Diversion, Maternity Services (Restricting Obstetrical Services)

Site Applicability: St. Paul's Hospital Maternity Centre only

Disciplines: Obstetrics, Family Practice, Pediatrics, Midwifery, Nursing

Related Documents/Guidelines

1. B-00-16-10023 - Maternity Services: Chain of Command Procedure

Policy:

The continuing demand for efficiency in health care has resulted in little flexibility around utilization. This means that at times of high census the nursing staff complement or the space available can be stretched beyond what is acceptable for the provision of safe care. At these times, diversion of families for care at another site is the best option for patients. Such an option is distressing for women and their care providers.

Accordingly, diversion should only be implemented as an extreme measure. All care providers should appreciate that attention to evidence based practice and, in particular, adherence to approved discharge practices will minimize the likelihood of patient diversion. As well this policy does not preclude authorized maternal transfer/triage that should occur prior to the restricting of obstetrical services.

Expected outcomes

To have a contingency plan when available resources at St. Paul's Hospital cannot assure a safe level of care. The decision to restrict obstetrical services is a serious decision to be taken only when our ability to provide care will be less safe than transfer to another hospital.

Practice Guidelines:

Procedures/Interventions

1. Responsibility

0700 to1500 hours, weekdays

- Clinical Nurse Leader / Charge Nurse Delegate and Obstetrician On-Call together make decision to go on diversion
- Operations Leader is notified
- Clinical Nurse Leader / Charge Nurse notifies / updates Patient Transfer Network and updates BC Bedline as changes occur on the unit

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After 1500, and 24-hour weekend coverage/stats

- Charge Nurse (CN) Delegate and Obstetrician On-Call together make decision to go on diversion
- Clinical Coordinator is notified
- Leader-on-Call is notified
- Charge Nurse notifies / updates Patient Transfer Network and updates BC Bedline as changes occur on the unit
- Pediatrician on call

2. Guidelines for Restricting Obstetrical Services

Determining when obstetrical services need to be restricted is a collaborative decision made by the above responsible group. The activity and acuity of all patients in the Maternity Services Program, including the Neonatal Intensive Care Unit (NICU), must be taken into consideration. Factors that must be considered when determining whether services need to be restricted are:

- Ratio of qualified staff to patient
- Acuity of the patients currently admitted
- Available patient beds and equipment
- Available NICU beds
- The decision to go on diversion should be based on current occupancy and staffing levels, not anticipated occupancy and staffing

In the event that access to patient services needs to be restricted at SPH, the following will be initiated:

- All action should be taken to ensure patients are discharged if appropriate outcomes are met and they have met discharge criteria.
- Evaluate all bed “needs” before a decision is made to redirect patients.
- In consultation with the Obstetrician-on-call and the most responsible care provider, delay or discontinue initiation of elective procedures that will impact inpatient beds (e.g. inductions, elective caesareans).

All actions should be taken to ensure optimal utilization of staff. Arrange for additional qualified staff on the unit if required.

- Rearrange nursing assignment
- Call additional RN’s into work
- Exhaust overtime options for nursing staff

3. Diverting Patients when Obstetrical Services Need to be Restricted

The decision to restrict obstetrical services is a serious decision made after a full assessment (see #2) has been completed.

Once a decision is made to go on diversion, the Clinical Nurse Leader / Charge Nurse will notify Patient Transfer Network and update the hospital status online and instigate notification as per #1.

Decision to transfer will be made only after it is clear the patient meets the clinical criteria for "safe transfer".

Clinical Criteria for Diversion of Low Risk Patients:

Inclusion

- 37 to 42 weeks gestation
- Cephalic presentation
- Multips 3 cm or less; not active labour
- Primips 6 cm or less
- Normal health assessment
- Singleton fetus

Exclusion

- Imminent delivery
- Abnormal fetal heart rate assessment requiring immediate delivery
- Patient medically or obstetrically unstable

All obstetrical patients presenting to the hospital will be assessed prior to making the decision to transfer them to the hospital that best meets the needs of the patient. All physicians and midwives involved in patient care must be notified of the diversion status. The decision regarding 'who' gets diverted is made in collaboration with the OB on-call and the CNL or Charge Nurse. The decision is not made unilaterally. The Chain of Command policy can be initiated if there are disagreements.

The attending primary care provider is responsible for contacting the Obstetrician/Family Physician/midwife on-call at the accepting hospital to transfer the care of the patient and to share relevant clinical information.

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The reason for transfer will be discussed with the patient and family by the primary care provider and CNL/CN. This discussion should include an expression of our appreciation and their understanding and patience. If they have any significant concerns, the attending physician with the support of the Physician Program Director should be contacted and made available to the patient (by phone or on-site).

The regional Diversion Policy that enables patients to be diverted from home or from their physician's offices after they have been assessed is consistent with all of the above.

Process – Patient out of hospital

- All patients require an in-person or telephone assessment by the physician or midwife. Patients who have not received an in-person or telephone assessment by an MD or midwife cannot be diverted.
- Any woman requiring immediate care will be admitted to the nearest facility even if a bed is not available until an appropriate place of transfer is found. (Consistent with Life, Limb and Threatened Organ Policy.)
- A physician/ midwife with the authority to make a decision about the care of a mother/baby is responsible for calling the hospital where the patient is registered to see if there is a bed available for admission.
- Physician/midwife calls patient transfer network and identifies service, type of provider and level of bed required. Physician/midwife provides patient transfer network patient name, city of residence, DOB, PHN and any other available demographics.
- Patient transfer network identifies where capacity for admission exists and patient transfer network will conference sending physician to receiving physician/midwife at that hospital
- Patient transfer network will connect to practitioner through switchboard which will have daily on call schedule (default is to on-call OB)
- Sending physician/midwife contacts patient and directs them to site with available bed
- When patient movement to another site is required, every effort is made to transfer to the closest bed in VCH/PHSA and/or to the patient's residence.

4. Obstetrical Services will be Restricted Related to the Shortage of Neonatal Intensive Care (NICU) beds.

If Obstetrical services need to be restricted due to a lack of capacity in the NICU, maternity patients under 37 weeks at risk for delivery or with potential need for level II or III care will be diverted and/or transferred to a more appropriate facility after discussion with pediatrician on call.

All attempts should be made to transfer or divert the woman prior to delivery. If this is not

feasible, the baby will be delivered at SPH and transferred after delivery.

5. Special Instructions

The decision to restrict obstetrical services will be reassessed on an ongoing basis with the goal being to open for all obstetrical patients as soon as possible. Consistent regular communication between the CNL / CN and the OB-on-call and all relevant primary care providers will occur to minimize risk and inconvenience to patients:

Decisions or disagreements, that appear to contravene the diversion policy, must be brought forward to the attention of the Operations Leader, Program Director, Physician Program Director and / or the Leader-on-Call via the Chain of Command Guidelines.

The decision of which patients to divert is based on medical / clinical status only. The Obstetrician on-call may not select to exclude their own patients from being diverted. All patients (Midwifery, Family Practice, and Obstetric) shall be equally considered for diversion based on the inclusion and exclusion criteria outlined above.

All diverted patients and circumstances will be reviewed by the Maternal Quality & Safety Council.

References

Author. Vancouver Coastal Health Coastal Policy Net PCG-GE-05 (2003) Diversion of Patients. Accessed May 1 2017

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British Columbia Woman's Hospital. (March 2015) WW.05.27 – Diversion Standard Process for Labour and Delivery. Accessed http://policyandorders.cw.bc.ca/ May 1 2017

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Nurse Educator, St. Paul's Maternity Centre

Approved By:

Maternity Safety and Quality (MSQC)

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Questions, concerns, comments about PHC guidelines can be emailed to: nursingstds@providencehealth.bc.ca