GUIDELINE: Escalation plan for Maternity

AUTHORITATIVE SOURCE: New Zealand Safe Staffing Healthy Workplaces Committee of Inquiry Report (2006) and MERAS Midwifery Staffing Standards

AUTHOR: Director of Midwifery/Clinical Midwife Manager

SCOPE: This guideline applies to all midwives, obstetricians, nurses and healthcare assistants working in the maternity unit and in particular to the person designated as the shift coordinator.

PURPOSE: To ensure all staff are aware of what to do in the event that staffing levels do not meet the requirements of the acuity due to variables in the workload, work environment, patient complexity, skill mix or safe staffing requirements and/or patient and whanau expectations

DEFINITIONS:

CMM: Clinical Midwifery Manager
CNM: Clinical Nurse Manager
CCM: Clinical Care Manager
CD: Clinical Director
DNM: Duty Nurse Manager
DOM: Director of Midwifery
HCA: Healthcare Assistant
HOD: Head of Department of Obstetrics
ME: Midwife Educator & Quality Coordinator
O&G: Obstetric and Gynaecologist Consultant
SC: Shift coordinator

GUIDELINE:
• The roster is developed to provide a balance of skill mix and experience across each 24 hour period in order to provide for appropriate delegation, direction and supervision with a culture of safety embedded into this practice.

• The minimum expected staffing levels for maternity are two midwives for morning and afternoon shifts and a third person who could be a registered nurse or midwife. The minimum expected staffing levels on night duty are two midwives with a third midwife on call.

• All roster changes are to be approved prior to any change by the CMM or ME

• New grad midwives will be rostered on a shift with a minimum of one experienced midwife.

• Normally the on call person is only called to cover when a woman requires a caesarean section. However, when staffing levels or skill mix does not meet the acuity the on call person can be called to assist clinically to maintain safety and also if an unbooked woman arrives in labour. If that midwife is rostered to work the next day this should not be an early shift. Their shift may need to be covered to enable a 9 hour break from completing a call back. Therefore they will start and end their shift later than previously rostered with the gap covered by another member of staff.

• The roster is built by a designated senior midwife who is aware of the skill mix required to maintain safe staffing requirements and will notify the DOM/CMM if any concerns, before this is approved and published.

• Once approved the roster will be loaded into Trendcare by a designated midwife.

• There will be a minimum of 4 weeks roster in advance.

• The roster is monitored monthly by the DOM/CMM with regards to budget versus actual service requirements; occupancy, vacancies; training education and professional development activities and sick leave.

• Corrective action is taken by negotiation with DOM/CMM, or equivalent, human resource department and the CCM.

• The DOM/CMM or ME (in the absence of the DOM/CMM) will monitor shift coverage daily, anticipating potential concerns out of hours and the foreseeable future and will rectify anticipated problems through Variance Response Management.

• The SC monitors and anticipates needs out of hours on a daily basis and liaises with the DOM/CMM and/or ME or if out of hours, the DNM, regarding any additional requirements.

• Annual leave is actively managed and planned throughout the year using approved Hauora Tairāwhiti processes and compliance with the Leave Policy and relevant legislative requirements.

• Where, despite escalation and appropriate actions staffing remains suboptimal, the actions and decisions preceding the situation will be incident reported and documented using the Safe Staffing record of decision making form sheet accessible in Appendix 2 in this document. This will provide an accurate record of the situation and provide a means of communicating to prospective staff who may not have been party to the decision making process.

• Trendcare is to be completed by each staff member; the shift coordinator is responsible for ensuring it is completed by all before completing their shift.
- Trendcare entries must be accurate so that the variance response management reflects the acuity and demand which is captured and can be monitored to identify inadequate staffing levels trends.
- Dependant upon the situation it may also be pertinent to communicate directly with prospective staff and inform them of the situation.
- Use the SBARR tool when actioning the escalation plan to ensure clear, effective communication.
### DAILY MONITORING / ESCALATION PLAN

**Short notice / unplanned roster variance**

**N.B:** The following should be used as an escalatory process. Do not jump a level without following the preceding steps.

<table>
<thead>
<tr>
<th>TRIGGER</th>
<th>STANDARD</th>
<th>ACTIONS/POTENTIAL SOLUTIONS</th>
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| • Additional capacity available on current and/or next shift as low acuity | • Roster completed with all shifts covered to maintain safe staffing  
• Casual staff wishing to work in maternity will be fully orientated, programme in place  
• Roster is published 4 weeks ahead of commencement with an opportunity for permanent part time staff to pick up additional shifts to cover gaps  
• If gaps remain, shifts offered to casual staff – midwives and nurses with attention to skill mix  
• If gaps remain, ME will be | • Business as usual, capacity meeting demand.  
• Utilise this guideline if Variance Response Management required  
• Trendcare is completed by all staff during each and every shift  
• All staff are familiar with escalation plan guideline and this flow chart  
• Maternity staff to liaise with NNU to offer to relieve staff for breaks  
• Request to take an annual leave day or some hours may be considered but shift must remain covered by a staff member on call or ME or CMM if during working hours and minimum staffing standard met (2 midwives)  
• Use time to complete quality activities and QLP portfolios or emergency scenario practice or MSR preparation |

(Sc=shift coordinator, ME = Midwife Educator, DOM=Director of Midwifery, CMM=Clinical Midwife Manager, CNM=Clinical Nurse Manager, HCA=Health care Assistant, DNM=Duty Nurse Manager, CCM=Clinical Care Manager, LMC=Lead Maternity Carer, HOD=Head of Department)
<table>
<thead>
<tr>
<th>Sufficient beds and capacity to respond to emergency or unexpected admission</th>
<th>Roster completed with all shifts covered to maintain safe staffing</th>
<th>Business as usual, capacity meeting demand.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resourced beds almost (90%) maximized OR</td>
<td>Rosters are checked by daily by DOM/CMM or ME and/or SC to ensure adequate cover, skill mix and safe staffing. Gaps and potential coverage problems are identified and planning commences immediately to resolve</td>
<td>Text message goes out to all midwifery staff off duty to cover any gap in roster not filled or for additional staffing to meet demand on this or the next shift</td>
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<tr>
<td>Staffing numbers or Skill level inadequate to meet patient demand or complexity</td>
<td>Limited ability to take over</td>
<td>If gaps in HCA roster, shifts initially offered to other employed HCA and then casual HCAs</td>
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<td>If out of hours DNM to look at who can be re-deployed, midwife from NNU or preferably nurses with maternity or neonatal experience from other</td>
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- Business as usual, capacity meeting demand.
- Utilise this guideline if Variance Response Management required
- Trendcare is completed by all staff during each and every shift
- Meal break times allocated at the start of the shift by SC and written on white board
- Staff requesting sudden sick or bereavement leave inform the DOM/CMM (ME if not available) directly or the DNM and SC if out of hours
- Text message goes out to all midwifery staff off duty to cover any gap in roster not filled or for additional staffing to meet demand on this or the next shift
- If gaps in HCA roster, shifts initially offered to other employed HCA and then casual HCAs
- DOM/CMM to contact CNMs from NNU and paediatric ward to assess if redeployment of nurses from these two areas is possible
- If gaps remain, shifts offered to nurses with attention to skill mix
- If out of hours DNM to look at who can be re-deployed, midwife from NNU or preferably nurses with maternity or neonatal experience from other
midwifery care or support
LMC’s as per Service
Specifications
- Limited capacity to provide
1:1 care if required above
current workload
- Limited capacity to deal
with emergency or
unexpected admission
- Staff are missing breaks due
to workload

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| • The situation will be
  discussed with DNM and
  the CCM if the problem
  persists. | • ME will work clinically to help meet demand |
| | • If there is a sudden change to a published roster due to unplanned leave then the
  DOM/CMM or ME are informed (DNM if out of hours) |
| | • Escalation plan activated and all staff on duty informed |
| | • CMM or ME informed if staff missing meal breaks and will relieve if possible |
| | • If during normal working hours healthcare assistant and receptionist to answer
  postnatal call bells |
| | • Complete a Safe Staffing- record of decision making form – copies kept in roster
  folder |
| | • Update the Change to roster form so staff will get paid correctly and Trendcare
  to accurately capture this negative variance |
| | • Identify who can be discharged and support early discharging to free up bed
  capacity |
| | • IF STAFFING MATCHES ACUITY AND DEMAND, RETURN AREA TO GREEN |

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| If staffing resources remain
  problematic: |
| • In usual working hours the
  SC will consult with the
  DOM/CMM and/or ME who
  will review the situation and
  may take on the floor
  coordination to release the
  shift coordinator to work
  clinically. HOD, DNM and the |
| | • SC to perform a ‘fresh eyes’ round & update the white board. This should be
  carried out 2 hourly by the SC. |
| | • SC, O&G (if applicable) and CMM/ME to review the situation and prioritise care
  and reallocate workloads |
| | • Out of hours SC, O&G (if applicable) and DNM review the situation |
| | • DNM to look at who can be re-deployed, midwife from NNU or nurses preferably
  with maternity or neonatal experience from other wards/departments |
| | • Ask staff to extend which can be before or after official start time e.g. 12 hour
  afternoon shift 10.45hrs to 23.15hrs to help cover high acuity or gap in the
  morning or 14.45hrs to 03.15hrs to help cover part of night shift |
| | • Offer shorter hours to cover a shift e.g. break a 12 hour shift into two six hour
  shifts or an 8 hour shift into two four hours shifts |
- Potential delay in emergency response escalation of risk and harm potential
- Unable to take over or provide 1:1 care if required or support LMC’s as per Service Specifications
- Inability to consistently provide 1:1 care in established labour
- Delay in ability to respond to acute assessments or admissions
- Care rationing occurring

midwife
CCM will be informed.
- Out of hours the shift coordinator will liaise directly with the DNM. The DNM will take on the responsibility in liaison with the SC to assess the situation and plan what can be done and inform/include the O&G on call.

- No meal on shift allocated
- Overtime if no 9 hour break
- If at night, call in the on call person to work clinically. If rostered to work the next day the beginning of their shift may need to be covered to enable a 9 hour break e.g. out on call until 06.45hrs, rostered on afternoon shift, start time will now be 15.45hrs to enable a 9 hour break from official end of on call hours)
- ME to work clinically & DOM/CMM to manage the situation during normal working hours
- Alert LMCs to the situation and ask those present if they can provide continued care for their woman i.e. early labourers, not to hand over or to give sufficient notice of a handover if unable to remain to offer support
- IOL will be rescheduled - a 4 way conversation will take place & a revised plan will be agreed and written in patient records & Maty schedule updated
- Elective LSCS will be rescheduled - a 4 way conversation will take place with a provisional new date agreed and planned, this is written in patient records & Maty schedule updated
- Contact women on the Maty schedule and cancel and/or reschedule their appointment for a later time or another day
- SC to liaise with LMC’s to expedite discharges of their women and babies if appropriate to do so
- Consider which women and babies can be moved to paediatric ward if not ready to go home but stable, this will free up postnatal rooms
- Complete a Safe Staffing- record of decision making form – copies kept in roster folder
- Update the Change to roster form so staff will get paid correctly and Trendcare to accurately capture this negative variance

As per Amber actions AND:

- SC to perform a ‘fresh eyes’ round & update the team and white board on the
• Occupancy over capacity, unable to accommodate any further admissions with all potential beds maximized
• Staffing numbers or Skill level inadequate to meet patient demand or complexity AND
• Inability to provide 1:1 in labour and other required safe staffing needs
• Lack of timely response to emergencies/acute assessments
• Midwifery /nursing staff resources depleted

If staffing resources cannot meet demand:

- The midwifery team should be instructed to provide ONLY priority midwifery care, referred to as care rationing. Prioritising care to ensure essential care is delivered offers a practical step when:
  - demand exceeds resource
  - staff numbers are insufficient to meet the requirements of patients
  - all efforts have been made to find additional staff to meet demand
  - service need exceeds the resources available.

This decision should only be made after liaising with the DOM/CMM, CCM & HOD or if out of hours the SC will liaise directly with the DNM & O&G. The DNM will need to notify the CCM on call of this hour and every hour.

- Reallocate staff to meet fluctuating demand e.g. midwives priority is birthing suite, one midwife or nurse allocated to cover all postnatal women and babies and care rationing implemented after discussion and advice from SC
- Consider which women and babies can be moved to paediatric ward if not ready to go home but stable, this will free up postnatal rooms. Orderlies to help with move
- Request HCA support from DNM if out of hours
- DOM/ME (CCM if out of hours) to explain the situation to women & whanau in the unit and that care will be prioritised but safety maintained
- DOM/ME (CCM if out of hours) to inform women to use their call bell for urgent matters only
- DOM (CCM if out of hours) to inform women that care will be prioritised and what will be prioritised e.g. Blood sugar monitoring for babies at risk of hypoglycaemia, BP checks for women with known hypertension, post LSCS observations, medication and pain relief
- Encourage women / whanau participation with own care as appropriate
- Encourage earlier discharge than planned if woman and baby physically well
- Alert LMCs of this situation
- Liaise with LMCs for any help they may be able to offer
- The SC to ensure all team are fully aware of this situation and allocate tasks accordingly (care rationing)
- The O&G will provide assistance and stand by on unit where appropriate
- Patient safety comes first
- Complete a Safe Staffing- record of decision making form – copies kept in roster folder and can be obtained from: APPENDIX 2.
- Update the Change to roster form so staff will get paid correctly and Trendcare to accurately capture this negative variance
situation. The DHB will recognise the extreme pressure under which staff are working and are only able to provide essential midwifery care. The DOM and CD will be informed by the CCM.

If the situation becomes critical the CCM may request assistance from nurses who do not usually work in maternity. The CCM will request DOM/CMM & ME to return to work if able to do so and any other core staff that are on leave will be contacted to ask them to return to work.
RELATED STANDARDS AND PROCEDURES:

Hauora Tairāwhiti – Safe staffing policy (Nursing and Midwifery)

Hauora Tairāwhiti – Leave policy

Hauora Tairāwhiti – Shift coordinator role – Nursing & Midwifery

Hauora Tairāwhiti- Guideline on the deployment of Nursing & Midwifery staff

MERAS Safe Staffing Standards

MERAS – DHB’s/MERAS Multi-Employer Collective Agreement 1 Feb 2018 – 31 Jan 2021


EVALUATION METHOD: This incident will be investigated as part of the incident reporting system. This investigation will follow the guideline recommendations and action any learning outcomes.

________________________________________

Authorised By (DOM/CMM)

________________________________________

Authorised By (HOD Obstetrics)

________________________________________

Authorised By (Clinical Care Manager, WCY)

Date of Approval:

Next Review Date:
APPENDIX 1
Flowchart for Escalation Guideline

Staﬃng levels or skill mix do not match the requirements of acuity (Unsafe staﬃng)

During normal working hours inform the DOM/CMM and/or ME

During out of hours inform DNM & O&G

- SC to perform fresh eyes round & repeat 2 hourly & update white board. Prioritise care & liaise with O&G & LMC’s to discuss cancellation of IOL, elective LSCS, expedite discharges, ask LMC’s to see women booked in for BP checks in community & reschedule women on Maty schedule
- Inform all women and whanau of the situation
- Encourage woman/whanau participation with own care as appropriate and early discharge home
- Update CMM/DNM
- CMM/DNM to ask staﬀ if they can extend their shift, call in casual or RN from other department, if at night call in on call staﬀ

Problem resolved

Problem escalates, staﬃng levels remain problematic.

Fresh eyes round performed & white board updated to reﬂect acuity every hour. O&G to be present. CCM notiﬁed if out of hours and unit is in RED

O&G’s to provide assistance where ever possible

The Midwifery team will be advised to provide priority midwifery care only. CCM will decide if to call in DOM/ME and staﬀ on leave to assist clinically

SC/DOM/CMM to explain the situation to all women & whanau

Complete a safe staﬃng – record of decision making form, update Roster change form and Trendcare
Safe Staffing – Record of Decision Making

This document should be completed when the escalation process has failed to totally resolve a problem, staffing remains suboptimal or it is anticipated to be so in the near future – for example the next shift.
Please submit this to the DOM and ensure Trendcare is accurate. Complete an incident report.

DATE & TIME: ____________________________ NAME: ____________________________

What is the situation?
(Where, when what staff, patient acuity, patient numbers, empty beds, anticipated workload)

What is the background?
(When did you become aware of the problem? What had occurred prior to then, staff sickness, unexpected high acuity? What have you done since then? Try to document your actions and decisions in a methodical time-ordered fashion)
What is your assessment of the situation?
(What decisions have you made? E.g. Activated the Escalation Plan as more than 2 high dependency women or more than two women requiring 1:1 care, per available midwife, Potential delay in emergency response, escalation of risk and harm potential, Unable to take over or provide 1:1 care if required or support LMC’s as per Service Specifications, Inability to consistently provide 1:1 care in established labour for women under secondary care, Delay in ability to respond to acute assessments or admissions, Care rationing occurring, staffing is not meeting demand, skill mix not consistent with safe staffing, all women informed of this situation and safety will be maintained but patient care prioritised. To what level has the situation been escalated?)

Your Recommendation:
(What decisions have you made? 3 way conversation with O&G and CMM (DNM if out of hours.. All staff aware of escalation plan activated, reallocation of patient load, call in additional staff, deployment of staff from other wards, notify CCM if out of hours, care rationing, transfer postnatal women and babies to Paediatric ward if not enough beds in maternity to meet current demand, ensure Trendcare reflects this acuity.)

What was the outcome to this situation?
(e.g. Additional staffing, all mothers and babies remained safe, incident reporting completed, delayed care e.g. IOL, elective LSCS, no meal breaks, extension of staff shifts)