

# SESLHD POLICY COVER SHEET



**Health**  
South Eastern Sydney  
Local Health District

<b>NAME OF DOCUMENT</b>	Maternity Services Clinical Escalation Policy
<b>TYPE OF DOCUMENT</b>	Policy
<b>DOCUMENT NUMBER</b>	SESLHDPD/273
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<b>LEVEL OF EVIDENCE</b>	National Safety and Quality Health Service Standards: Standard 1 - Clinical Governance Standard 8 - Recognising and responding to acute deterioration
<b>REVIEW DATE</b>	March 2025
<b>FORMER REFERENCE(S)</b>	SESLHDPD/2009_003 Maternity –Clinical Risk Management Program
<b>EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR</b>	Clinical Stream Director, Women’s and Children’s Health
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<b>FUNCTIONAL GROUP(S)</b>	Women and Babies Health
<b>KEY TERMS</b>	Escalation, concern, inform, communication, maternity, clinical escalation
<b>SUMMARY</b>	The Policy is specific to Maternity Services and provides advice and clarity to clinical staff to escalate clinical situations of concern. The policy should be used in conjunction with <a href="#">NSW Health Policy Directive PD2020_018 Recognition and management of patients who are deteriorating.</a>

**COMPLIANCE WITH THIS DOCUMENT IS MANDATORY**  
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**1. POLICY STATEMENT**

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

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

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

**1.2 EVIDENCE FOR ESCALATION**

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

Perinatal Safety education training and in house face to face education is mandatory for all New South Wales (NSW) health midwives, obstetricians and trainees. SESLHD encourages clinicians, including nurses working in maternity services to undertake this training. The education training provides multidisciplinary role play, which improves staff’s confidence to escalate in situations of clinical concern. Staff access education via [My Health Learning](#).

Misinterpretation of Electronic Fetal Heart Rate patterns is a common theme. The CEC report published in 2013 – *Fetal Monitoring: Are we getting it right?* cites numerous cases where inadequate monitoring and interpretation of clinical observations contributed to delays in diagnosis and treatment of fetal distress. Since 2013, fetal monitoring, failure to recognise the deteriorating patient and failure to escalate the deteriorating patient, continue to be the most frequently recognised clinical risk factors identified in the [CEC Root Cause Analysis reports](#).

2. **AIM**

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

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

3. **TARGET AUDIENCE**

- Departmental MUMs/ NUMs
- Registered Midwives/Nurses
- Medical Staff
- After Hours Nurse/ Midwifery Manager

4. **RESPONSIBILITIES**

- 4.1 The clinician's concerns should be documented in the woman's and/or baby's medical record, as well as a description of their clinical condition at the time. Judgments in respect to an individual clinician's clinical practice must not be documented, only objective data regarding the patient's condition and management plan should be included.
- 4.2 As per NSW Health PD2020\_018 [Recognition and management of patients who are deteriorating](#), the frequency of observations should be reviewed and increased as required, and maintained until a further review and plan of management has been made and documented in the medical record.
- 4.3 Where the situation remains unresolved, to the satisfaction of the staff member who is concerned, the consultant should be contacted and a clear request made for a further expert opinion and/or assistance as appropriate. This conversation and any subsequent clinical management plan should be clearly documented in the medical record.
- 4.4 If the nominated or on-call consultant responsible for the woman or baby cannot be contacted, the obstetric director of the specialty should be contacted directly. If there is any conflict in regards to treatment, the midwifery manager of the service and/or the after-hours midwifery/nurse manager should be contacted.
- 4.5 If at any time there is difficulty in contacting the next level of seniority or the situation remains unresolved, the Director of Clinical Services or Executive member on-call should be contacted directly. See [Appendix 1](#) for the Maternity Services Clinical Escalation Policy Flow Chart or [Appendix 2](#) for Neonatal Services Escalation Policy Flow Chart.

5. **COMMUNICATION**

The on-call consultant is frequently required to make decisions regarding clinical management. In making these decisions the consultant is dependent upon the accuracy of the information provided. For this reason, protocol language should always be used as

per local policy, RCOG/RANZCOG/Maternity – Fetal Heart Rate Monitoring guidelines. This is particularly relevant for discussion around fetal heart rate patterns. [Appendix 3](#) details the accepted terminology in NSW for the interpretation, escalation and referral of fetal heart rate patterns.

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

- 5.1** Human factors help identify and mitigate risk in clinical practice, enhance patient safety and improve clinical quality. The below elements may act as a precursor to accidents and incidents, or influence staff to make mistakes. Staff awareness of how human factors can affect them and their colleagues, during times of heightened activity may help avoid or minimise risk.

Lack of Communication	Complacency	Pressure	Lack of Assertiveness
Distraction	Stress	Lack of Knowledge	Norms
Lack of Resources	Lack of teamwork	Fatigue	Lack of Awareness

**6. DEFINITIONS**

Fetal heart rate pattern definitions can be found in [Appendix 3](#).

**7. DOCUMENTATION**

- Electronic Medical Record/ data bases
- Partogram
- Birth Details Summary
- Antenatal and Intrapartum fetal heart rate pattern labels
- Maternal postnatal pathways
- Neonatal care plan
- Standard maternity observation chart SMOC
- Standard neonatal observation chart SNOC
- eMR Clinical Review Response Form
- eMR Rapid Response Form

**8. REFERENCES**

- [Australian College of Midwives, 2021, National Midwifery Guidelines for Consultation and Referral 4th Edition](#)
- [National Institute of Clinical Excellence \(NICE\), Clinical Guideline CG190, Intrapartum care for Healthy Women and Babies, February 2017](#)
- [Clinical Excellence Commission, Human Factors](#)
- [Clinical Excellence Commission, Maternity and Neonatal Safety Program](#)
- [Clinical Excellence Commission, Biannual Incident Report](#)
- [NSW Health Clinical Excellence Commission \(CEC\) Patient Safety Team Focus Report 2013 'Fetal Monitoring- Are we getting it right?'](#)

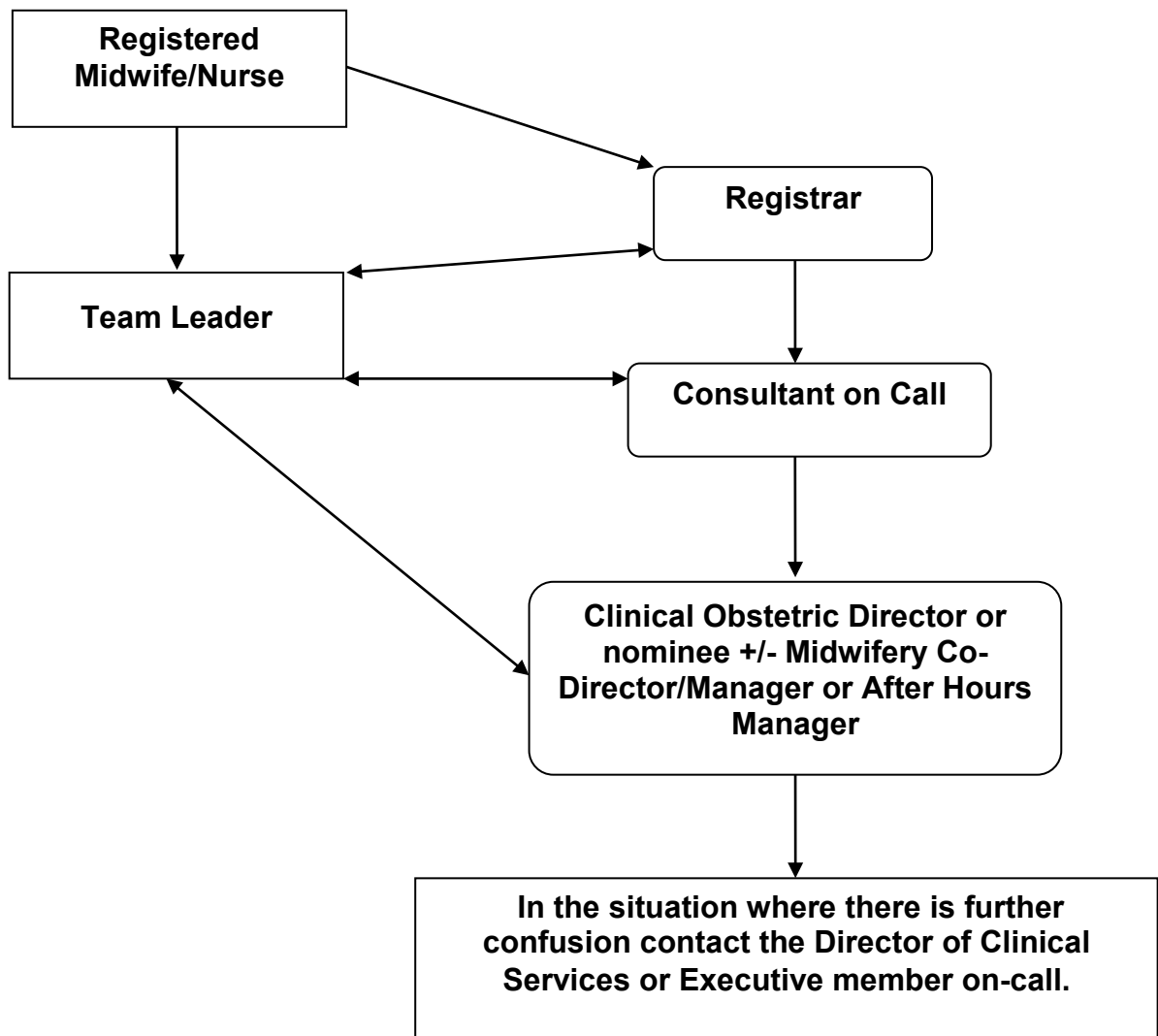
- [NSW Ministry of Health Policy Directive PD2020\\_018 - Recognition and management of patients who are deteriorating.](#)
- [NSW Ministry of Health Policy Directive PD2019\\_020 Clinical Handover](#)
- [NSW Ministry of Health Guideline GL2018\\_025 Maternity - Fetal heart rate monitoring](#)
- Royal College of Obstetricians and Gynaecologists. The Use of Electronic Fetal Monitoring Evidence-based Clinical Guideline Number 8, 2001.

**9. REVISION AND APPROVAL HISTORY**

Date	Revision No.	Author and Approval
May 2014	3	Reviewed by Dee Sinclair, CMC Maternity Clinical Risk Management
July 2016	4	Reviewed by Expert Group, endorsed by Clinical Governance Committee
July 2016	4	Updates endorsed by Executive Sponsor
September 2016	4	Final draft submitted to Executive Services with associated paperwork
March 2022	5	Minor Review: human factors added, appendices updated, scenarios removed from aims, references and hyperlinks updated. Endorsed by Executive Sponsor.

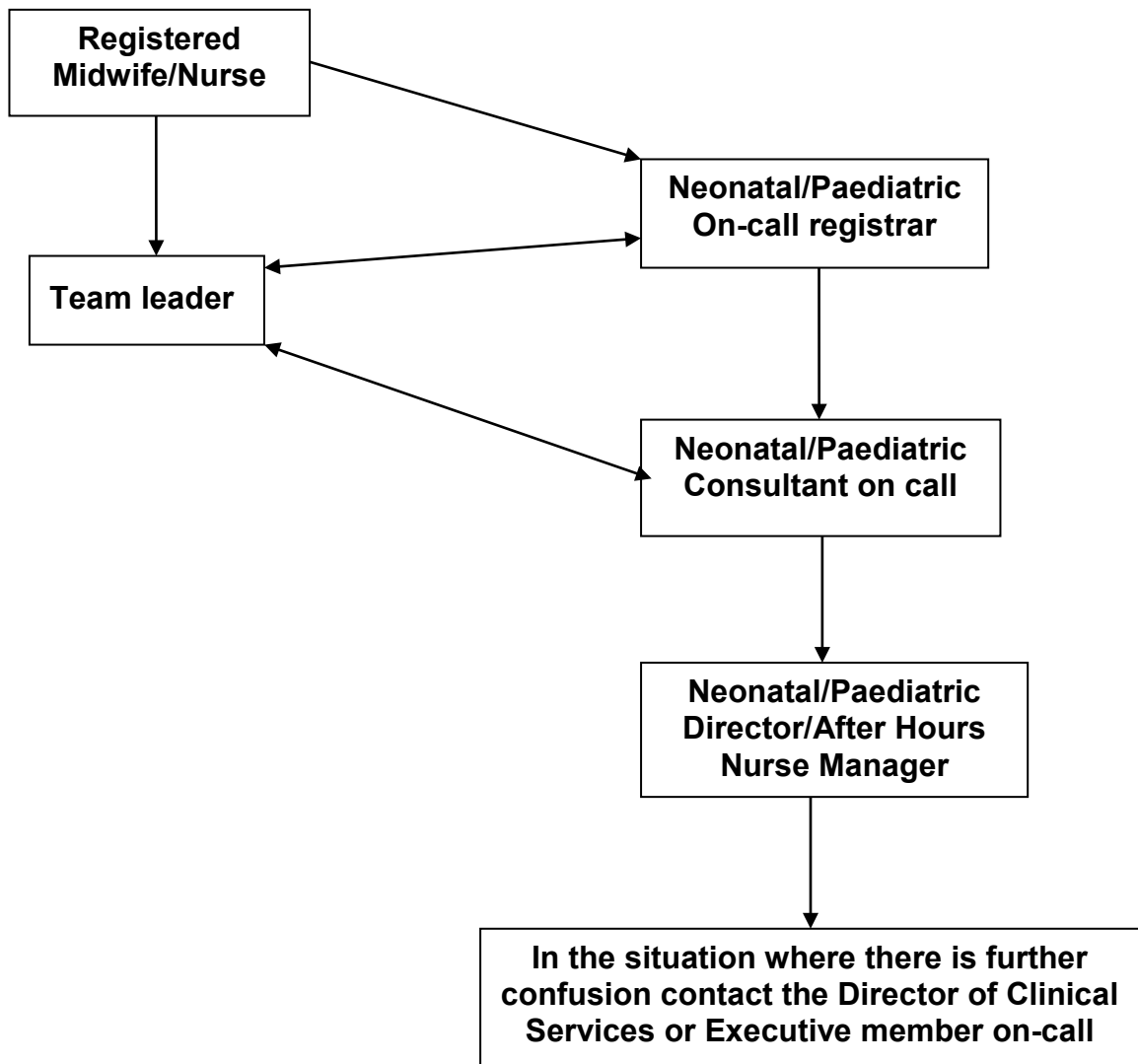
**Appendix 1: Maternity Services Clinical Escalation Policy Flow Chart**

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



**Appendix 2: Neonatal Services Clinical Escalation Policy Flow Chart**

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



# SESLHD POLICY

## Maternity Services Clinical Escalation Policy

SESLHDPD/273

### Appendix 3:

### Antenatal Fetal Heart Rate Pattern Interpretation and Management Algorithm

ANTENATAL ≥ 32 WEEKS	Name	MRN	Date	Time	Gest Age
Determine Risk / Indication for CTG			Fetal movements		Maternal Pulse
Altered Calling Criteria	<input type="checkbox"/> NO <input type="checkbox"/> YES	Collaborative care plan in place	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Uterine Activity	Baseline	Rate	Variability	bpm	Reactivity
Nil or gestation ≥37 weeks gestation	≥110-160		6-25		Present
Present < 37 /40	100-109 >160-180		Reduced ≤5 or absent for >45 mins; or >25 for >15 mins		Absent >45 mins
Present and occurring > 5:10, Lasting ≥ 2 mins and/or <60 secs between contractions	<100 >180		Reduced <5 or absent >90 mins Sinusoidal /sawtooth >15 mins		Absent >90 mins
<b>Clinical Escalation Response</b>					
Normal	Abnormal Yellow feature - Clinical Review within 30 mins 2 or more Yellow features=Red Zone=Call a Rapid Response Time of call			Abnormal Red Zone feature/s - Call a Rapid Response Time of call	
Name (s)		Date	Time		
Signature(s)					
Name (s)		Date	Time	Agree with Clinical Response	
Signature(s)				<input type="checkbox"/> Yes <input type="checkbox"/> No	

### Intrapartum Fetal Heart Rate Pattern Interpretation and Management Algorithm

INTRAPARTUM	Name	MRN	Date	Time	Gest Age	Mat Pulse
Antenatal risk factors						
Intrapartum Risk Factors	Uterine scar	Second stage	Epidural	Oxytocin	Abnormal labour progress	Persistent pain
Risk Factors Affecting Fetal Reserve	IUGR	Hypertension / Pre-eclampsia	Temperature / Infection	Meconium	Prematurity	Diabetes
Altered calling criteria	<input type="checkbox"/> No <input type="checkbox"/> Yes	Collaborative care plan in place	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Contractions	Baseline	Rate	Variability	bpm	Accelerations	Decelerations
Normal uterine activity ≤5 in 10 minutes	110-160		Normal 6-25 Cycling present		Present	Nil
Abnormal uterine activity ≥6 in 10 minutes or lasting ≥2 minutes <60 seconds between contractions	100 to 109 >160 Rising baseline >10%  <100 for >10 minutes		Absence of cycling in last 60 minutes  Reduced ≤5 or absent for >50 minutes Increased >25 for >30 minutes Sinusoidal pattern >30minutes		Absent  <i>The absence of accelerations are unlikely to be associated with fetal compromise</i>	Early Occasional variable Repetitive variable Single prolonged >90 seconds and <3 minutes Repetitive complicated variables Repetitive late Single prolonged (>3 minutes and no signs recovery)
<b>Clinical Escalation Response</b>						
Normal	Blue Zone Alert	Abnormal Yellow feature - Clinical Review within 30 mins 2 or more Yellow features=Red Zone=Call a Rapid Response Time of call			Abnormal Red Zone feature/s - Call a Rapid Response Time of call	
Name	Date	Name	Date	Time		
Signature	Time	Signature			Agree with Clinical Response <input type="checkbox"/> Yes <input type="checkbox"/> No	