 Standard clinical tools

- In SESLHD general observations for a maternity woman must be recorded on the NSW Health Standard Maternity Observation Chart (SMOC) for all women of 20 weeks gestation and over, up to 6 weeks (42 days), post-partum

    - NSW Health Standard Maternity Observation Chart

    (NSW Health Standard Maternity Observation Charts can be accessed via NSW Health Standard Observation Charts link and Maternity drop down box)

- Other antenatal and birthing tools include;
    - NSW Health Antenatal Short Stay Observation Chart (Less than 32 weeks)
    - NSW Health Antenatal Short Stay Observation Chart (Greater than or equal to 32 weeks)
    - NSW Health Obstetric Epidural Analgesia Chart
    - NSW Health Maternal Sepsis Pathway
    - K2 Guardian

- Other maternity tools may be used to identify deviations from normal
- Standardised observations charts may be incorporated into electronic medical records and data bases.

4.3 Minimum requirement for vital sign monitoring

- Frequency of observation are to be attended as per Appendix 2 unless:
  - An individualised monitoring and assessment plan is documented by a Medical Officer (MO) (registrar level or above) in the health care record
- Observations can be increased by both midwifery/nursing and MO (registrar level or above). Observations frequency is to be increased when:
  - The woman's observations fall into the coloured zone of BTF
  - On assessment it is identified that there are further signs of deterioration
  - The woman has a CERS call
- In addition, a full set of vital signs observations must be performed and documented at the time of admission, within one hour of arrival to clinical unit and within one hour prior to discharge.

4.4 Individualised monitoring and assessment plans

- A woman who requires less monitoring due to clinical situation or diagnosis may have an individualised monitoring and assessment plan as determined by the clinical team and in consultation with the Admitting Medical Officer (AMO)
- The plan must consider the woman's clinical situation, including her diagnosis, clinical risks, goals of care, and specify the vital signs and other relevant physiological/mental state observations to be monitored and include the frequency of the monitoring
- Individualised monitoring and assessment plans, along with the rationale for the plan, are to be documented in the woman's health care record
- All yellow and red zone breaches must be escalated as per local CERS unless an alternative response is documented in the resuscitation plan. Frequency of observations are to be increased following a CERS call and documented in the monitoring and assessment plan.

4.5 Alterations

- Standard calling criteria may be altered by a MO (registrar level or above) following assessment of a maternity woman only in consultation with the AMO / delegated clinician responsible. When altering calling criteria, a rationale must be documented in the health care record. This must include a minimum timeframe for review.

4.5.1 Chronic

Chronic alterations may be set to align with a woman's altered baseline and can be set for the duration of the woman's episode of care. Usually, this function is NOT expected to be used in the maternity woman.

4.5.2 Acute

Acute alterations are to be set for no longer than eight hours and are not to be used for extended periods of time. Acute alterations should be reviewed sooner than the set time if indicated by changes in the clinical condition. Regular review of the woman is required – see Appendix 2.

4.6 Vital sign monitoring for a woman in non-hospital settings/residential settings

- It is expected that each woman who receives maternity care outside of a hospital like; home midwifery support programs, hospital homebirth service, primary health service and community service; is monitored for signs of deterioration, with local protocols in place to guide and escalate care as required.

4.7 Mental Health

- Women should be observed for acute changes in their mental health. Postpartum psychosis is a rare psychotic episode (1:1000) that can occur in the early postpartum period. Women with known mental health conditions may also show deterioration so staff should be aware of plans to manage mental health changes
- Screening tools like the Edinburgh depression scale can be used to assist in assessments
- Safety of the newborn, other children and family members should be considered with acute deterioration of maternal mental health.

4.8 Cultural Support

- Aboriginal and Torres Strait Islander women may require additional supports sometimes as an inpatient. This can include family, Aboriginal health professionals such as, Aboriginal liaison officers, health workers or other culturally specific services.

- Support for non- English speaking culturally and linguistically diverse (CALD) families is available through cross cultural workers (weekdays, business hours) and the interpreter service.
  NSW Ministry of Health Policy Directive PD2017_044 – Interpreters – Standard Procedures for Working with Health Care Interpreters.

5. CLINICAL EMERGENCY RESPONSE SYSTEMS (CERS)

- All facilities that admit a maternity woman must have an obstetric CERS in place. The agreed CERS program for SESLHD is BTF.
  - All facilities are to use the Clinical Review, Rapid Response and Code Blue process. All calls are to be made dialling 2222
  - Clearly outline the patient and family escalation model available for maternity women and their families/carer's which enables them to directly escalate to a clinician, if they have any clinical concerns on deterioration. The R.E.A.C.H. program offers a direct escalation pathway through the local CERS.

5.1 CERS in specialty areas

- All speciality areas that require an obstetric CERS response must have localised protocols in place to manage the response.

5.2 Maternity woman - transfer processes

Intra hospital (transfer to higher level of care exempt)

- Yellow zone: The maternity woman with an observation in the yellow zone can be transferred between clinical areas provided there is a clinical plan in place
- Red zone: Each facility must have local process in place for the intra-hospital transfer of the maternity woman in the red zone.

Inter hospital

Maternity woman transfers:

- **RHW** Access Demand Manager OR After Hours Nurse Manager
  0434 565 264 /or 95651577- page 44020

Transfer Coordinator for the network as per the Tiered Network Operational Plan.

6. EDUCATION

- Education will be provided as by CEC Deteriorating Patient Education Strategy
  - Mandatory Maternity and Fetal Safety Education Program accessed via My Health Learning.

7. REFERENCES

- NSW Ministry of Health Policy Directive PD2017_044 – Interpreters – Standard Procedures of working with Health Care Interpreters
- NSW Ministry of Health Guideline GL2018_025 - Maternity Fetal Heart Rate Monitoring
- NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating
- NSW Health Tiered Perinatal Network Operational Plan, 2022

8. APPENDICES:

1. Key Terms
2. Minimum number and frequency for vital sign observations

9. VERSION AND APPROVAL HISTORY

Date	Version No.	Version and approval notes
March 2021	DRAFT	Rebecca Hughes CNC Deteriorating Patient Programs SGH, Alison Brown CMC Women's &Children's Clinical Stream, on behalf of the Deteriorating maternity woman working party: Louise Everitt CMC, Complex Pregnancy Care SGH , Maria Bulmer A/CMC Risk & Practice Development SGH, Joanna Pinder, CMC Risk and Practice Development TSH, Jacqui Andrews Midwifery Educator RHW. Draft for comments period.

May 2021	DRAFT	Final version approved by Executive Sponsor. To be tabled at Clinical and Quality Council for approval to publish.
June 2021	0	Endorsed by Clinical and Quality Council
27 July 2023	1	Minor Review by Rebecca Hughes CERS CNC SESLHD, Stephanie Rhodes RHW CERS CNC and Women's and Children's Stream members. Links, references and cultural support updated. Additional information included into Section 4.5.2 and responsibilities section defined.

Appendix 1 – KEY TERMS

Acute alterations to calling criteria	Alterations made to calling criteria for a condition where the maternity woman's observations will fall outside the standard parameters for a defined period of time, while treatment is taking effect. Acute alterations to calling criteria are set for a defined period of time (not longer than eight hours), after which they revert back to standard calling criteria. Women with acute alterations to calling criteria must have daily medical reviews to ensure their clinical progress aligns with their individual treatment plan.
Additional criteria	Signs or symptoms of deterioration depicted on the standard observation chart that a maternity woman may exhibit outside of, or in addition to, the standard calling criteria for vital signs observations.
Agreed signs of deterioration	Signs or symptoms of deterioration that a maternity woman may exhibit outside of, or in addition to, the standard calling criteria and additional criteria that are agreed following engagement of the woman, carer and family, and tailored to the woman's specific circumstances.
Altered calling criteria	Changes made to standard calling criteria by the AMO/delegated clinician responsible. To take account of the maternity woman's unique physiological circumstances and/or medical condition. Alterations may be 'acute' or 'chronic'.
A-G systematic assessment **A-I systematic assessment**	A structured approach to physical assessment that considers a maternity woman's **A**irway, **B**reathing, **C**irculation, **D**isability, **E**xposure, **F**luids, **G**lucose A structured approach to physical assessment that considers a maternity woman's **A**irway, **B**reathing, **C**irculation, **D**isability, **E**xposure, **F**luids, **G**lucose, Holistic, Infection
Attending Medical Officer (AMO)/Delegated clinician responsible	Senior medical practitioner who has primary or delegated responsibility and accountability for a woman on a temporary or permanent basis. For the maternity woman inpatient, this is the named Attending Medical Officer (AMO) or another consultant, staff specialist or visiting medical officer with delegated responsibility. As defined in local guidelines and following a risk assessment, the delegated clinician responsible may also be a senior clinician such as a nurse practitioner.
Behaviour change	Changes to the way a maternity woman interacts with other people or their environment that deviate from their baseline or their expected response, based on developmental age. Changes may present as shifts in cognitive function, activity/tone, perception, or emotional state, such as abnormal thinking, irritability, agitation, inconsolability and /or delirium.
Blue Zone	A coloured zone on the standard clinical tools that requires an increase in the frequency of observation. Staff are to consider calling for an early clinical review.
Clinical Emergency Response System (CERS)	A formalised system for staff, maternity women, carers and families to obtain timely clinical assistance when a maternity woman deteriorates (physiological and/or mental state). The CERS includes the facility-based and specialty unit based responses (clinical review and rapid response), as well as the formalised referral and escalation steps to seek expert clinical assistance and/or request for transfer to other levels of care within the facility (intra-facility) or to another facility (inter-facility).

CERS Assist	A NSW Ambulance program whereby urgent additional clinical assistance is provided in response to a rapidly deteriorating maternity woman (red zone observations or additional criteria) in a public health care facility.
Chronic alteration to calling criteria	Alterations to calling criteria where a maternity woman has a chronic (lasting >3 months) health condition which causes their normal observations to fall outside standard parameters. Chronic alterations are set for the duration of the patient's episode of care and are reviewed during routine medical review and assessment of the patient.
Clinical Review	A review of a deteriorating maternity woman undertaken within 30 minutes by the clinical team responsible for the maternity woman's care, or designated responder/s, as per the local CERS protocol.
Clinical team responsible for the maternity woman's care	The clinicians, led by the AMO/delegated clinician responsible, who are involved in, and responsible for, the care of the maternity woman on a temporary or permanent basis. In most cases this is the medical team unless otherwise specified.
Clinical Service	A health professional or group of professionals who work in cooperation and share common facilities or resources to provide services to patients for the assessment, diagnosis and treatment of a specific set of health-related problems/conditions in a facility or in the community.
Clinical Unit	A subset of a facility or service with a special clinical function.
Clinician/s	Medical, nursing, midwifery and allied health professionals who provide direct care to the maternity woman.
Deterioration in mental state	A negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.
Deteriorating Patient Safety Net System	The NSW Health Deteriorating Patient Safety Net System refers collectively to the various individual programs and frameworks implemented by NSW Health facilities/clinical services or clinical units to support the recognition and appropriate management of maternity women who deteriorate.
Facility	A building or structure where healthcare is provided by a public health organisation, such as a hospital, multi-purpose centre or office-based clinic.
Individualised monitoring and assessment plan	A plan for assessing and monitoring the maternity woman's clinical situation that Considers her diagnosis, clinical risks, goals of care and proposed treatment, and specifies the vital signs and other relevant physiological and behavioural observations to be monitored and the frequency of monitoring.
ISBAR	An acronym for **I**ntroduction, **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation, a structured communication tool.
Public health organisation (PHO)	Local health districts, statutory health corporations and affiliated health organisations (with respect to their recognised services) that provide direct patient care.
Rapid response	An urgent review of a deteriorating maternity woman by a rapid response team (RRT), or designated responder/s, as defined in the local CERS protocol.
R.E.A.C.H.	An acronym for **R**ecognise, **E**ngage, **A**ct, **C**all, **H**elp is on its way. R.E.A.C.H is a CEC program for all patients, including maternity women, carers and families to directly escalate concerns about deterioration through the local CERS.

Red zone	Coloured zone on the standard clinical tools that represent warning signs of deterioration for which a rapid response call (as defined by the local CERS protocol) is required.
Resuscitation Plan	A medically authorised order to use or withhold resuscitation measures (formerly called 'No CPR Orders'). Resuscitation Plans can also be used to document other time-critical clinical decisions related to end of life. A Resuscitation Plan is made: ☐ With reference to pre-planning by patients (such as Advance Care Directives or plans) ☐ In consultation with patients, carers and families ☐ Taking account of the patient's current clinical status, as well as their wishes and goals of care. Resuscitation Plans are intended for use for patients 29 days and older in all NSW PHOs, including acute facilities; sub-acute facilities; ambulatory and community settings; and by NSW Ambulance
Special Care Nursery	A clinical unit with space designated for the care of neonates who require additional support, or who need additional monitoring and/or observation
Standard Calling Criteria	Signs and symptoms that a patient/maternity woman is deteriorating and may require review of their monitoring plan or escalation of care through the Clinical Emergency Response System to appropriately manage the deterioration. Standard calling criteria are depicted on standard observation charts as blue, yellow and red zones.
Standard clinical tools	A tool or resource that supports clinicians to recognise when a maternity woman is deteriorating and outlines the appropriate response, such as the sepsis pathways; electronic fetal heart rate monitoring algorithm and labels; Comfort Observation and Symptom Assessment chart; and Resuscitation Plan, as well as the NSW Health standard observation charts.
Standard Observation Chart	Standardised observation chart approved for use by the NSW Ministry of Health. These have been developed for a variety of clinical settings
Track and trigger tool	A tool, such as the standard observation chart, that records vital sign observations and allows them to be tracked over time to support identification of a change in the maternity woman's condition that requires a review and/or change in management or frequency of observation.
Transfer of care	The transfer of professional responsibility and accountability for some or all aspects of care for a maternity woman, on a temporary or permanent basis. Also known as clinical handover.
Yellow zone	Coloured zone on the standard observation charts and standard clinical tools that represent warning signs of deterioration for which a clinical review or other CERS call may be required.

Appendix 2 – Minimum number and frequency for vital sign observations

At a minimum, a full set of vital signs observations must be performed and documented at the time of admission, within one hour of arrival to a clinical unit, and within one hour prior to discharge.
NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating

Group	Minimum frequency of assessment	Minimum set if vital sign observations	Comments
Maternity/ antenatal inpatient	Four (4) times per day at six (6) hourly intervals	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change* For fetal heart rate monitoring requirements refer to Maternity- Fetal heart rate monitoring guideline	SMOC Recommended for women greater than 20 weeks gestation and less than six weeks post- partum
Maternity/ postnatal inpatient with no identified risk factors	**Before leaving the birth environment** One full set of vital signs observation and a completed A-G or A-I maternity risk assessment	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*	If a woman has observations in a coloured zone or identified risk factors, vital sign observations are to be performed four times per day at six hourly intervals. Women receiving midwifery care at home monitor - according to local protocols
Maternity / postnatal inpatient with risk factors	One full set of vital signs observation plus a completed A-G or A-I maternity risk assessment. Four (4) times per day at six (6) hourly intervals	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, accumulated blood loss	SMOC Recommended for women greater than 20 weeks gestation and less than six weeks post- partum
Special Care Nursery	Six (6) times per day at for (4) hourly intervals	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, behaviour change*,pain score	
Newborn Care	**Before leaving birth environment** One full set of vital signs observation, plus a newborn risk assessment. If risk factors are identified and /or observations are within blue, yellow or red zone and /or additional criteria present further observations must be recorded on Standard Newborn Observation Chart (SNOC) six (6) times per day at four (4) hourly intervals.	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature.	Newborns with low or no identifiable risk factors are to be monitored/ assessed in-line with local protocols

*Includes an assessment of the patient's behaviour in the context of their development age and/or baseline assessment, noting changes in their cognitive function, activity, tone, perception or emotional state such as abnormal thinking, agitation, inconsolability and/or delirium.