QUESTIONS AND ANSWERS Re: Levels of Maternal and Newborn Care from the PCMCH Webinars

Updated June 2, 2011

Q: Will there be an opportunity to participate in the 30-32 weeks (Level IIc) trial?

A: A proposal has been submitted to PCMCH for this study however we are still seeking funding. Once funding has been identified the participants will be identified and will likely be the current Modified Level III and Advanced Level II Units.

Q: Can you clarify that an on-site ICU is required. None of the Maternal Centers have "Yes" in the Diagnostic Test or Treatment for Maternity Care document other than what's identified in Level III.

A: There are no requirements for on-site ICUs for anything other than Level III. What are described in the documents are the minimum requirements for each level.

Q: Is 24/7/365 EEG for newborns at Levels IIIa and IIIb a requirement?

A: EEG is generally not available 24/7 at any of the sites. The need for 24/7/365 EEG will be revised in the levels document to read: "timely access to". This was not referring to amplitude integrated EEG (aEEG), which was still new and at various stages of adoption at the time these guidelines were developed. aEEG may need to be revisited in the future.

Q: What if we meet all the criteria for Level IIc except 24/7/365 PICC insertion? We can provide PICC maintenance.

A: At Level IIc organizations should have on-site insertion capability. It can be scheduled and does not have to be available 24/7.

Q: In the document chest tubes and PICC lines were categorized as "no" for a Level IIb. Should this classification be changed to include chest tube insertion and PICC insertion for the Level IIb for neonates?

A: Drainage of a pneumothorax was a "yes" for all levels. Maintenance was "no". Babies requiring a chest tube may be unstable and if they need ventilation they may need to be transferred to a Level IIc or Level III, thus maintenance was not a minimum expectation but an optional one. The document outlines the minimum requirements for each level of care. Some centres will be able to provide some services over and above the minimum requirements for their level and that is fine. Centres that are not able to provide this service will have to transfer the infant as necessary.

Q: Can you please comment on whether there are designated sites for triplets?

A: Level IIc for uncomplicated, otherwise level III.

Q: Can you provide clarification regarding Level IIIa neonatal care and 24/7 echo criteria?

A: This will be revised in the levels document to reflect the need for timely access for IIIa.

Q: What is the requirement for ROP Screening especially for centres with limited or no Ophthalmology coverage?

A: Not having a screening service (on-site or remote) is a confining feature and a major obstacle to retro- transfer. Centres with limited coverage are encouraged to explore local or regional cross-coverage. At this point we will remove ROP screening as a "must have" for Level IIb. We will re-survey the province to evaluate the current level of ROP screening support and will review the results of that survey at M-NAC and will then reassess the minimum criteria for Level IIb.

Q: What defines competency and skill requirements for the levels of care?

A: All personnel are required to provide competent care as stipulated, for example, by NRP at a minimum. Personnel should have the capability to perform the care for the pregnant mother and infant as described in the scope of service.

Q: In rural hospitals where the volume of service is not available to maintain competency how does one maintain competency with such small volumes?

A: This process did not address the optimal size of the maternal or newborn service to support the maintenance of competency. Providing a service in a rural hospital is a balance between access to service versus the ability to develop and maintain competency with low volumes.

Q: When is the sign-off for the levels of care due?

A: June 3rd, 2011 and the sign-off form should be submitted to your LHIN.

Q: If you have 2 or more sites providing care should we be providing sign-offs?

A: Yes – one for each site

Q: If we assess and determine we are currently at one level (but on the cusp of the next level) what will be the process for updating the level?

A: If you are planning to advance to the next level you will want to notify the LHIN of your intent. Once you have met the criteria for the next level you should notify the LHIN and the LHIN should notify the MOHLTC, PCMCH and Criticall as with the current process.

Q: How does this fit with a regionalized model of care? What if everyone strived to be a Level III in a LHIN?

A: Advancing to another level would require dialogue with your LHIN as this change should be based on regional needs and may require additional resources to implement. Changing levels of care will need to be coordinated with the LHIN, taking into account need, and is thus regional.

Q: It is stated in the document that all newborn levels with the exception of Level I require Fetal Scalp PH, is this practice being completed in most organizations?

A: Fetal Scalp PH is a component of the SOGC guidelines however is not in common use in Ontario. The levels document will be adjusted to reflect this position.

Q: For Level I newborn care a Registered Nurse is stipulated but many centres use RPNs for mother-baby dyad care.

A: The document will be revised to reflect that RPNs can be part of the team providing care.

Q: For Level I dyad care midwives are also used and there are no healthy newborn nurseries.

A: While healthy newborn nurseries have been phased out with Mother-Baby Dyad Care, an observation area to facilitate treatment of minor transitional issues can be very valuable in

preventing the separation of mom and baby by decreasing the need for a transfer to a SCN or NICU.

Q: Criteria for low, medium, high risk at the Level II.....who defines this?

A: The Work Group did not specify criteria for stratification of maternal risk as it is very subjective. Units can refer to the Ontario antenatal record guideline.

Q: Why the differentiation between uncomplicated dichorionic and uncomplicated monochorionic diamniotic twins at term from Level Ib to IIc?

A: Dichorionic twins are designated to a Level I if there are no complications as long as the centre has the ability to do C-Sections, otherwise they should go to a Level IIa.
Overall the risk with monochorionic twins is higher and there may be a need for emergency C-Section. Monochorionic twins may have imbalances in blood flow and twin-to-twin transfusions and are designated for a Level IIc or III.

Q: Is there a formal template for the self-assessment, how/where do we access it?

A: There is not a self-assessment template however there is a sign-off form that the LHINs have sent to the CEOs of the hospitals.

Q: There was a mention of benchmarking activities from BORN and PCMCH. Has the Access Work Group developed a template with metrics for the organizations to monitor their performance within the scope of service designation?

A: This is in progress. We anticipate that BORN data will be very useful and will eliminate redundant data collection.

Q: On the slides there was an indication of the need for nursing education. Should this be for any health care provider group instead of just nursing?

A: Yes, education should be focused on inter-professional teams involved with care. The human resource requirement tool will be revised accordingly.

Q: Regarding the Level IIc trial, it may take 1-2 years for that study (30-32 week prem study) to be finished - will CritiCall be involved prior to this in order to monitor current admissions/ transfers?

A: CritiCall will be using the levels of care to direct patients.

Q: We used to deliver twins in our facility and it was recommended we stop delivering twins as they were all considered higher risk. Many of our MDs lack the comfort level to deliver twins - we do have C-Section capability and Electronic Fetal Monitoring - will we still be considered a Level Ib?

A: Yes as long as you are able to provide the minimum requirements for the category. Delivering twins is optional at Level Ib based on staff comfort level. We will clarify that some aspects of the LOC guidelines are optional as opposed to minimum requirements.

Q: Are all the Neonatal Transport teams able to support transport of neonates from Level I, IIa and IIb to Level IIc?

A: Neonatal transport teams can support transport to a Level ll or lll for acute transfers, but they do not do all neonatal transports in the province. ORNGE transports most of the neonates in the North. In some areas, less acute transfers can be done by the referring centre.

Q: What about hospitals that do not have an Obstetrical program, but end up doing emergency births. Is there a Level 0 or a non-OB designation? Any designation for home births or is this just related to hospitals?

A: These hospitals would be designated as a non-provider of maternal-newborn services.

Q: Does "lactation support" mean that we need to have a certified lactation consultant on staff or is it sufficient to have nurses provide lactation support during admission and provide the mom with information about lactation support in the community?

A: Lactation support means nurses with the knowledge and skill to provide such care. Parents should be provided with appropriate information about lactation support in the community upon discharge as suggested.

Q: This Level I facility has always triaged and transferred when surgery coverage not available, 1 w/e every 4. Does Level Ia imply that labor and delivery continue with 35 min transfer to Level II?

A: **Closing services one weekend per month does not provide 24/7/365 coverage. If you do offer the services without surgical backup you must inform patients that c- section is not immediately available and be able to transfer in a timely manner. The 30 min guideline applies.**

Q: When will centres be expected to be fully functional at their level?

A: Now. This is an assessment of current status.

Q: How do you access the documents for supporting services. The webinar has a few different things than the handouts as far as I can see.

A: It is an Excel document with multiple pages.

Q: We meet all criteria for Level Ib except we do not deliver twins - should we be Level Ib?

A: Twins are optional depending on the comfort level of the staff.

Q: If you are unable to provide 24/7 C-section coverage but can on a sporadic basis are you considered to be Level Ib?

A: This would be a Level Ia.

Q: In the questionnaire re: coverage, is the assumption that the service (i.e. physio, respiratory) are available 24/7?

A: There should be access to the services that are provided Monday to Friday. With roles such as respiratory therapy, availability should be based on your model of care i.e. are they a pivotal member of your resuscitation team.

Q: The excel spreadsheet says CPAP "or" brief ventilation but another document indicates both for Level IIb....which is it?

A: Both. Brief ventilation will be a judgment call. Any consideration for more than 24 hours ventilation should be transferred out for a IIb.

Q: Can you define long term IV?

A: Greater than a week. A distinction is made because of challenges in long term IV maintenance and the problem of NPO, IV and no TPN.

Q: What information or criteria should be included in the informed consent? Is there an existing document or tool available?

A: No existing tool is available. The informed consent component centered around providing C-section support for laboring women. Pregnant women should be given the option to transfer to centres that can provide such care.

Q: How can you distinguish between intermittent and continuous feeds by gavage? This may present as a barrier to repatriation.

A: No distinction was made during the development of the guidelines. Continuous feeds would be a specific type of gavage feed and would not be part of a baseline expectation.

Q: Can you be a Level II for maternal and a Level I for newborn?

A: Alignment of maternal and newborn levels is important in order to ensure that the appropriate level of care is available for the babies that will be delivered.

Q: Once level of care has been approved, what is the process for accountability and how will performance be monitored?

A: This work is about describing what currently exists. Accountability for organizational performance does not change. PCMCH will, however, monitor the number of preterm babies requiring care who are born in centres not staffed and equipped to care for them.

Q: We are surprised to see TPN included in Level IIb, and weight requirements between IIa and IIb. This leads to some crossover between the levels. Why is UVC not included in Level IIa?

A: UVC maintenance is allowed in Level IIa but is not a minimum expectation. The TPN and weight criteria are similar to the CPS guidelines. We thought the gradation in level of care between Levels IIa, IIb and IIc made sense and were varied enough to allow distinctions in the level of care provided.

Q: Are there minimum requirements for Level IIb and Level IIc in regards to professional manpower?

A: The guidelines cover the type of individuals but not the numbers. There is no requirement for an in-house NNP or physician. Individual centers could decide that is a minimum requirement, particularly in Level IIc. There should be a RT in-house for Level IIc and on-call but not in-house for Level IIb.

Q: Can you speak to what the implications of the levels of care are for breastfeeding?

A: Wherever babies are born there is an expectation that staff would be able to support mothers with breastfeeding.

Q: Would there be any consideration to give some extra time to get TPN programs up and running in current Level IIb centres, otherwise centre such as ours will need to drop to Level IIa?

A: According to these guidelines you are a level lla, you would not drop to a lla.
We are committed to giving CritiCall levels of care that reflect what is currently being provided. Even though you would be labeled a Level IIa, given that the descriptions reflect minimal requirements there is no need to stop what you are currently doing while you put TPN services in place. The LHIN should be notified of your intention to change designations once TPN is in place. Once that is done, resubmit a new designation sign-off to the LHIN as with the current process.

Q: If we are a Level IIa designation and accept a 33 stable weeker knowing our resources are fully qualified to care for the 33 weeker are we exposing ourselves?

A: Flexibility on a case by case basis is reasonable. It would be prudent to document the situation.

Q: Why are GP Anesthetists not in the Level IIa section?

A: This is not a minimum requirement but they can be there.

Q: What are the U/S requirements for Level IIa and IIb?

A: U/S technician should be available at both levels.

Q: We only have GP anesthestists but meet the Level IIa requirements

A: We will consider changing the category to GP Anesthetists/Anesthesiologists, particularly for Level IIa.

Q: What are the specific u/s required? Community organizations may not have specific u/s capabilities i.e., head u/s.

A: The intent was for the abilities to be general including head u/s. We thought this would be within most centres capabilities but if it is not we may need to reconsider.

Q: When will the presentation document be circulated?

A: The presentation documents will be posted on the PCMCH website (www.pcmch.on.ca) once all the webinars are complete (May 19th).