

Perinatal Emergency Education Strategy Policy Directive 2018

Version No.: 2.0
Approval date: 10/07/2018



Contents

1.	Policy Statement.....	3
2.	Roles and Responsibilities	3
2.1	CHIEF EXECUTIVE OFFICER	3
2.2	DIRECTORS, MANAGERS AND SUPERVISORS.....	3
2.3	STAFF	4
2.4	PRIVATELY PRACTISING GENERAL PRACTITIONERS AND MIDWIVES PROVIDING SERVICES IN PUBLIC HEALTH UNITS	4
3.	Policy Requirements.....	4
3.1	BACKGROUND.....	4
3.2	PRINCIPLES	5
3.3	DETAIL.....	5
3.3.1	FETAL SURVEILLANCE EDUCATION	7
3.3.1.1	Online Fetal Surveillance Education Program (OFSEP).....	7
3.3.1.2	FSEP face to face study day (Facilitated by RANZCOG).....	7
3.3.1.3	Fetal Surveillance Practice Review (FSPR).....	8
3.3.2	OBSTETRIC EMERGENCY MANAGEMENT TRAINING	9
3.3.3	NEWBORN LIFE SUPPORT PROGRAMS	10
3.3.3.1	Newborn Life Support Program (NLS)	10
3.3.3.2	Newborn Advanced Life Support Program.....	10
4.	Implementation & Monitoring.....	11
5.	National Safety and Quality Health Service Standards (2017)	12
6.	Definitions	12
7.	Associated Policy Directives / Policy Guidelines and Resources	12
8.	Document Ownership & History	13
9.	Appendices	14
9.1	Appendix 1: RANZCOG FSEP Practitioner Level Description.....	14
9.2	Appendix 2: Graphical Item Map (GIM) Information	15
9.3	Appendix 3: Fetal Surveillance Practice Review.....	16

Perinatal Emergency Education Strategy Policy Directive

1. Policy Statement

The Perinatal Emergency Education Strategy (*Strategy*), has been developed by the Maternal, Neonatal and Gynaecology Community of Practice Executive Committee and the South Australian Department for Health and Ageing, Safety & Quality Unit in conjunction with lead clinicians and representatives from across SA Health, with the aim to reduce the number of critical incidents associated with electronic fetal surveillance, maternal and neonatal resuscitation and management of the deteriorating pregnant woman and/or neonate.

The *Strategy* is a Policy Directive applicable to all SA Health employees providing perinatal services and includes those contracted in this area on behalf of SA Health. The *Strategy* provides SA health sites with a clear perinatal education governance framework and aims to provide high quality accessible education across all SA Health sites to increase the capability of staff in providing safe, efficient and quality maternal and neonatal care. The *Strategy* determines the education requirements for the distinct perinatal health care professional groups and the inter-professional perinatal education; including frequency, assessment, completion of the individual components of the program and monitoring of compliance.

2. Roles and Responsibilities

In accordance with the SA Health *Standards for Maternal & Neonatal Services in South Australia* (Dept. for Health and Ageing 2015), the following outlines the respective roles of relevant parties in the context of this Policy Directive.

The *Strategy* requires a state-wide collegial approach between Local Health Networks (LHN)s to ensure credentialed trainers are available for the required face to face study days/skills sessions and experienced health practitioners are able to support relevant competence assessment.

2.1 CHIEF EXECUTIVE OFFICER

The LHN Chief Executive Officer has ultimate responsibility for the effective implementation of this policy and must ensure:

- > all levels of management are aware of their responsibilities in relation to this Policy Directive
- > all employees are aware of their responsibilities in relation to this Policy Directive
- > all relevant non-employee health practitioners providing services to the LHN, (i.e. visiting medical specialists,) are aware of their responsibilities in relation to this Policy Directive
- > adequate resources are made available to implement and sustain this Policy Directive
- > an annual report of compliance with the Strategy is provided to the Executive Director SA Health Quality, Information and Performance.

2.2 DIRECTORS, MANAGERS AND SUPERVISORS

Directors, managers and supervisors have direct responsibilities for implementing the Policy Directive's strategies including:

- > providing resources and staff support
- > informing staff about the Policy Directive and the consequences of non-compliance
- > creating a culture which is supportive of the Perinatal Emergency Education Strategy
- > creating a culture which is safe and supportive to enable staff to learn and reflect on the education received
- > ensuring that all relevant health practitioners complete the required education
- > performance management of health practitioners that do not meet required education standards.
- > providing advice that will inform the process for tracking, monitoring and assessment of the programs.
- > monitoring compliance

2.3 STAFF

Staff are responsible for:

- > complying with the Policy Directive
- > managing their own perinatal emergency education/training, ensuring they remain competent for their scope of practice and level of responsibility
- > completing required education within six (6) months of commencement of employment; cognisant of logistics and availability of locally based education programs.

2.4 PRIVATELY PRACTISING GENERAL PRACTITIONERS AND MIDWIVES PROVIDING SERVICES IN PUBLIC HEALTH UNITS

Privately practising practitioners providing services in public health units are responsible for:

- > complying with the Policy Directive
- > managing their own perinatal emergency education/training
- > ensuring they remain competent for their scope of practice and level of responsibility.

3. Policy Requirements

In accordance with the SA Health *Standards for Maternal & Neonatal Services in South Australia* (Dept. for Health and Ageing 2015), SA Health will ensure that a risk management approach is adopted to ensure that:

- > Education provided is evidence based and encourages best practice
- > Service provision is sustainable
- > Work health and safety principles are adhered to.

3.1 BACKGROUND

The importance of the strategic management of perinatal clinical risks has emerged from the number of perinatal cases with suboptimal clinical outcomes reported within SA Health, interstate and worldwide.

The *Australian National Safety and Quality Health Service Standards* (2017), Standard 8, refers to the recognition and response to clinical deterioration in acute health care. Early identification of deterioration, followed by prompt and effective action, can minimise the occurrence of adverse events and may improve outcomes.

Literature reviews show that maternity emergency response training and the introduction of interdisciplinary teamwork training is effective in the reduction of errors and improvement of performance in perinatal emergency situations. A blended- learning approach incorporating interdisciplinary groups and use of simulation is beneficial in promoting teamwork, communication and situational awareness resulting in improved outcomes for mothers and babies, healthcare workers and healthcare facilities (Shoushtarian et al, 2014).

The *Strategy* recognises that the role of a health service described within a service delineation framework relies on the presence of a perinatal health care workforce appropriately educated to execute the services defined. The SA Health *Standards for Maternal & Neonatal Services in South Australia* (Dept. for Health and Ageing 2015) states that health care sites providing maternity services levels 3-6 will have access to regular cardiocography training with competency assessment which includes:

- > sound understanding of fetal physiological responses to hypoxia
- > the ability to integrate this knowledge with each clinical situation

Maternity emergency training literature suggests that inadequate or inappropriate use of intrapartum fetal surveillance is too often a feature of adverse obstetric outcomes. The failure or delay in interpreting and responding to cardiocography (CTG) changes suggestive of hypoxia is a common finding, highlighting the potential for inconsistencies in interpretation of fetal wellbeing by practitioners. Incorrect, inconsistent and inaccurate interpretation of intra-partum fetal surveillance has been identified as a significant contributing factor to adverse perinatal outcomes, both in Australia and elsewhere (RANZCOG, 2014).

In addition, the SA Health *Standards for Maternal & Neonatal Services in SA (Dept. for Health and Ageing, 2015)* state health facilities providing care to neonates must have the clinical capabilities to support the neonate whilst waiting for assistance from more qualified perinatal health practitioners and/or the perinatal retrieval service.

The Australian Resuscitation Council (2016) suggests that all those who may need to participate in resuscitation of the newborn should undertake training that specifically includes individual and teamwork skills. As such, all professional perinatal health care providers across SA Health must undertake regular resuscitation education with a focus on the recognition and management of the deteriorating pregnant woman and/or fetus and newborn resuscitation.

In support of related literature, the *Strategy* provides an inter-professionally focused education program using a blended learning approach and provides focused simulated education opportunities for all health practitioners involved in the care of maternity and neonatal patients to embed the learnings.

3.2 PRINCIPLES

The *Strategy* provides the minimum education standards required to support the provision of safe emergency perinatal surveillance and care in response to local or contemporaneous circumstances whilst recognising the need to transfer care of the pregnant woman, fetus and/or neonate between different organisations as determined by the patient's complexity of care needs. The *Strategy* will be made available to all SA Health staff via their Local Health Network (LHN) communication/professional development programs.

The *Strategy* directs each unit providing maternity and neonatal services to ensure that all relevant health practitioners undertake the standardised perinatal emergency care training. Locally based, onsite delivery of this education and training will optimise the familiarity and use of specific local unit procedures/protocols relevant to the local workforce available. The need to develop additional specific local unit emergency management procedures / protocols may arise as a result of the education and training.

It is accepted that knowledge and skills deteriorate after twelve (12) months dependent upon frequency of exposure (Thornton 2017), therefore the *Strategy* aims to provide annual education updates where possible. Extension of education frequency beyond two (2) years is not supported.

Completion of the required level of education must form part of a health practitioner's Personal Review and Development (PRD) plan. Inability to complete requirements (e.g. due to not undertaking the education or failure to meet required practitioner level), will require an individual learning and development plan with set time-frames, learning experiences and expectations +/- modifications in roles or responsibilities, as determined by the relevant LHN. LHNs will ensure individuals have access to a mentor during this time.

The *Strategy* must not operate in isolation, but as part of an overall locally-delivered education program that supports the provision of safe and effective care. Additional activities such as simulation and CTG review meetings in the context of clinical scenarios will support practitioner competence, particularly when exposure to real-life cases is limited.

3.3 DETAIL

The *Strategy* consists of three (3) compulsory education components:

1. Fetal Surveillance Education

- > Online Fetal Surveillance Education Program (FSEP)
 - Royal Australia and New Zealand College of Obstetrics and Gynaecology (RANZCOG) OFSEP (no assessment)
 - K2 Perinatal Training Program (certificate of completion) or RANZCOG OFSEPlus (with assessment and certificate) – NB Country Health SA LHN staff are encouraged to use OFSEPlus ONLY
- > RANZCOG FSEP face to face seven hour study day and assessment.

- > Fetal Surveillance Practice Review (FSPR): an assessment of competence for clinicians experiencing difficulty attaining the required practitioner level in the assessment component of the FSEP study day

2. Obstetric Emergency Management

- > Practical Obstetric Multi-Professional Training (PROMPT) face to face seven hour study day

3. Newborn Life Support (NLS)

- > Newborn Life Support Program
 - Online NLS (theory)
 - Practical / skills session
- > Newborn Advanced Life Support Program (NALS)
 - Online NLS (theory)
 - Practical / skills session

Table 1: Education Requirements per Professional Stream

	Online FSEP OFSEP, K2/OFSEPlus <small>CHSALHN are not encouraged to use K2</small>	FSEP face to face	PROMPT workshop	Online NLS	NLS Skills	Online NALS <small>CHSALHN staff: only if working with midwifery/neonatal patients</small>	NALS Skills <small>CHSALHN staff: only if working with midwifery/neonatal patients</small>
HEALTH CARE WORKERS							
Mother carers					BLS Only		
Aboriginal MICW*			Observer		BLS Only		
NURSING / MIDWIFERY							
Assistant in Midwifery			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Enrolled Nurse(EN)*			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Registered Nurse(RN)*			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Registered Midwife(RM)*	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
MEDICAL							
Intern Obstetrics and Gynaecology (O&G)	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Intern (Neonatal)				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
O&G Registered Medical Officer(RMO)	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
O&G Registrar	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
DRANZCOG RMO	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
O&G Consultant	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
General Practitioner(GP)			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
GP Obstetrician	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
GP Advanced Proceduralist (Obstetrics)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
GP Anaesthetist			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Neonatal RMO				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Neonatal Registrar				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Neonatal Fellows				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Neonatal Cons				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Anaesthetic RMO/Reg			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Anaesthetic Consultant			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

*Site specific based on level of perinatal service delivery. Refer to local site protocols and policies.

FETAL SURVEILLANCE EDUCATION

3.3.1.1 Online Fetal Surveillance Education Program (OFSEP)

Health practitioners that undertake fetal surveillance at any time during the peri-partum period are required to complete annual fetal surveillance education.

SA Health supports the following online fetal surveillance education programs:

- > OFSEP (Available via the RANZCOG webpage at no charge). No user name or password is required and can be accessed by all health practitioners), is required:
 - As a pre-requisite for FSEP study day
 - For staff not required to undertake FSEP study day in alternate year to K2/OFSEPlus
 - At any time as part of individual learning and development plan
- > K2 (Accessed via SA Health web site. A user name or password is required which is obtainable from a nominated manager(s) at each site), is required:
 - For staff required to undertake FSEP study day in alternate year to study day
 - For staff not required to undertake FSEP study day in alternate year to OFSEP
 - NB Country Health SA LHN staff are encouraged to use OFSEPlus ONLY
- > OFSEPlus is an alternate online fetal surveillance education program to K2 (Accessed via RANZCOG website for a fee or free for RANZCOG Fellows).

3.3.1.2 FSEP face to face study day (Facilitated by RANZCOG)

The FSEP study day is a compulsory component of the perinatal emergency education program and should be repeated biennially by the following specified health practitioners:

- > Medical Staff (as indicated in Table 1)
- > Midwives who work in CHSALHN and shift coordinators/team leaders in metropolitan LHNs

Completion of an online OFSEP is a necessary pre-requisite to the FSEP face to face study day. The FSEP face to face study day (seven hour education program) builds on the learning from online OFSEPs. The last hour is designated to a multiple choice question assessment. Health practitioners are required to achieve an assessment score that aligns with a 'level' commensurate with their experience and level of responsibility in the delivery of perinatal care (Table 2).

The participant and their employing hospital will receive their assessment results via email following the study day. The score awarded to the participating health practitioner is interpreted through descriptions of knowledge and skills using an item response modelling analysis technique. It is presented as a score out of 100 and places the individual within a Practitioner Level (Appendix 1). It also includes a 'Graphical Item Map' (GIM) highlighting the categories where the individual has answered questions correctly or incorrectly to assist with further targeted reading and study (Appendix 2).

Table 2: FSEP Practitioner Level required per Professional Stream		
<i>Professional Stream</i>	<i>LHN</i>	<i>Minimum Required Practitioner Level</i>
Midwives working in antenatal or intrapartum areas – all CHSA and Team Leaders (TL)/ Shift Coordinators (SC) / Midwife Unit Managers (metro LHNs)	SALHN, NALHN, WCHN, CHSA	Level 2
Midwives undertaking fetal surveillance at any time during the pregnancy where TL/SC is available	SALHN, NALHN, WCHN	Level 1
Consultant Obstetrician	SALHN, NALHN, WCHN, CHSA	Level 3
GP Obstetrician	CHSA	Level 3
GP Advanced Proceduralist (Obstetrics)	CHSA	Level 3
Obstetric Fellows	SALHN, NALHN, WCHN	Level 3
Obstetric Registrar (Core trainee)	SALHN, NALHN, WCHN CHSA	Level 2
Obstetric Registrar (Advanced trainee)	SALHN, NALHN, WCHN	Level 3
Obstetric Service Registrar	CHSA	Level 1 aiming for Level 2 at 1 year
Resident Medical Officers (DRANZCOG)	SALHN, NALHN, WCHN	Level 1

3.3.1.3 Fetal Surveillance Practice Review (FSPR)

Those health practitioners that do not achieve the required Practitioner Level must meet with their line manager (for GPs - Medical Supervisor as allocated by the LHN) within one (1) month of the study day to initiate a Learning and Development Plan. This plan must include an assessment of competence via Fetal Surveillance Practice Review (FSPR) no later than six (6) months after the FSEP study day. Where the practitioner successfully completes the FSPR and is thought to be able to continue in their current role, they must repeat the FSEP study day and assessment no later than twelve (12) months after the failed attempt (See Appendix 3 for process and FSPR Tool).

Any modification of individual duties or responsibilities during this time is determined by the line manager, relevant Director and/or LHN.

The health practitioner should be allocated a ‘fetal surveillance peer mentor’ until the FSEP study day and assessment is repeated to support the practitioner with their Learning and Development Plan. The mentor and the practitioner should identify areas of difficulty using the Graphical Item Map (Appendix 2), to target educational activities. Suggested activities for the plan might include:

- > Regular review of CTGs cases within a clinical context
- > Online FSEPs
- > Use of the RANZCOG FSEP Teaching and Assessment Tools (available online)
- > Tools for increasing skills in multi-choice assessment.

A health practitioner is assessed as competent following the FSPR when they are able to demonstrate appropriate clinical decision-making relevant to their required Practitioner Level Characteristics (Appendix 1). For the FSPR, a minimum of six (6) CTG cases are to be reviewed, with three (3) cases from the RANZCOG resources and three (3) “real cases” from the health practitioner’s recent clinical experience, (the case notes/medical record from “real cases” should be brought to the FSPR). Four (4) of the CTG cases reviewed should address the areas of concern identified in the GIM (Appendix 3).

Each LHN is responsible for facilitating and managing the FSPRs required in their LHN. In some circumstances, the Practitioner Level 3 assessor may be secured from an alternate LHN.

FSPR assessors must:

- > be separate to the allocated mentor
- > have achieved 'Practitioner Level 3' in the FSEP study day assessment
- > be from the same professional stream as the practitioner undertaking FSPR
- > use the practitioner's GIM to identify and assess areas of weakness as part of the FSPR

Table 3 outlines the suggested assessor for the FSPR assessment.

Table 3: Suggested Assessor for FSPR	
Practitioner being assessed	Supervisor
RMO/Registrar	Consultant Obstetrician / Senior Registrar
Consultant Obstetrician	Consultant Obstetrician
GP Obstetrician	GP Obstetrician / Consultant Obstetrician
Midwife	Midwife Manager / Educator

Where an individual does not demonstrate an appropriate level of knowledge or competence or there are concerns regarding their ongoing practice after the FSPR, the Director of Nursing/Midwifery, Divisional Midwifery Director or Medical Director must meet with the practitioner and their line manager (for GPs - Medical Supervisor as allocated by the LHN), to undertake a performance review and develop an ongoing work and learning plan that will support the practitioner to reach the required practitioner level.

Where the health practitioner continues to either, not meet their required practitioner level in the FSEP study day assessment or be assessed as not competent in their FSPRs, the individual must meet with their relevant Director for further performance management that may include restrictions on their practice.

3.3.2 OBSTETRIC EMERGENCY MANAGEMENT TRAINING

The *Strategy* supports the Practical Obstetric Multi-Professional Training (PROMPT) for the obstetric emergency management training. PROMPT is a seven (7) hour face to face study day. Originating in Bristol, UK, it was developed to reduce adverse neonatal and perinatal outcomes through multi-professional training aimed at improving communication and teamwork in clinical scenarios. The program, licenced by RANZCOG, has been adapted to and tested in the Australian context with positive results (Shoushtarian et al 2014).

PROMPT training is a compulsory component of the perinatal emergency education program for all medical, midwifery and nursing practitioners involved in the care of women at any time during the peri-partum period. Required staff (see Table 1), must repeat the training every two (2) years. PROMPT has no formal assessment component but a certificate is issued on completion; therefore attendance equals compliance.

At least one (1) PROMPT credentialed trainer must be in attendance during the PROMPT study days conducted at local sites. The education consists of lectures, teamwork drills, skills stations and emergency scenarios enacted by multidisciplinary teams. Learning outcomes are achieved by participants observing and executing clinical scenarios using PROMPT cards and providing feedback on teamwork, communication, situational awareness as well as the clinical management of the emergency outlined in the clinical scenarios.

Ideally the PROMPT education should:

- > be provided on site as close to the clinical areas as possible to optimise replication of the real life situation.
- > consist of multidisciplinary training teams which represent those onsite during a real emergency situation, with each team member assuming their usual role within the team.
- > have a participating team and an observing team.
- > use 'actors' to enable feedback to be provided from a consumer perspective.
- > use real equipment as far as possible.
- > have the participating team enact every aspect of the clinical scenario and play it out as if it were a real life situation.

- > adjust the scenario to accommodate the idiosyncrasies of the local site. (This may differ greatly from a metro site where a full team is available within minutes)
- > have the observing team conduct the PROMPT clinical scenarios and provide feedback using the PROMPT Assessment cards on clinical management and how the participating team worked together and communicated.

3.3.3 NEWBORN LIFE SUPPORT PROGRAMS

3.3.3.1 Newborn Life Support Program (NLS)

The Newborn Life Support (NLS) Programs utilise information from the Australian and New Zealand Committee on Resuscitation Guidelines 2016 and the International Liaison Committee on Resuscitation Guidelines 2015. They have been adapted to suit the South Australian environment by the South Australian Neonatal Resuscitation Group.

The NLS is a compulsory component of the perinatal emergency education program for all health practitioners providing care at birth, who may be expected to participate in the resuscitation of the newly born infant and/or who provide inpatient postnatal care for newborns or (see Table 1). NLS must be completed every two (2) years. Ideally the online component is undertaken in the alternate year to the skills session. Where practitioners are required to undertake both NLS and NALS, the programs should be completed in alternate years.

NLS has the following components:

1. NLS online program

Participants can access the eLearning courses via <http://digitalmedia.sahealth.sa.gov.au> (using any email to register) **or** <http://www.saheducation.com/moodle/> (using SA Health email to register) To 'unlock' the courses, staff will need to enter an access code/key. This access code/key is available from the SA Health Safety and Quality eLearning Courses intranet page or via a local nominated manager(s) at each site.

Completion of the online NLS program is a pre-requisite to the NLS face to face/skills session.

2. NLS face to face skills session

Sessions provide an opportunity to review the online content and apply clinical practice techniques such as preparation for resuscitation, assisted ventilation and cardiac compressions, with a series of skills 'stations'. NLS face to face sessions are of 1 hour duration.

NLS face to face skills sessions are conducted by credentialed trainers at 'education hubs' that have been established at the 3 public metropolitan maternity units and across CHSA health sites.

NLS 'Train the Trainer'

To become a NLS credentialed trainer the practitioner must successfully complete basic NLS training, complete the 'Train the Trainer' workbook and attend a four hour NLS training workshop either at Flinders Medical Centre (FMC) or Women's & Children's Hospital (WCH). Trainers are then required to attend an update annually either by attending FMC or WCH or liaising with the NLS coordinator to arrange for a member of the state wide Neonatal Resuscitation team to attend a local NLS session. NLS trainers are required to facilitate education/training for at least four (4) NLS sessions per year to remain credentialed to deliver the NLS education program.

3.3.3.2 Newborn Advanced Life Support Program

In addition, the Newborn Advanced Life Support (NALS) program is a compulsory component of the *Strategy* for staff that may be required to offer advanced neonatal support at the time of birth (i.e. members of a neonatal emergency response team – see Table 1), every 2 years. Completion of the NLS program is a pre-requisite for the NALS and should be undertaken in the alternate year to NALS.

Skills in the NALS sessions include those needed for advanced resuscitation such as endotracheal intubation, laryngeal mask insertion, umbilical catheter insertion and electrocardiograph monitoring. NALS has the following components:

1. NALS online program

Participants can access the eLearning courses via <http://digitalmedia.sahealth.sa.gov.au> (using any email to register) or <http://www.saheducation.com/moodle/> (using an SA Health email to register) To undertake the online course, participants will need to register on the site using an email address (can be non-SA Health email). To 'unlock' the courses, staff will need to enter an access code/key. This access code/key is available from the SA Health Safety and Quality eLearning Courses intranet page or via a local nominated manager(s) at each site.

Completion of the online NALS program is a pre-requisite to the NALS face to face/skills session.

2. NALS face to face skills session

Sessions provide an opportunity to review the online content and apply clinical practice techniques such as preparation for resuscitation, assisted ventilation and cardiac compressions, with a series of skills 'stations'. NALS face to face sessions are of 4 hours duration.

Health sites requiring the NALS program should contact the Neonatal Educator at WCH or FMC or Midwife Manager Maternal & Neonatal Services at CHSA for more information. Wherever possible, the metropolitan sites must support their neonatal education staff to facilitate NALS training in local CHSA sites. It is anticipated that this will represent six (6) sessions per year.

4. Implementation & Monitoring

The *Strategy* compliance results must be managed at the local sites. Local systems must enable managers at all levels to identify staff having completed the appropriate education and having achieved the required level within the timeframes set out in this Policy Directive whilst being cognisant of logistics and availability of locally based education programs.

The LHN CEO(s) will provide a report on the Strategy annually to the Executive Director SA Health Quality, Information & Performance.

Where it is identified in individual sites, units or LHNs that multiple or key individuals are not meeting the Policy requirements due to low completion rates or failure to achieve required FSEP practitioner levels, the LHN CEO(s) must undertake a risk assessment and develop risk mitigation strategies. For example:

- > A metropolitan hospital with numerous clinicians who have achieved FSEP practitioner level 3 may feel that any risk posed by an individual who has not achieved their required FSEP practitioner level is low. The manager may simply ask that the CTG is reviewed by a second set of eyes appropriate to the level of the practitioner (i.e. managed at local LHN level)
- > A large CHSALHN hospital might adopt the same approach as a metropolitan site.
- > A smaller CHSALHN site where the GP Obstetrician is the main/lead maternity provider and has achieved FSEP practitioner level 2 (rather than the required level 3); and where a number of the midwives have achieved FSEP practitioner level 1 (rather than the required level 2), would be deemed to be 'high' risk and therefore require implementation of 'risk mitigation strategies'.

In addition, any risk mitigation strategies must be presented to the Executive Director SA Health Quality, Information & Performance to inform any potential discussion with the South Australian Insurance Corporation (SAICORP) re indemnification of specific sites. Strategies and individual risk assessments must also be documented at the relevant credentialing committee(s).

Compliance with this Policy Directive will be monitored by the Executive Director SA Health Quality, Information & Performance and further follow up will be initiated as required.

5. National Safety and Quality Health Service Standards (2017)

 National Standard 1 Clinical Governance	 National Standard 2 Partnering with Consumers	 National Standard 3 Preventing & Controlling Healthcare- Associated Infection	 National Standard 4 Medication Safety	 National Standard 5 Comprehensive Care	 National Standard 6 Communicating for Safety	 National Standard 7 Blood Management	 National Standard 8 Recognising & Responding to Acute Deterioration
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6. Definitions

Assessment in the context of this Policy refers to the evaluation of knowledge and skills and the ability to apply these to clinical situations as part of ensuring competence to practice

7. Associated Policy Directives / Policy Guidelines and Resources

Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards (2nd Edition)*, 2017, <https://www.safetyandquality.gov.au/>

Australia Resuscitation Council, <https://resus.org.au/guidelines/>

Department for Health and Ageing, *Standards for Maternal and Neonatal Services in South Australia 2015*, <https://extapps.health.sa.gov.au/PracticeGuidelines>

Department for Health and Ageing, *SA Health Performance Review and Development Policy Directive*,

www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/resources/policies/performance+review+and+development+policy+directive

Department for Health and Ageing, *SA Health Perinatal Practice Guidelines*

www.sahealth.sa.gov.au/perinatal

RANZCOG Online Fetal Surveillance Education Program, <https://www.fsep.edu.au/Home>

RANZCOG (2013) PROMPT – ‘PRactical Obstetric Multi-Professional Training’, <http://www.promptmaternity.org/au/>

RANZCOG, Intrapartum Fetal Surveillance Clinical Guideline (3rd edition) 2014, <https://www.ranzcog.edu.au>

SA Health Performance Review and Development,

<http://inside.sahealth.sa.gov.au/wps/wcm/connect/non-public+content/sa+health+intranet/business+units/workforce/workforce+development+and+improvement/high+performance+culture/performance+review+and+development>

Shoushtarian M, Barnett M; McMahon F & Ferris J, Impact of Introducing PRactical Obstetric Multi-Professional Training (PROMPT) into maternity units in Victoria, Australia. *BJOG*, 121: 13, 2014, pp1710-1718

Thornton,

8. Document Ownership & History

Document developed by: Quality, Information and Performance: Safety & Quality
Document reviewed by: SA Maternal, Neonatal & Gynaecology Community of Practice
File / Objective No.: 2014-00312
ISBN: 978-1-74243-971-6
Next review due: 10/07/2023
Policy history: Is this a new policy? **N**
Does this policy amend or update an existing policy? **Y**
If so, which version? V1.1
Does this policy replace another policy with a different title? **N**

Approval Date	Version	Who approved New/Revised Version	Reason for Change
10/07/18	V2.0	SA Health Safety and Quality Strategic Governance Committee	Complete review
5/11/15	V1.1	SA Health Portfolio Executive	Minor amendments to reflect new online course
6/08/15	V1.0	SA Health Portfolio Executive	Original PE approved version.

9. Appendices

9.1 Appendix 1: RANZCOG FSEP Practitioner Level Description

Practitioner Level	Score	Experience, scope of practice and level of responsibility.
<p>PRE LEVEL 1 PRACTITIONER CHARACTERISTICS</p> <p>The Pre Level 1 practitioner is a developing practitioner, working towards the skills and characteristics of the Level 1 practitioner</p>	<55	Information from the assessment undertaken by this practitioner indicates they were not yet able to demonstrate the knowledge and cognitive skills required of a Level 1 practitioner.
<p>LEVEL 1 PRACTITIONER CHARACTERISTICS</p> <p>The level 1 practitioner is typically a supervised practitioner who would not necessarily be expected to have comprehensive clinical (birth suite) experience</p>	55-65	<p>The level 1 practitioner should:</p> <ul style="list-style-type: none"> • have a basic understanding of the physiology of fetal heart rate control • have read and understood the RANZCOG Clinical Practice Guidelines • be able to correctly perform intermittent auscultation (as per RANZCOG Guidelines) • be aware of the different types of fetal monitoring and their indications • be expected to be correctly applying Electronic Fetal Monitoring under supervision • know and be able to define the components of a normal antenatal or intrapartum CTG • be able to recognise common CTG abnormalities • understand the principals of conservative management for common CTG abnormalities and be able to apply them under supervision • be expected to notify a Level 2 or 3 practitioner of an abnormal CTG
<p>LEVEL 2 PRACTITIONER CHARACTERISTICS</p> <p>The level 2 practitioner is typically an independent practitioner with several years clinical (Birth suite) experience and access to Level 3 staff.</p>	66-75	<p>In addition to the Level 1 characteristics the Level 2 practitioner should:</p> <ul style="list-style-type: none"> • have an in depth appreciation of the different approaches of intrapartum fetal monitoring including the indications, implications and limitations of each • have a sound knowledge of maternal, uteroplacental and fetal physiology underlying the common CTG abnormalities • have an understanding of how antenatal problems may impact on the health of the fetus in labour • be able to recognise and effectively manage common CTG abnormalities • be able to recognise trends in fetal heart rate patterns and the implications of these trends for maternal and fetal health • be able to initiate emergency responses in the case of suspected severe fetal compromise • be able to provide advice and education for Level 1 practitioners • be expected to notify a Level 3 practitioner regarding an abnormal CTG where active management is required
<p>LEVEL 3 PRACTITIONER CHARACTERISTICS</p> <p>The level 3 practitioner will typically have extensive clinical (birth suite and/or fetal surveillance) experience and may, as part of their regular duties, be involved in the training of less experienced staff</p>	>75	<p>In addition to the Level 2 characteristics, the Level 3 Practitioner should:</p> <ul style="list-style-type: none"> • have a detailed knowledge of the normal and abnormal CTG including the underpinning maternal, uteroplacental, and fetal physiology • be able to recognise and manage the less common CTG abnormalities • know the indications for other investigations as required and appreciate their limitations and implications • have a detailed understanding and appreciation of the physiology of the high risk pregnancy • be able to manage and prioritize multiple patients with an appreciation of the likely implications of their actions • be able to make advanced management decisions based on accurate synthesis of information from a wide range of sources • be able to recognise errors in information and interpretation

9.2 Appendix 2: Graphical Item Map (GIM) Information

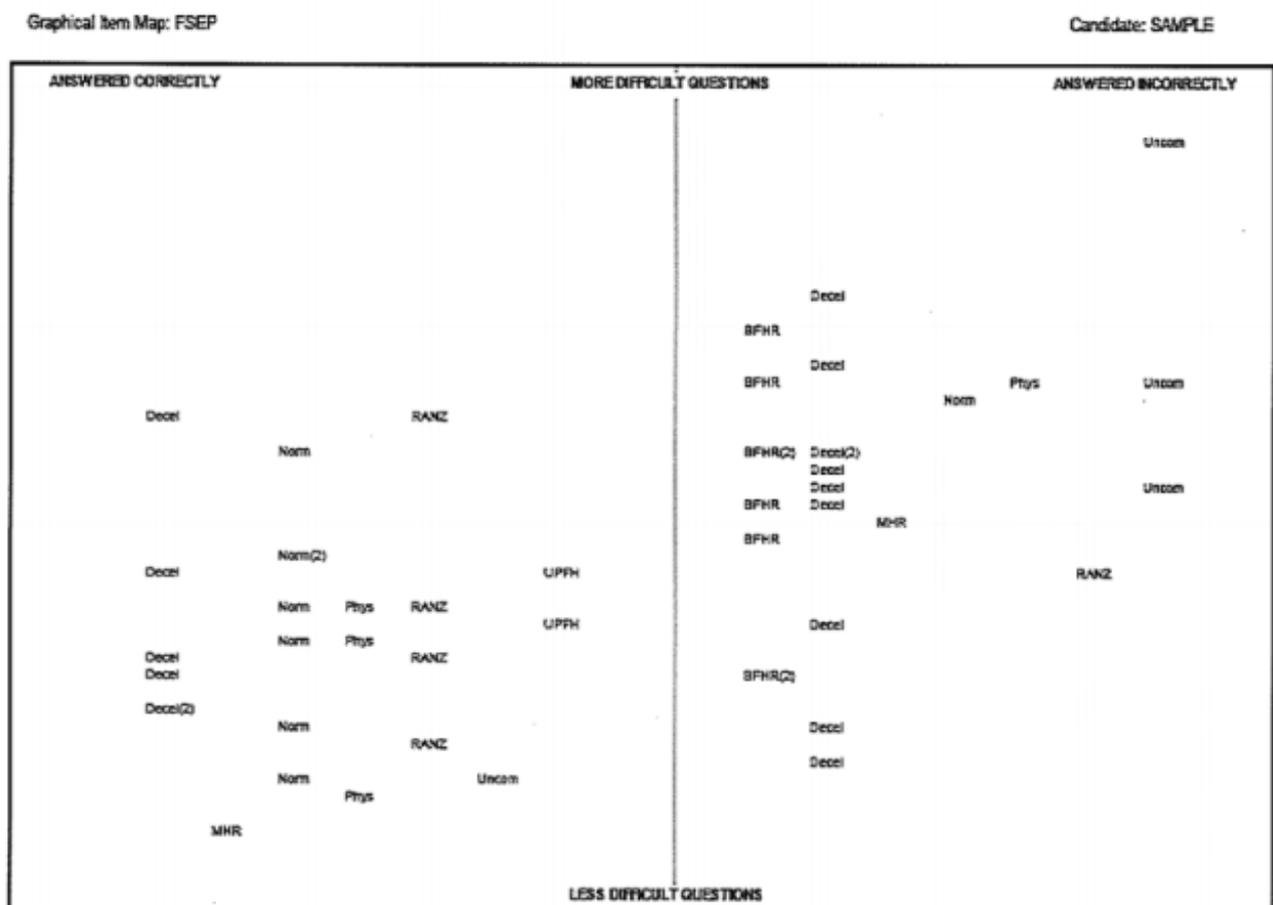
The GRAPHICAL ITEM MAP will provide the participant score with each question (items in the assessment ranked from easiest at the bottom of the map, to hardest at the top. This information is derived from previous extensive and ongoing testing of the individual items.

Items answered correctly are to the left of the map and those answered incorrectly are to the right of the map. The presence of brackets following an item i.e. phys(2), indicates multiple items at that position with the same degree of difficulty.

If the majority of items in a given subject are grouped to the left of the map (answered correctly) this is an area the participant has covered well in their study. If items are clustered to the right of the map (answered incorrectly) this is an area the participant may wish to focus on in future study. This is especially true if these items are also close to the bottom of the map.

Interpretation of the GIM will assist both FSPR mentors and assessors to identify and prioritise areas of weakness. Accessing the RANZCOG short video, 'How to Interpret your Graphical Item Map (GIM)' available at <https://www.fsep.edu.au/What-We-Offer/Assessment-Tool> will assist in this process.

Attachment 3: Graphical Item Map (sample)



9.3 Appendix 3: Fetal Surveillance Practice Review

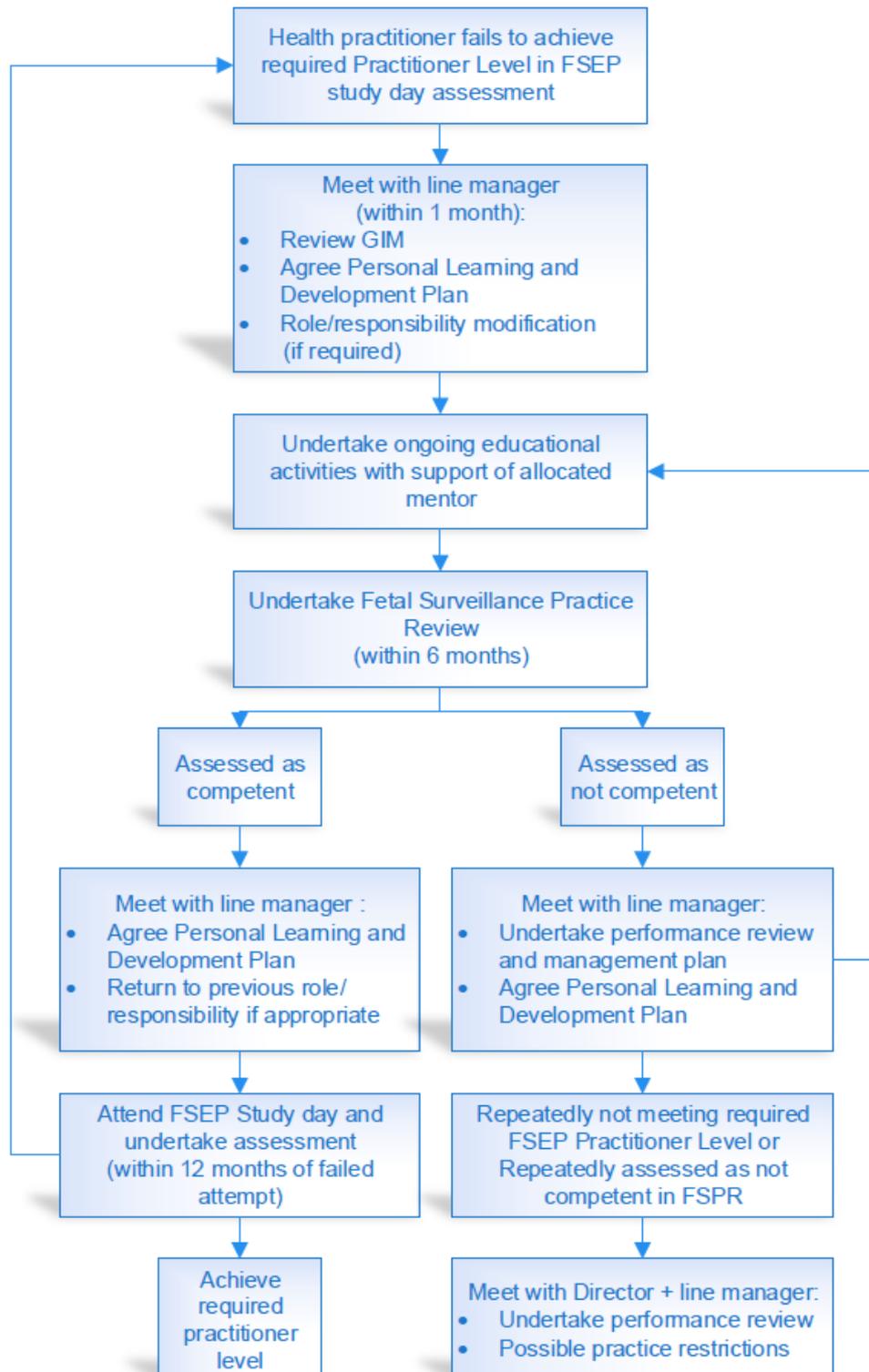
See over page

INFORMAL COPY WHEN PRINTED

FETAL SURVEILLANCE PRACTICE REVIEW

Fetal Surveillance Practice Review (FSPR) forms part of the SA Health Perinatal Emergency Education Strategy (PEES) Policy Directive and must be utilised to assess competence in fetal surveillance by clinicians experiencing difficulty attaining the required Practitioner Level in the assessment component of the FSEP Study Day. The FSPR process supports clinicians to engage with ongoing learning and assessment to enable them to reach the required FSEP Practitioner Level. Any modification of individual duties or responsibilities during this time is determined by their line manager, Director and/or LHN.

Each LHN is responsible for facilitating and managing the FSPRs required in their LHN. In some circumstances, the Practitioner Level 3 assessor may be secured from an alternate LHN.



FSPR – Activities to complete

Meeting with clinical supervisor / manager (within 1 month of FSEP study day)

- > This should be the person who is designated to perform the PR&D for the practitioner.
- > It can also be another practitioner of a similar seniority level suggested by the line manager.
- > The outcome of the meeting should be to develop an individual learning plan.

Graphical Item Map (GIM) review

- > Each participant / practitioner will receive a result letter, and their individual GIM. The clinician should be instructed to bring their GIM to a review meeting where, together with the clinical supervisor; areas that need to be targeted can be ascertained.
- > The clinical supervisor (in conjunction with a local educator or allocated mentor) is suggested to
 - Read the RANZCOG guidelines on assessment and watch the short video, 'How to Interpret your GIM' available at <https://www.fsep.edu.au/What-We-Offer/Assessment-Tool>
 - Discuss the Individual FSEP GIM to ascertain areas that require extra support and guide educational activities.

Allocation of a Mentor (separate to the allocated assessor)

- > It is suggested this be a practitioner who has attained a suitable practitioner level (i.e. a peer, line manager, clinical supervisor or a clinical educator who will not undertake the assessment).

Ongoing activities - once the above specific aspects have been completed

- > Reviewing the RANZCOG online resources.
- > CTG case reviews / meetings.
- > Discussions with local educator around how to answer/sit Multi-Choice Questions.

FSPR – Assessment of Competence

- > The health practitioner required to undertake the FSPR must be notified by their line manager/unit manager 4 weeks in advance of the planned assessment to allow preparation.
- > The notification should include the details of the nominated assessor for the FSPR (see Table 3 in PEES Policy Directive for suitable assessors), and the date/time of the FSPR session (this should be scheduled at a mutually convenient time).
- > The practitioner's GIM must be forwarded to the nominated assessor 4 weeks prior to FSPR.
- > It is imperative that FSPRs are undertaken in a non-threatening learning environment.
- > A minimum of six (6) CTG cases are to be reviewed, with three (3) cases from the RANZCOG resources and three (3) "real cases" from the health practitioner's recent clinical experience, (using the case notes/medical record). Four (4) CTG cases reviewed should address the areas of concern identified in the GIM - see Discussion and Assessment Tool below.
- > RANZCOG Teaching and Assessment Tools (2) describe the clinical picture, CTG trace description and interpretation, management and outcome for antenatal and intrapartum clinical cases. They are available at <https://store.fsep.edu.au> at a small cost.
- > The practitioner should be able to discuss their assessment and management of various clinical situations and provide evidence of specific required knowledge.
- > The practitioner should be able to effectively communicate the level of risk present in the clinical cases and articulate any change in the risk.
- > The practitioner should demonstrate appropriate clinical decision-making relevant to staff designation.
- > FSPR sessions must provide formative feedback with the health practitioner made aware of the outcome/result of the FSPR session at the completion of the session.
- > The assessor must notify the line manager of the outcome/ result of the FSPR.

Ongoing Performance Management

- > If there are concerns about the practitioner's competence after the FSPR, the relevant Director must meet with the practitioner and their line manager to undertake a performance review and develop an ongoing work and learning plan that will support the practitioner to become competent.
- > Where the individual continues to either, not meet their required practitioner level in the FSEP study day assessment or be assessed as not competent in their FSPRs, the individual must meet with their relevant Director for further performance management that may include restrictions on practice.



FETAL SURVEILLANCE PRACTICE REVIEW

Discussion and Assessment Tool

Part 1: RANZCOG Guidelines and Indications for CTG monitoring	
1.1 List at least 4 indications for antenatal CTG monitoring.	
1.2 List at least 4 antenatal reasons to apply a CTG during labour.	
1.3 List at least 4 intrapartum reasons to apply a CTG during labour.	
1.4 Define the fetal heart rate features of a normal CTG <ul style="list-style-type: none"> • Baseline • Variability • Reactivity • No decelerations 	
Part 2: Features of the Normal CTG (Use RANZCOG FSEP T&A Tool #2 for 1 case)	
From the CTG (Case 1 FSEP Teaching & Assessment Tool #2), the clinician identifies: <ul style="list-style-type: none"> • Baseline • Variability • Accelerations/decelerations • Uterine activity Clinical actions identified and management plan agrees with FSEP T&A Tool	CTG #1 RANZCOG T&A Tool #2
Part 3: Interpreting CTGs and Identifying Abnormalities (Use RANZCOG T&A Tool for 2 cases)	
3.1 RANZCOG FSEP Teaching & Assessment Tool # ____ Case Number ____ From the CTG and the clinical picture the practitioner identifies: <ul style="list-style-type: none"> • Baseline • Variability • Accelerations/decelerations • Uterine Activity Clinical actions identified and management plan agrees with FSEP T&A Tool	CTG #2 RANZCOG T&A Tool
3.2 RANZCOG FSEP Teaching & Assessment Tool # ____ Case Number ____ From the CTG and the clinical picture the practitioner identifies: <ul style="list-style-type: none"> • Baseline • Variability • Accelerations/decelerations • Uterine Activity Clinical actions identified and management plan agrees with FSEP T&A Tool	CTG #3 RANZCOG T&A Tool
Part 4: Interpreting CTGs and Demonstrating Appropriate Clinical Action (Use 3 real cases)	
4.1 The practitioner describes the clinical story including: <ul style="list-style-type: none"> • Indication for the CTG (risk assessment) • Stage of pregnancy or labour CTG was commenced • CTG assessment (baseline, variability, accelerations, decelerations, uterine activity) • What action has been taken based on CTG • What plan or follow-up was required (either at cessation of CTG or for duration) • Who the case was discussed with and why (if appropriate) Practice is consistent with guidelines and local expectations	CTG #4 CTG from recent experience
4.2 The practitioner describes the clinical story including: <ul style="list-style-type: none"> • Indication for the CTG (risk assessment) • Stage of pregnancy or labour CTG was commenced • CTG assessment (baseline, variability, accelerations, decelerations, uterine activity) • What action has been taken based on CTG • What plan or follow-up was required (either at cessation of CTG or for duration) • Who the case was discussed with and why (if appropriate) Practice is consistent with guidelines and local expectations	CTG #5 CTG from recent experience
4.3 The practitioner describes the clinical story including: <ul style="list-style-type: none"> • Indication for the CTG (risk assessment) • Stage of pregnancy or labour CTG was commenced • CTG assessment (baseline, variability, accelerations, decelerations, uterine activity) • What action has been taken based on CTG • What plan or follow-up was required (either at cessation of CTG or for duration) • Who the case was discussed with and why (if appropriate) Practice is consistent with guidelines and local expectations	CTG #6 CTG from recent experience



Part 5: Assessment Summary and Ongoing Learning and Development Plan

Blank area for writing the assessment summary and ongoing learning and development plan.

Practitioner's Name: Signature:

Assessor's Name: Signature:

Date: / /

