CLINICAL GUIDELINE

GGC Site Activity Escalation and potential divert process for Maternity

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Approval Group:	Maternity Clinical Governance Group

Important Note:

The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Women and Children's Directorate

GGC Site Activity Escalation and potential divert process for Maternity

The purpose of the guide is to support the maternity unit coordinator during times of increased operational pressures, ensuring safe staffing levels and safe effective care are maintained.

Factors requiring escalation:

1. The acuity of women/workload exceeds available staffing levels/skill mix levels.
2. The flow of women remains impeded by bed occupancy when all usual actions for managing flow have been exhausted.
3. Temporary suspension of maternity admissions is advocated due to activity, bed capacity, or reduced staffing levels.
4. Fire and other major incidents.
5. Professional concerns.

A local site specific safety brief should be undertaken, led by Lead Midwife/ Unit Coordinator. Following this, escalate to joint site reviews with LMs/CSM/ DoM/Associate Chief Midwife in hours and coordinators across sites out of hours:

GREEN: NORMAL WORKING / NO ISSUES
AMBER: MODERATE PRESSURE
RED: EXTREME PRESSURE

GREEN: Normal working	
SITUATION	**MITIGATION**
The maternity unit has appropriate staffing/ skill mix levels.	Review the current and planned workload including staffing and skill mix at the beginning of each shift. Huddle at agreed unit time (08.15 or 08:30).
All presentations at Maternity triage reviewed timeously.	Cross site huddle
Planned workload facilitated (Planned Caesarean Births, Induction of Labour, and Augmentation of Labour), in collaboration with neonatal service.	Identify early transfers home postnatally Identify neonatal status
Availability of beds on intrapartum floor; Able to provide1:1 Midwifery care for women in active labour.	Continuous review of workload/workforce required at all handovers morning, afternoon and evening.
Workload manageable to support all women and babies.	
Able to admit all women to intrapartum floor with no delay, for example, those requiring continuous monitoring/epidural; able to admit women suitable for midwife led intrapartum care to CMU or AMU	

AMBER : Moderate pressure	
SITUATION	**MITIGATION**
Availability of inpatient beds leading to cause for concern: 1. Delayed transfers from AN ward to LW 2. Delayed transfers from LW to PN ward 3. Delayed transfers from Maternity Triage to AN/PN/LW	**Midwifery Co-ordinator:** Continue to review workforce across all areas within the maternity unit and reallocate staff to areas of highest need according to current risks within the areas. Senior charge midwives to work clinically for a period to reduce pressure and ensure staff rest breaks facilitated. Identify and rank level of urgency for each delayed transfer, based on the individual woman and baby's level of risk. Offer overtime and/or bank shifts to cover peak activity in next shift period.
Limited bed capacity on maternity floor for pending admissions	Review planned workload, decide if safe to proceed or if there is an option to delay or transfer to other units considering risk factors prior. This should be conducted in conjunction with on call clinicians on both sites. Review, identify and rectify where possible causes for delay in discharge of women and babies from postnatal ward to home, identify any women willing to go home earlier than originally planned, if they and baby are well; This may require further review / consultation with maternity / neonatal colleagues. Consider offering NIPE/DEON by community midwife if appropriate or return to ward for NIPE/DEON. Consider early transfer home directly from AMU/CMU/labour ward if appropriate. Open where possible postnatal contingency beds to support flow. Request on call team to consider additional ward round to facilitate any further postnatal / antenatal discharges.
Staffing level leads to concerns about ability to provide necessary care and for staff to have allocated breaks.	Consider increasing the frequency of multidisciplinary site huddles to review situation and agree a plan. Identify whether all support workers and senior student midwives are being fully mobilised to provide maximum care within their scope and experience.

RED: EXTREME PRESSURE	
SITUATION	**MITIGATIONS: Actions for midwifery coordinator**
Unable to provide safe levels of care due to: • staffing levels • activity • acuity	Review all amber actions. Request movement of staff from less busy or pressured unit to red unit. Consider mobilising non clinical midwifery staff working in the unit to provide short term relief for breaks and/or transfer of woman from one area to another.
No inpatient beds available (reached maximum capacity)	Continue to risk assess and prioritise the workload in conjunction with senior medical staff and labour ward coordinator. Open any contingency areas. Raise concerns to Director of Midwifery/Associate Chief Midwife/General Manager and/or clinical service manager (in working hours). Raise concerns to on call duty manager out of hours with proposed plan of review and reassessment.
Major incident occurring	Escalate to Director of Midwifery/Associate Chief Midwife/General Manager and/or clinical service manager (in working hours).
	Escalate to On call manager (out of hours) for approval.

Procedure for Site Divert

Following discussion with relevant personnel (see below; decision should be made by maternity management team (in-hours) and co-ordinators (out-of-hours)) about necessity to divert from one maternity unit to another. The maternity unit coordinator should complete Maternity Safety SBAR (see below) and contact on call manager via switchboard out of hours to confirm decision to divert. In working hours, the maternity unit coordinator should complete the Maternity safety SBAR (below) and contact their lead midwife /clinical service manager, who will discuss potential divert with DoM/General Manager/Associate Chief Midwife and lead clinician.

The lead clinician for the unit that is going on divert should communicate with the lead clinician of the receiving unit to agree the decision and timing for review.

Once the decision to divert has been made, the maternity unit coordinator should communicate with neonatal unit to identify their status and capacity to support, to identify the criteria for the divert.

It is recommended that the maternity unit coordinator is nominated to lead communication throughout the period to enable robust and consistent sharing of information. Wherever possible the coordinator should have no other responsibilities during this time. They should liaise closely with the receiving unit's hospital coordinator, who in turn should inform all relevant personnel within their site. The unit diverting remains responsible for the triaging of all women. Each woman being diverted should be communicated directly to the receiving unit's coordinator via maternity assessment staff. Capacity and suitability to retain the divert should be reviewed at regular intervals (2-4 hourly). If at all possible, the organisation of diverts should not be undertaken close to or during handover times. The unit that accepts the divert then assume responsibility for management of care.
Decision to divert must be communicated to:

- Delivery Suite Coordinators in each unit
- Consultant Obstetrician On-Call *(to be made aware divert is in place (in-hours).*
- Maternity Page Holder
- Lead Midwife (in hours)
- CSM, GM, DoM and ACM (in hours),
- Neonatal Nurse in Charge of shift
- Consultant Neonatologist On-Call (*to be called by Neonatal Nurse if divert impacts on delivery of current or expected neonatal care*)**.**

The decision to divert should be recorded within the General Women and Children's Microsoft Teams site to ensure that Director of Women and Children's and other senior team are informed.

Neonatal DECT contact numbers:

- PRM: 0141 451 5223
- RAH: 0141 314 6751
- RHC L1: 0141 452 2111
- RHC L2: 0141 452 4929

Person Centered Divert Criteria

Key Considerations	Actions of MAU/Triage staff of unit on divert
Does woman have transport and know where the receiving unit is? Is geographical location appropriate?	Give explicit directions as noted below to women being diverted and ensure they have given consent to be diverted. Ensure receiving unit triage is made aware woman on route.
Is the woman appropriate for transfer?	*Triage staff to access Badger and review pregnancy summary/ critical alerts, risk factors and medical history. * Do not divert women if known severe fetal anomaly with regular Fetal medicine unit attendance - a critical alert stating FMU not suitable for transfer should be noted in Badger. *Review clinical picture at time of divert e.g. Severe pain, Significant APH/PTL/ advanced labour etc. – Consider if local unit is more appropriate. *If in doubt, do not divert. *Alert Hospital coordinator of high-risk woman not suitable for divert (e.g. multiple pregnancy, complex maternal medical condition, woman attending FMU). In this situation the hospital co-ordinator will liaise with on call consultant to carry out a risk assessment on whether the risks involved with divert outweigh the risks of attending the unit who is on divert and decide on the safest option for woman taking all factors into account.
Consideration to NNU of receiving unit.	Is NNU in a position to support diverts or do parameters need to be explored? E.g. only women over 34 weeks.
Does the woman have additional psychosocial complexity? e.g. MNPI input, Blossom, Language barrier	Escalate these women to hospital co-ordinator who will liaise with on call consultant as above.

DIVERT ABLE TO BE ACCOMODATED BY RECEIVING UNIT

In hours – CSM/LM to request approval from GM/CD/DOM/ACM by phone (mobile numbers available through switchboard)

Out of hours – coordinator to the on-call duty manager (through switchboard)

Duration should be agreed locally – no more than 4 hours initially

Coordinators on both sites (diverting and receiving) will complete activity log to review safety (see activity log below)

Each Woman diverted should be communicated to the receiving unit through triage and reviewed on a case to case basis. Diverting unit assumes responsibility for ensuring woman has arrived in receiving unit and follows up if not. Named consultant should be emailed to inform them that a woman booked under their care had been divert for their information.

There should be two- four hourly reviews of site status and capacity including staffing, available beds alongside labour ward and neonatal acuity and activity so that agreed routine operational working can recommence as quickly as possible

When it is felt appropriate to lift divert a three site teams meeting should commence with all co-coordinators to reach agreement. All appropriate people should then be involved divert has been lifted (same individuals made aware divert has commenced).

When situation controlled - coordinator to contact relevant individuals, paperwork to be saved and sent to Lead Midwife for collation.

Lead Midwife to complete post analysis to determine causes of/reasons for safety concerns and how it can be avoided in the future.

List of relevant recipients of notification of Divert:

- Director of Midwifery
- Associate Chief Midwife
- Lead Midwives
- Clinical Service area
- General Manager
- On call consultants
- Obstetric Leads
- Partnership

DIVERT NOT ABLE TO BE SUPPORTED ACROSS GGC

In hours - Escalate to CSM/DOM/ACM/GM

Out of hours – coordinator to escalate to the on-call duty manager (through switchboard) the situation

Datix that escalation has taken place

Have frequent cross site reviews to examine position, (minimum 4 in 24 hours) to understand if anything changes and support can be given – staff/elective activity/bed status

Maternity Safety Assessment

Date and time of safety concerns

Situation

Action Taken

If divert, state where to, type of Women, date and time commenced and completed

Review complete by Name of (LM/Coordinator)

Agreed by Name of (Consultant on call)

Name of Manager (GM/CM/OOH Site Manager)

Activity Log - Hourly Status – If on divert complete for both diverting and receiving hospitals

Site_____ Date _____ Unit coordinator _____

Divert From _____ Start Time _____ Divert To _____ End Time _____

Divert specifics (i.e. labourers only, no women below 34wks) _____

Start Divert: Neonates informed: Yes/No Obstetric Staff informed: Yes/No Triage informed: Yes/No

End Divert: Neonates informed: Yes/No Obstetric Staff informed: Yes/No Triage informed: Yes/No

Time of initial phone call/ arrival in unit	Reason for attending	Outcome	CHI number	Named Consultant	Available Beds – Is divert appropriate to continue?

GGC Maternity Unit Information

ROYAL ALEXANDRA HOSPITAL (RAH)

Address: Corsebar Road
Paisley
PA2 9PN

Telephone number: 0141 314 6741

Follow M8 towards Glasgow Airport and continue onto A737 and exit at Linwood. Follow signs for RAH Hospital
Approach the main hospital grounds.
Drive up the hill with car park on your left
Turn into the road to your right after the pedestrian crossing on the hill
Maternity is a separate building situated just in front and to the right of the main hospital
Maternity triage is on the first floor. This access is open from 7am till 10pm, out with these times there is a buzzer entry.

PRINCESS ROYAL MATERNITY (PRM)

Address: 16 Alexandra Parade
G31 2ER

Telephone number: 0141 201 3454
0141 201 3452

Exit the M8 motorway at junction 15 if approaching from the west (Signposted Cathedral/Glasgow Cross)
Turn to your left at the traffic lights and follow road onto Alexandra Parade
Maternity building is on your right hand side.
Maternity assessment is on Level 2 of the maternity building
Parking can be found on Wishart Street behind the maternity building by driving past the front entrance and turning right. Parking also available in the multi-storey car park across from A&E.
Between 19.30 and 07.30 women can only enter via a buzzer system at the Wishart Street entrance of the PRM (at the rear of the maternity building). The buzzer is located at the first set of doors on the right hand side as you enter the building and it is connected directly to maternity triage. Out with these times women are encouraged to access the PRM via Alexandra Parade entrance however they will still get access from Wishart Street. When accessing the PRM via Alexandra Parade the lifts are situated at the left hand side.

QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH)

Address: 1345 Govan Road
G51 4TF

Telephone number: 0141 232 4363
0141 232 4377

Exit M8 motorway at junction 25 and follow signs for Hospital
Maternity building, separate from main hospital, signposted when arriving onto the Queen Elizabeth site.
Enter maternity building and follow corridor along until you reach Maternity Assessment on the left until 22:00.
After 22:00 enter by the side/ night entrance and buzz at the door – maternity assessment is directly ahead of you when entering.
Parking can be found in the car park P2 in front of accident and emergency or P8 in front of the maternity building.
This access is open 06:00 – 22:00, overnight entrance is signposted as maternity emergency entrance at rear of maternity building.

Neonatal DECT Phone numbers to be added across GGC
