Safe Midwifery Staffing Policy

1. Background

Midwives are fundamental to the safety of women and babies throughout the child birth continuum. Individual assessment of the midwifery care needs of each woman and baby is paramount when making decisions about safe midwifery staffing requirements. The assessments should take into account individual preferences and the need for holistic care and direct, as well as indirect, care time between the midwife, the woman and /or baby.

The peaks and troughs of maternity service demands are difficult to predict due to:

- estimation of due dates
- the nature and duration of pregnancy
- unpredictable timing of labour
- need for one to one support during labour/birth.

This, in turn, makes it difficult to ensure the midwifery workforce is flexible enough to be able respond to those unpredictable peaks and troughs in activity and meet care requirements.

The National Institute for Clinical Excellence (NICE UK) have implemented an evidence based toolkit for hospital executives, maternity managers, after hours managers and shift coordinators to ensure safe midwifery staffing . This policy will adapt the UK Safe Midwifery Staffing guideline for application in WACHS maternity services.

2. Policy Statement

Principles

2.1 Care must be safe for women and babies.
2.2 Care must be safe for midwives.
2.3 Safe midwifery workloads must be professionally determined by evidence based minimum standards.
2.4 Midwifery workload management must be considered in the context of workforce planning and staff satisfaction.
2.5 Midwifery workload management must be transparent, consistently applied and requires accountability.

This policy sets out the systematic process to enable determination of the safe midwifery staffing establishment required to maintain continuity of maternity services and ensure safe care for women and babies in all settings. This incorporates antenatal, intrapartum, postnatal and neonatal midwifery care including that provide in the home, community, outpatient clinics, midwifery group practice (MGP) and inpatient maternity hospitals.

Maternity and newborn services must have the capacity to provide the following:

- antenatal, intrapartum and postnatal midwifery care
- qualified newborn midwifery / nursing care as needed
- appropriately experienced midwives and/ or neonatal nurses to meet the demands and skill mix required 24/7
- **one to one midwifery care for women**:
  - in active phase of established labour (4cm or more dilated)
  - with an epidural
  - with syntocinon infusion
  - requiring continuous cardio-tocograph (CTG) monitoring
  - for at least the first two hours after the birth
  - unwell newborns awaiting transfer.
- a second registered health professional with appropriate training in neonatal resuscitation is available at every birth
- other locally agreed staffing ratios as required i.e. for planned outpatient clinics (antenatal, postnatal, bookings), early discharge home visiting, newborn hearing screening, unplanned presentations and admissions, transfers and increased surge
- to meet all locally agreed midwifery roles required for the service – for example midwifery manager, clinical midwifery specialist, staff development midwife
- FTE uplift allowance for paid leave of 22% (includes annual, long service, maternity and personal). For regions with additional annual leave allowances this should be added to the usual 22% uplift.
- time for supervision of students, graduates and orientation of new staff
- flexibility to respond to service demand fluctuations (which may include on-call or flexi-time, casual roster with no booked shifts, list of part timers willing to increase hours)
- time for mandated education requirements, professional development leave, mentoring, preceptorship and clinical audit responsibilities.

Procedure

Each maternity site will have a process for:

- maternity shift coordinators to capture Safe Midwifery Staffing **Red Flag events** using the WACHS Data Collection tool (see Appendix 1)
- monitoring Safe Midwifery Staffing on a shift by shift basis and following the WACHS Midwifery Staffing Escalation plan for amber, red and black status (see Appendix 2)
- reviewing Safe Midwifery Staffing Indicators six monthly (see Appendix 3)
- reviewing Safe Midwifery Staffing establishment levels six monthly (WACHS dashboard *in development*)

3. Definitions

Midwifery Red flag event	An event that requires urgent escalation to shift coordinator – check poster

4. Roles and Responsibilities

WACHS Executive Director of Nursing and Midwifery

- Ensure an appropriate and robust workload planning and monitoring system for quality midwifery care provision 24/7 at each maternity site including MGPs and community based services:
  - **Inpatient** midwifery workload tool is currently Nursing Hours per Patient Day (NHpPD)
  - **Outpatient** is occasions of service (OOS) per week multiplied by appointment time (hour equivalent) multiplied by number of days per week then divided by 38 hours per week to equate to midwifery FTE
    - Low risk women – 7 antenatal visits (regardless of care provider)
    - Women with risks – 10 antenatal visits (regardless of care provider)
    - Early postnatal discharge – daily midwifery assessments for mother and for baby to minimum day five (low risk may have phone or telehealth checks to determine needs for physical visit)
  - **Midwifery Group Practice:** quarterly monitoring and reporting of each midwife's caseload and activity timesheet as per the Midwifery Annualised Salary Agreement (MASA).
- Ensure a systematic process to determine the site midwifery staffing establishment for safe care and the midwifery budget in all settings:
  - students and manager / specialist roles are additional to establishment
  - regional centres may require a supernumerary coordinator except night duty

Regional and Hospital Executive

- Ensure each site implements the Safe Midwifery Staffing escalation plan to address service demand variation (see Appendix 2)
- Review the safe midwifery staffing establishment every six months including:
  - the service demand data for pregnancy bookings, OOS, inpatient separations and care needs (WACHS dashboard *in development*)
  - the number of Midwifery Red Flag events collected via the WACHS Data Collection (Appendix 1)
  - the Safe Midwifery Staffing Indicators (Appendix 3) (WACHS dashboard *in development*)

- frequencies and trends in escalation of **amber**, **red** and **black** status (analysis by site Manager from WACHS Midwifery Red Flag Data Collection tool)
- the numbers and trends in complaints
- frequency and trends of unplanned leave (WACHS dashboard in development)

Maternity Managers

- Track daily midwifery red flags events collected by shift coordinators
- Review the skill mix required for the maternity service and reallocate work that does not require a midwife. This may include use of Assistants in Nursing for bed making, re-stocking, baby bathing or other duties that can be undertaken by clerical staff or hotel staff
- Report, and review, the safe midwifery staffing establishment to the hospital Executive every six months

After Hours Managers / MGP Leaders

- Receive regular maternity ward handover during each shift – hourly is desirable
- Follow the local WACHS Safe Midwifery Staffing Escalation plan when notified by the Shift Coordinator of **amber** or **red** or **black** flag status

Maternity Ward Shift Coordinators

- Record Midwifery Red Flag events each shift in the WACHS data collection tool
- Hold regular shift staff huddles to update the journey board and monitor workload
- Action the local Safe Midwifery Staffing Escalation plan when status becomes **amber**, **red** or **black**

Midwives

- Notify the shift coordinator of any **Midwifery Red Flag** events

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

5. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) 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 is mandatory.

6. Records Management

Clinical:
All WACHS clinical records must be managed in accordance with Health Record Management Policy.

7. Evaluation

Evaluation of this policy is to be carried out annually by the WACHS Midwifery Advisory Forum via analysis of Maternity manager reports.

8. Standards

National Safety and Quality Health Service Standards 1.1.e, 1.7.a, 1.7.b and 1.7.c.

9. Legislation

The *Health Services Act 2016* (WA) refers to policy frameworks in ss. 26-27 and s. 34(2)(c).

10. References

National Institute for Health and Care Excellence (NICE) Safe midwifery staffing for maternity settings guideline (Feb 2015) https://www.nice.org.uk/guidance/ng4

11. Related Forms

Nil

12. Related Policy Documents

WACHS Safe Midwifery Staffing Shift Coordinator Red Flag Events Poster

13. Related WA Health System Policies

Nil

14. Policy Framework

Clinical Governance Safety and Quality

15. Appendices

Appendix 1: Shift Coordinator Midwifery Staffing Red Flag Events
Appendix 2: WACHS Safe Midwifery Staffing BRAG Status and Escalation Plan
Appendix 3: Safe Midwifery Staffing Indicators

This document can be made available in alternative formats on request for a person with a disability

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Appendix 1: Shift Coordinator Midwifery Staffing Red Flag Events

Red Flags events should be recorded by the Maternity shift coordinator each shift via the WACHS DCT tool and reviewed daily by the Maternity Manager

1. Unable to provide midwifery/nursing care according to your NHpPD insert here:
    - Insert # here antenatal /postnatal women
    - Insert # here SCN babies
    - One to one in active labour /epidural / synto /CTG / for 2 hours post birth
    - More than five home visits for visiting midwifery service
2. Unplanned leave and workload required replacement but unable to replace
3. No midwife available causing delay / postponement Elective LUSCS or induction
4. Delay of 30 minutes of more between presentation and midwifery assessment
5. Delay of 2/24 or more from admission to start of induction of labour
6. Delayed RRAD
7. Midwife notifiable events to shift coordinator due to inadequate time:
    a) Missed or delayed medications including pain relief
    b) Delayed full clinical examination
    c) Delay in commencing syntocinon infusion
    d) Delayed response to patient call bells (15 minutes or more)
    e) Delayed response to staff assist or code blue calls (3 minutes or more)
    f) Delayed transfers in
    g) Delayed transfers or discharge out
8. Inadequate staffing skill mix i.e. no staff available for Special Care Nursery
9. Midwife or neonatal nurse overtime required by one hour or more (including MGP over safe working hours of 12 hours)
10. Number of hours of approved overtime
11. Number of meal breaks delayed or unable to be taken
12. Percentage of casual or agency on shift

Appendix 2: WACHS Safe Midwifery Staffing BRAG Status and Escalation Plan

GREEN - 85% (or less) of beds occupied with capacity for unplanned activity and adequate midwifery / SCN staffing for NHpPD and outpatient services.

Routine coordination of activity to include:

- **Shift coordinator to:**
  - regular staff huddles to assess activity / changes
  - maintain up to date journey board with predicted date of discharge / transfer
  - Identify mothers/babies fit for discharge
  - ensure medical and midwifery discharge completion by 1000
  - communicate regularly with Maternity or After Hours Manager to escalate red flags or change in Safe Staffing Status as they occur and staffing needs for next shift.
- Midwives ensure electronic records are updated each shift to ensure timely discharge/transfer.

AMBER
Beds at 95% **capacity with no planned discharges, staffing adequate but no capacity for unplanned activity,** OR
Beds available but inadequate staffing (NHpPD + outpatient needs) and no capacity for planned / unplanned activity

Shift coordinator:

- Assess journey board 2/24 & escalate red flags / staffing status to Maternity / After Hours Manager
- provide safe care for unplanned presentations
- follow-up diagnostic results for those pending discharge / transfer

Maternity manager (in hours) or After Hours Manager to (not shift coordinator):

- Identify with medical staff those suitable for discharge / safe transfer to another ward /site (including mum of SCN baby)
- Identify, with Obstetric doctor, planned activity that can be postponed i.e. inductions / ELUSCS / transfers in
- Arrange adequate midwifery / nursing staffing for activity demand by:
  1. SMS to casual/ part time staff
  2. Deploy available staff from other maternity positions i.e., Staff Development Midwife, staff on inservice, midwives on other wards or paediatric staff for SCN or Visiting Midwifery Service etc
  3. Buddy RN's from other areas to work with a midwife in postnatal or SCN
  4. Approve overtime
  5. Secure staff to be oncall for unplanned activity if needed

RED – Beds at 95 – 98% capacity with inadequate staffingand green/amber actions exhausted

Maternity manager (in hours) or After Hours Manager to (not shift coordinator):

- Immediate and hourly handover with shift coordinator to determine status & further actions
- Implement additional staffing actions to amber above:
  1. In hours maternity manager to work clinically or coordinate
  2. Postpone routine clinic appts to utilise midwifery staff on ward
  3. Recall staff on RDO to attend ward
  4. Contact other local hospital to deploy staff
  5. Contact local maternity hospitals to divert transfer if needed (after escalation to Exec only)
- brief DoNM / Ops Manager (in hours) or Exec on Call (Out of hours)
- consider use of hospital area for discharge lounge to free up maternity beds
- Review planned admissions to ward in next 12-24 hours for postponement
- Identify suitable private patients for transfer to private hospital (if nearby)

BLACK - Beds at 100% and all options above exhausted

Maternity Manager or After Hours Manager:

- convene hospital executive crisis meeting to determine next steps
- issue sit-rep to key stakeholders.

Appendix 3: Safe Midwifery Staffing Indicators

Clinical outcomes (via Perinatal database):

- Skin to skin achieved at birth
- Breastfeeding rates at discharge
- Spontaneous birth rate
- Epidural rate in labour
- Apgar less than 7 at 5 minutes

Staff outcome:

- Staff satisfaction

Establishment outcomes (via HR) (WACHS dashboard *in development*):

- Vacancy rate
- Staff turnover
- Unplanned leave % and trended
- Compliance rates with mandatory education (LMS)
- Casual, agency and overtime usage
- Number of adverts placed versus number filled