# Maternal and Newborn Care Collaboration and Escalation Policy

## 1. Purpose

Maternal and newborn care is often dynamic across the continuum and can span various healthcare teams, as well as various services, dependent on the needs and preference of the woman and her baby. At all times, the care provided is to be individualised and women centred.

All women in pregnancy and birth at WA Country Health Service (WACHS) sites will have care from a midwife, as part of a wider midwifery team. As part of the broader team, women may also need obstetric care and women with more complex pregnancies may need care from the wider health care team. When supporting women in their decision making, consider risk and safety in the cultural, social, emotional, and financial context and include relevant team members where applicable.

This policy ensures the appropriate pathways are followed to achieve safe and timely care for women and their babies by the most appropriate members of the collaborative multi-disciplinary team. It also assists in resolution when differing clinical opinions may arise between health practitioners involved in maternal or newborn care and supports staff to 'speak up safely' with their concerns.

## 2. Policy Statement

### 2.1 Maternal and Newborn Risk Assessments

All women and newborns receiving maternity care must be assessed to determine their level of risk by using the Australian College of Midwives (ACM) categories in the National Midwifery Guidelines for Consultation and Referral (4th Edition, 2021). If a woman has conditions listed across two (2) categories in the ACM guideline the higher category is to be used.

The risk assessment must be made and documented on the MR70C WACHS Pregnancy Instruction Sheet at initial booking, 28 weeks, 36 weeks and on admission for labour/birth. A change in category may occur at any stage during the pregnancy and should be documented at the time of change. If there is a discrepancy in the category determined between midwifery and medical staff, the care must be discussed with the head of department and maternity manager.

Midwives can lead the care of a category A women/babies. Each site is to determine the involvement of medical team for category A patients. There is evidence that birth trauma can be reduced by women meeting team members that may be involved in their intrapartum care during the antenatal period. It would be expected if any category B or C conditions developed antenatally, intrapartum, or postpartum then consultation will occur with the obstetric medical team. Consultation may be via phone discussion which requires consensus documentation in the medical record and the woman's handheld pregnancy record.

### 2.2 Collaborative Care Pathways

Women who request care outside of WACHS endorsed maternal and newborn care guidelines must have an Obstetric consultation and management plan documented on the MR8B.2 WACHS Discussion and Partnership Care Plan: Declining Recommended Maternity Care and would not be considered category A. In conjunction, this policy also endorses the use of the Women and Newborn Health Service (WNHS) Partnering with the Woman who declines recommended maternity care clinical practice guideline for further guidance in situations where care is declined by the woman.

Each maternity site needs to develop their own local process to adapt the consultation and referral categories to consider their unique available staffing models and local resources. Some sites may choose to use the ACM guideline categories e.g. A= midwife, B = General Practitioner Obstetrician (GPO), C= Consultant. Other sites may choose to have a specific list of conditions that require escalation and to who the escalation should occur.

The local process must include antenatal, intrapartum, and postpartum clinical conditions with appropriate referral pathways. Some sites may include scheduled midwifery or obstetric appointments within ACM categories, as this helps avoid confusion for women and reduces overlap/over-servicing.

Each maternity site should develop a trigger list for intrapartum events that require the attendance of additional members of the team including consultant staff and paediatric teams. This list must be displayed in the labour ward so that all staff are aware. This list can include, if and when, the on call obstetric doctors would like to be notified after hours of a Category A woman in labour or who has given birth. An example is provided in Appendix A.

### 2.3 Escalation of Conflict of Opinion Pathway

Conflict of clinical opinion may arise (but not limited to) when:

- endorsed clinical guidelines are not being perceived as being followed
- concerns for client welfare held by one practitioner are not acknowledged by another
- intervention is deemed:
  - necessary by one practitioner but not by another
  - unnecessary by one practitioner but not by another
- there is disagreement as to:
  - a diagnosis, or
  - there is disagreement as to the appropriate management of a situation.

Where a conflict or difference in clinical opinion arises during maternal and newborn care, the clinicians involved should follow the escalation flow chart in Appendix B, until there is an agreed management plan in place.

## 3. Roles and Responsibilities

**Regional Medical Directors and Regional Nurse / Midwife Directors** are responsible for ensuring:

- there is review and investigation of all cases where the conflict resolution pathway resulted in a requirement to contact either the Midwifery Obstetric Emergency Telehealth Service (MOETS) or the WACHS clinical director

- that all medical and midwifery staff involved in providing maternity care of patients have access to this policy and have acknowledged its content
- compliance with this policy.

Any **midwife/nurse or doctor** involved in the care of a client can follow the conflict pathway to assist resolution where there are any conflicts of clinician opinion.

**All staff** are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

## 4. Monitoring and Evaluation

### 4.1 Monitoring

Monitoring of compliance to this policy is to be undertaken by:

- review and investigation of all cases by the relevant local and regional Obstetrics, Medical and Nursing / Midwifery Directors where the conflict resolution pathway resulted in a requirement to contact either MOETS, WACHS Coordinator of Midwifery or the WACHS Clinical Director Obstetrics and Gynaecology.
- monitoring of feedback from team leaders reporting issues experienced by staff with policy implementation
- identified concerns reviewed and managed via regional reporting processes and WACHS Coordinator of Midwifery or the WACHS Clinical Director Obstetrics and Gynaecology.

### 4.2 Evaluation

All instances where the conflict resolution pathway resulted in escalation to either MOETS or WACHS Clinical Director are to be tabled for review by the maternity Obstetric Leadership Group with oversight of the WACHS Safety and Quality Executive Committee. This policy will be reviewed and evaluated as required when the conflict resolution pathway was initiated to determine effectiveness, relevance and currency.

## 5. Compliance

This policy is aligned with the *Health Services Act 2016* (WA).

Failure to comply with this policy document may constitute a breach of the WA Health system Code of Conduct. The Code is part of the Integrity Policy Framework issued pursuant to Section 26 of the *Health Services Act 2016* and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies and procedures is mandatory.

## 6. References

Douglas, N; Robinson, J and Fahy, K. (2001). Inquiry into the Obstetric and Gynaecological Services at KEMH 1990-2000. Recommendation R5.20.28, Perth: WA Government.

Queensland Clinical Guidelines. (2021). Maternity shared care operational framework. Guideline No. MN21.27-V3-R26. [cited 2024 May 22].

Watkins V, Nagle C, Kent B, et al. (2017). "Labouring Together: collaborative alliances in maternity care in Victoria, Australia—protocol of a mixed-methods study". BMJ Open;7:e014262. doi:10.1136/bmjopen-2016- 01426. [cited 2024 May 22].

Department of Health. (2020). Australian Pregnancy Care Guidelines. [cited 2024 May 22].

National Health and Medical Research Council (Australia). (2010). National guidance on collaborative maternity care. [cited 2024 May 22].

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). (2017). Maternity care in Australia: a framework for a healthy new generation of Australians. Melbourne: RANZCOG.

## 7. Definitions

Nil

## 8. Document Summary

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| **Coverage** | WACHS wide |
| **Audience** | Clinical midwives and obstetric doctors |
| **Records Management** | Clinical: Health Record Management Policy |
| **Related Legislation** | • *Health Services Act 2016* (WA) |
| **Related Mandatory Policies / Frameworks** | • MP 0122/19 - Clinical Incident Management Policy 2019<br>• MP 0175/22 - Consent to Treatment Policy<br>• Clinical Governance, Safety and Quality Framework |
| **Related WACHS Policy Documents** | • Consent to Treatment Policy<br>• Maternal and Newborn Care Capability Framework Policy |
| **Other Related Documents** | • WNHS Partnering with the woman who declines recommended maternity care clinical practice guideline<br>• National Midwifery Guidelines for Consultation and Referral (4th Edition, 2021) |
| **Related Forms** | • MR30A Patient consent to treatment or investigation - Adult or Mature Minor<br>• MR70C WACHS Pregnancy Instruction Sheet<br>• MR8B.2 WACHS Discussion and Partnership Care Plan: Declining Recommended Maternity Care<br>• MR8B.3 Discussion and Partnership Care Plan: Declining Recommended Maternity Care Continuation Sheet |
| **Related Training Packages** | Nil |
| **Aboriginal Health Impact Statement Declaration (ISD)** | ISD Record ID: 3262 |
| **National Safety and Quality Health Service (NSQHS) Standards** | 1.01b, 2.04, 2.06, 2.07, 5.05-5.07, 5.10-5.13, 6.03, 6.9-6.11 |
| **Aged Care Quality Standards** | Nil |
| **Chief Psychiatrist's Standards for Clinical Care** | Nil |

## 9. Document Control

| Version | Published date | Current from | Summary of changes |
|---|---|---|---|
| 6.00 | 30 September 2024 | 30 September 2024 | This document has been reviewed with the following updates:<br>• change to policy title (previously Maternity Care Clinical Conflict Escalation Policy)<br>• addition of wording in purpose statement to support and consider risk and safety in the cultural, social, emotional and financial context – inclusive of relevant team members where applicable.<br>• minor changes to text to support escalation process for clinical team members and Appendix A<br>• addition of the WNHS Clinical Practice Guideline partnering with the Woman who declines recommended maternity care. |

## 10. Approval

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|---|---|
| **Policy Owner** | Executive Director Nursing and Midwifery Services |
| **Co-approver** | Executive Director Clinical Excellence |
| **Contact** | WACHS Coordinator of Midwifery |
| **Business Unit** | WACHS Nursing and Midwifery |
| **EDRMS #** | ED-CO-13-127730 |



**This document can be made available in alternative formats on request.**

## Appendix A: Example Intrapartum Care Escalation Trigger list

Women with the following conditions should have their care discussed/handed over to a practitioner or medical officer with Associate RANZCOG (Advanced procedural) / RANZCOG advanced diploma and obstetric credentialling qualifications and obstetric credentialing **[Adv DRANZCOG / ARANZCOG (Adv. P)]** or an **Obstetric Consultant**:

- abnormal CTG with likely fetal compromise and consideration of fetal scalp pH/lactate
- trial of instrumental delivery (for all OP position or at spines)
- failed instrumental delivery
- 3rd/4th degree tears
- PPH > 1000 mL
- pre-eclampsia requiring magnesium sulphate or emergency treatment of hypertension
- preterm labour and birth
- other significant issues of concern to the GPO/midwife.

An Obstetric Consultant must be in attendance for:

- vaginal delivery of twins
- breech vaginal delivery
- caesarean section for placenta praevia
- suspected ruptured uterus.

Paediatric team must be in attendance for:

- instrumental and operative delivery
- birth prior to 37 weeks
- abnormal CTG with likely fetal compromise
- neonate delivered in poor condition
- request by the treating maternity team.

Paediatric team including consultant must be in attendance for:

- birth prior to 34 weeks gestation
- breech vaginal delivery
- multiple pregnancy (any gestation)
- severe acute fetal compromise
- known high risk congenital abnormalities e.g. cardiac, diaphragmatic hernia
- any delivery where the **Paediatric Registrar** or **District Medical Officer (DMO)** or **General Practitioner Obstetrician (GPO)** with Associate RANZCOG (Procedural) / RANZCOG diploma qualification and obstetric credentialling requests assistance.

## Appendix B: Maternity Care Clinical Conflict Escalation Pathway