SESLHD GUIDELINE COVER SHEET

NAME OF DOCUMENT	Maternity – identifying, reviewing and reporting trigger and critical clinical events
TYPE OF DOCUMENT	GUIDELINE
DOCUMENT NUMBER	SESLHDGL/095
DATE OF PUBLICATION	July 2021
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards Standard 1.1
REVIEW DATE	July 2024
FORMER REFERENCE(S)	N/A
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical services
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POSITION RESPONSIBLE FOR DOCUMENT	Deputy Director of Clinical Governance and Medical Services
FUNCTIONAL GROUP(S)	Women and Babies Health, Clinical Governance
KEY TERMS	Trigger cases, maternity, neonatal, risk management, incident investigation,
SUMMARY	The guideline outlines the maternity events that require identification, review and reporting.

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Maternity – identifying, reviewing and reporting trigger and critical clinical events

Section 1 – Background

NSW Ministry of Health Policy Directive PD2009_003 - Maternity – Clinical Risk Management Program requires that there is routine review of maternity events to ensure appropriate care and best practice is provided to women receiving care in a maternity unit.

It is acknowledged that such events/complications are not always preventable and will occur even when best possible care is provided and all protocols and policies are followed.

Routine and regular review of trigger cases enables assurance that best practice protocols, guidelines and policies are complied with and that the care provided is in accordance with the woman's wishes.

Routine and regular review of trigger cases allows for the identification of emerging trends, which may need proactive remedial actions.

Maternity trigger events can occur throughout pregnancy (including <20 weeks gestation), during pregnancy, labour, delivery and up to 6 weeks post-natal.

PD2021_006 refers to the "late" maternal period which concludes 365 days after birth.

Section 2 - Principles

The Clinical Excellence Commission (CEC) guiding principles reflect contemporary safety and quality principles and are guided by human factors science which support learning and system improvements.

Safe Place for Learning – discussions are blame free with a focus on education

Multidisciplinary – enhancing active participation across the disciplines

Meeting Framework – systemic agenda selection process with support from clinical analytics

Comprehensive discussion – to generate actionable learning and/or system improvement

Lessons learnt – documentation of lessons learned and dissemination of recommendations to ensure action

Governance – pathways for reporting to support learning and recommendations

Reference: Clinical Excellence Commission – Guidelines for conducting and reporting Morbidity and Morbidity/Clinical review meetings.

Section 3 - Definitions

Definition:

- IMS+ - the NSW Health Incident management system
- Harm – patient harm is any unintended and unnecessary harm resulting from, or contributed to, by health care. This includes the absence of indicated medical treatment
- Harm score 1 – Unexpected death of a patient unrelated to the natural course of the illness and differing from the immediate expected outcome of patient management, or Australian Sentinel Event (discharge or release of a child to an unauthorised person)
- Harm score 2 – event which has caused major harm
- Harm score 3 – event that has caused minor harm
- Harm score 4 – no harm caused or a near miss
- Near Miss – an incident that could have caused harm but did not or an incident that was intercepted before causing harm
- Incident review – a structured process to identify what happened; how and why it happened; what could be done to reduce risk and make care safer; and what has been learned
- "Trigger" events in maternity can occur as a result of the birthing process regardless of the care provided
- Review of "Trigger" events allows for care to be explored to identify aspects of care which may need to be improved/amended
- Trending of "Trigger" events allows for the themes and aspects of care which may need to be improved/amended
- Serious adverse event review (SAER) is the investigation undertaken to investigate a Harm Score 1 incident. Harm score 2, 3 or 4 incidents can be investigated by SAER if the CE determines there may be serious systemic problems.

Section 4 - Responsibilities

Clinical staff (midwifery, medical, allied health) are responsible for:

- Identify and reporting trigger events
- Notify incidents in IMS+ where harm resulted
- Participate in the review process by providing the team with information
- Implement the recommendations made.

Managers are responsible for:

- Ensuring a robust process of identification, review and reporting occurs within the maternity unit
- Contribute to the development of recommendations
- Implement and monitor the effectiveness of recommendations.

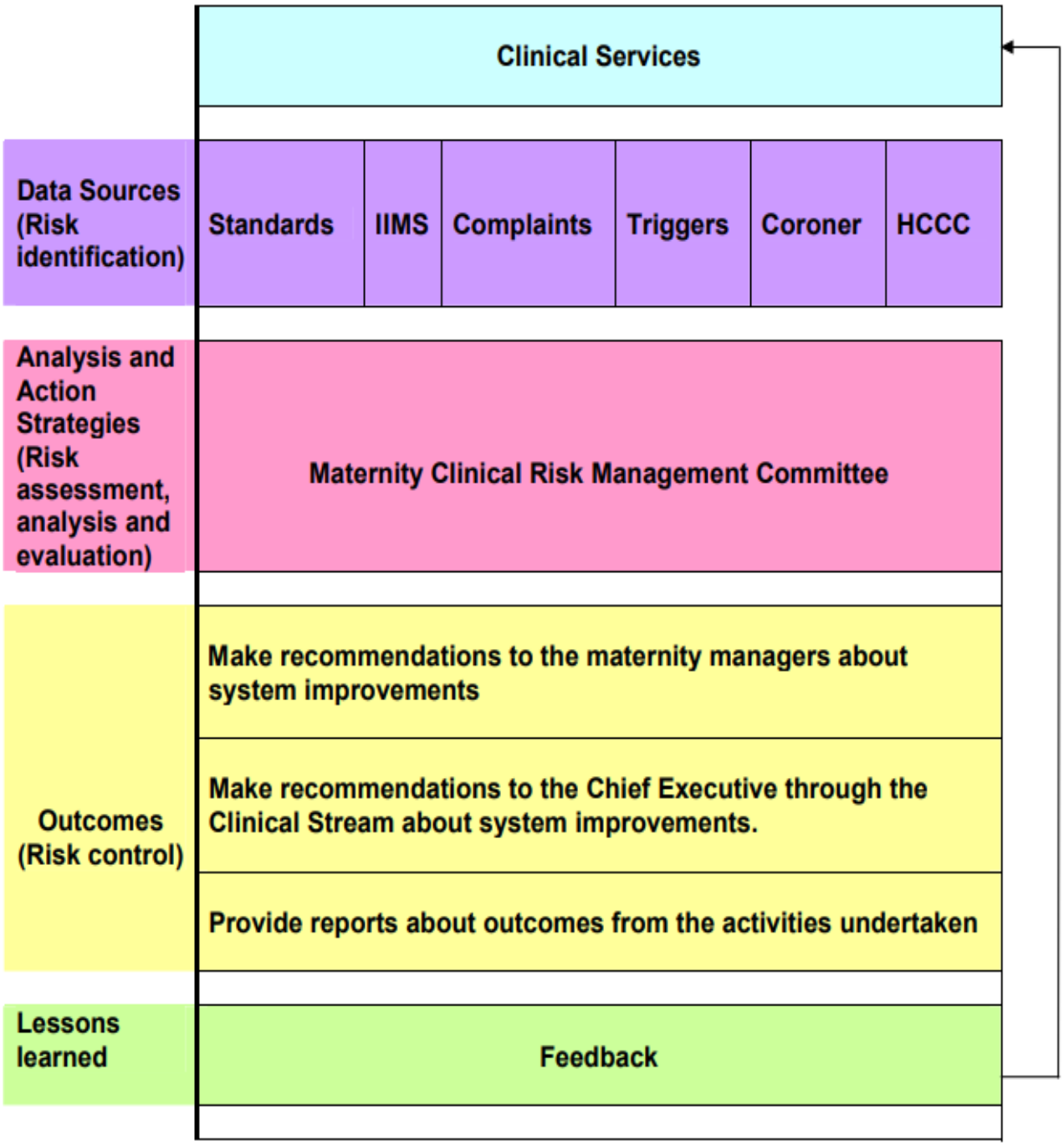
Governance Staff are responsible for:

- Support the systems and process for ongoing review of trigger and critical events
- Assist with identification of themes and systemic issues
- Report themes, systemic issues and recommendations to the Maternity Quality and Patient Safety Committee, hospital executive and Stream Governance Committee
- Monitor the implementation and effectiveness of the recommendations.

Hospital executive are responsible for:

- Supporting the systems and process for the ongoing review of trigger and critical events
- Approve the local processes for the ongoing review of trigger and critical events
- Support the implementation of approved recommendations.

Appendix 1 Maternity Clinical Risk Management process



Note: Reference PD2009_003 – which refers to the IIMS incident reporting system, not IMS+

Section 5 - Identification of cases:

As detailed in NSW Ministry of Health Policy Directive PD2009_003 - Maternity – Clinical Risk Management Program, the trigger events to be reviewed are:

Maternal:
Severe postpartum haemorrhage >1500 mls
Peripartum blood product transfusion
Unplanned return to theatre
Anaesthetic complications
Admission to a critical care area outside of the maternity unit
Thromboembolic events
Caesarean section at full dilatation (all presentations)
3rd/4th degree tears
Uterine rupture
Unplanned readmission
Transfer to a higher level facility
Maternal death

Neonatal:
Shoulder dystocia where more than positioning and/or McRoberts manoeuvre are required to effect delivery
Term baby admitted to NICU (except if admitted for closer observation before being reunited with mother)
Transfer to a higher level facility
Stillbirth

Organisational:
Unavailability of health record
Delay in responding to call for assistance
Faulty equipment
Conflict over case management
Potential patient complaint
Failure to follow local protocol

Other events can be included in this list, as determined by the Stream Governance Committee or Maternity Service.

Maternity Trigger events are identified by:

- Clinical staff (maternity and neonatal) - reporting
- At Clinical handovers – women who have experienced a “trigger” event can be identified
- Reports from data sources such as eMaternity, IMS+, eMR
- Woman’s feedback – obtained directly or during “debriefing” conversations
- Complaints – directly received or via HCCC.

Section 6 - Screening:

Trigger events are identified regularly by the clinical teams and eMaternity reports

The incident has an initial review by clinical experts (ideally 2-3) as soon as possible after the event to:

- to assess if there are concerns requiring a more formal investigation
- to ensure the mother and her family are provided with the appropriate care and have the opportunity for a debrief, or an open disclosure conversation
- to ensure that culturally appropriate decision making and cultural beliefs are undertaken and addressed for women of Aboriginal and Culturally and Linguistically Diverse background
- the event has been documented correctly, within the medical record
- an IMS+ incident has been notified if harm has occurred
- staff are supported when a critical incident has occurred.

Review:

Cases are referred to a multidisciplinary team (Maternity Clinical Risk Management Committee) for investigation using an approved investigation method such as Comprehensive Incident Analysis method or Concise Incident Analysis method.

The review will include medical records review, staff interviews, analysis, consideration of learnings and recommendations and a report is generated.

The summary of the case, results of the analysis and recommendations are documented.

Any performance issues identified are referred for appropriate management.

Any themes identified are to be included in reports to governance committees.

Section 7 - Documentation and reporting:

The outcome of the triage of all trigger cases is to be documented

- Trigger events where no harm resulted, or harm occurred where all appropriate care was provided are to be documented as per local reporting requirements

- Incidents that resulted in patient harm are to be reported in IMS+ - ideally, at the time of the incident, with outcomes of review included prior to completion/finalisation.

Reports for each case reviewed by the multidisciplinary team is produced which includes analysis and identification of issues.

Issues and themes identified by either the triage, investigating team or governance staff are to be reported to the Maternity Quality and Patient Safety Committee.

Reports provided to Maternity Quality and Patient Safety Committee are to include:

- Numbers of triggers identified
- Principle incident types of triggers
- Outcomes from case review
- Recommendations from the reviewing teams
- Themes

Clinical staff are provided with regular feedback and reports.

Themes and recommendations are to be provided back to the clinical teams– as soon as is practicable, with the aim to promote learning and continuous improvement.

A report is to be provided to the Stream Governance Committees and is to include data such as rates, recommendations and themes.

Section 8 – Reporting of neonatal death or severe brain injury:

The NSW Ministry of Health Policy Directive PD2020_047 - Incident Management states that a RIB to MoH (via IMS+) is required for term babies born with suspected or confirmed harm

Severe brain injury diagnosed in the first seven days of life:
- Diagnosed with Grade III hypoxic ischaemic encephalopathy (HIE) OR
- Therapeutically cooled (active cooling only) OR
- Decreased central tone AND was comatose AND seizures of any kind

Please note: An updated RIB can be re-submitted to MoH if a change in the baby's condition occurs (for example: if the baby is cooled then on further investigation, HIE is not evident)

Unexpected intrapartum stillbirth and early neonatal death (0-6 days) are considered to be a Harm Score 1 incident and are a reportable incident to be investigated by SAER team.

Section 9 - Reporting of maternal deaths:

Refer to NSW Ministry of Health Policy Directive PD2021_006 - Reporting of Maternal Deaths to the Clinical Excellence Commission.

Unexpected death of woman who are ether pregnant (any stage) or up to 6 weeks post-natal are reportable incidents and must be managed as per NSW Ministry of Health Policy Directive PD2020_047 - Incident Management.

Late maternal deaths are to be reported – women who are more than 6 weeks but less than 1 year after the end of the pregnancy and be from any cause.

Documentation & References

- NSW Ministry of Health Policy Directive PD2020_047 - Incident Management
- NSW Ministry of Health Policy Directive PD2021_006 - Reporting of Maternal Deaths to the Clinical Excellence Commission
- NSW Ministry of Health Policy Directive PD2009_003 - Maternity – Clinical Risk Management Program
- The NSW Aboriginal Perinatal Health Report (2003)

Revision and Approval History

Date	Revision no:	Author and approval
April 2021	DRAFT	Initial draft. Draft for Comment period.
June 2021	DRAFT	Final version approved by Executive Sponsor. For tabling at Clinical and Quality Council for approval.
July 2021	1	Approved at Clinical and Quality Council.

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Notification of trigger list – Maternity / Obstetrics incidents

Health facilities are required to notify Gallagher Bassett, claims manager for the NSW Treasury Managed Fund, of any incident which might reasonably give rise to a health liability claim. This document provides examples of adverse clinical obstetric or maternity incidents which have a high risk of raising a claim and should be notified to Gallagher Bassett. It should be read in conjunction with the general clinical incident trigger list.

There are no fixed rules to determine which clinical incidents may lead to a claim, but a risk mitigation approach should be applied.

Ask these questions:

1. Has there been a potential breach of acceptable clinical practice?
2. Did the incident result in a loss or injury and what are the actual or likely consequences of that loss?
3. Is there known, or is their likely to be temporary or permanent impairment or death?
4. Will there be long term or on-going care considerations as a result of the impairment?
5. Will the impairment affect the patient's ability to work, live or function independently?
6. Does the patient have young children or other dependents who require care?
7. Does the patient have relatives who may be at risk of suffering psychological harm as a result of a potential breach?

Maternity and obstetric adverse incidents are in a special category because the extent of any injury to the baby may not be clear at the time of delivery. Follow up information about the baby's condition will be required.

Claims arising from maternity/obstetric incidents may also arise many years after the event – for example when the child is not meeting developmental milestones, or cognitive impairment only becomes known after the child starts school. Early notification of adverse incidents to Gallagher Bassett optimises the LHD's investigation and defence of claims by allowing:

- the early identification and preservation of relevant clinical notes/staff diary notes/CTG traces/ pathology results/medical and midwifery staff rosters/equipment batch numbers/sterilisation or other theatre records; and
- early identification of potential witnesses, and collection of statements if needed, while memories are fresh.

What to report to Gallagher Bassett

The following list provides some examples of the types of clinical incidents which should be notified to Gallagher Bassett as soon as possible where prognosis or clinical outcome has been adversely impacted as a result of the treatment or care.

Maternal
Maternal death
Unplanned admission to a critical care area outside of the maternity unit
Unplanned hysterectomy or Laparotomy post-partum
Placental abruption
Uterine rupture
Retained or missing swab / instrument
Thromboembolic events
Foetal/Neonatal
Stillbirth
Neonatal death

Apgar score <7 at 5 minutes with admission or transfer to NICU
Cord ph <7.10 arterial or cord lactate >5.2 with admission or transfer to NICU
Neonatal seizures
Neonatal encephalopathy
Traumatic delivery resulting in brachial plexus injury such as Erb's palsy, facial nerve palsy, fractured clavicle, femur
Birth trauma from instrumental delivery e.g. sub-galeal bleed post vacuum delivery
Undiagnosed major congenital anomaly
Term baby admitted or transferred to NICU
Jaundice requiring exchange transfusion: and/or with delay commencing phototherapy
Delayed diagnosis of hip dysplasia
Organisational
Failure to follow local protocol (eg. Guidelines on the use of Oxytocin for the Induction of Labour) in connection with maternal or neonatal injury
Patient complaint about clinical care
Patient declining recommended treatment with adverse outcome
Any indicator that the patient/family may develop a significant psychological response to an adverse clinical event

What NOT to report to Gallagher Bassett

Adverse clinical incidents where there is no known (or anticipated) maternal or neonatal injury or impairment, and/or a full recovery is likely. These may include:
Post-partum haemorrhage with return to stable haemodynamics, and no known adverse effects of hypoxia
Unplanned return to theatre with no ongoing injury
Anaesthetic complications with no ongoing injury
Caesarean section at full dilation with no adverse effects
Maternal or neonatal transfer to a higher-level facility with no adverse effects
Unavailability of health record, faulty equipment, delay in responding to call for assistance with no effect on eventual patient outcome
Conflict over case management, with no effect on eventual patient outcome

Ultimately, you will have to exercise your own judgement in determining what matters to report to Gallagher Bassett.

Actions to seek to minimise loss

Depending on the nature of the incident, the LHD / VMO scheme may wish to consider various options to provide support for patients or their family members, such as counselling. This can help to reduce the risk of claims being brought or the severity of the claimed loss. In circumstances involving children, it may be appropriate to consider monitoring their development so there is an objective measurement against which any claimed loss can be assessed.

To discuss further, ring Gallagher Bassett

- If a clinician or member of the hospital staff is unsure whether an incident ought to be reported, they should speak to the Risk Manager responsible for notifying matters to TMF.
- If the Risk Manager is unsure whether to report an incident, they can call Gallagher Bassett Claims on 1300 407 022 or email generalclaims@icare-gb.com.au to seek advice.