

1 Maternity Designation Level II (Specialty Care)

2 (a) Level II (Specialty Care)

- 3 (1) The level II facilities will be well suited for pregnant women who may have
4 medical, surgical, or obstetrical conditions that may pose a mild to moderate
5 risk of maternal morbidity or mortality. These patients may be directly admitted
6 or transferred from another facility.

- 7 (2) The Level II maternity designation facility will:

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9 (A) Provide care of pregnant women with the ability to detect, stabilize, and
10 initiate management of unanticipated maternal–fetal or neonatal problems
11 that occur during the antepartum, intrapartum, or postpartum period until
12 patient can be transferred to a facility at which a higher level of neonatal
13 and/or maternity care is available
14 (B) Provide skilled personnel with documented training, competencies and
15 annual continuing education specific for the patient population served

- 16 (b) Maternity Medical Director (MMD). The MMD shall be a physician who:

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18 (1) Is a board eligible/ certified in obstetrics and gynecology or maternal fetal
19 medicine with experience and special interest in the care and delivery of
20 pregnant women;
21 (2) Demonstrates effective administrative skills and oversight of the Quality
22 Assessment and Performance Improvement (QAPI) Program;
23 (3) Is actively practicing and a member of the medical staff
24 (4) Has completed continuing medical education annually specific to maternity care
25 including complicated conditions.

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27 (c) Program Function and Services

- 28 (1) Triage and assessment of all patients admitted to the perinatal service with:
29 (A) identification of pregnant women who are at high risk of delivering a neonate
30 that requires a higher level of neonatal care than the scope of their neonatal
31 facility shall be transferred to a higher level neonatal designated facility prior
32 to delivery unless the transfer is unsafe
33 (B) identification of pregnant or postpartum women with conditions or
34 complications that will likely require a higher level of maternity care will be
35 transferred to a higher level maternal designated facility unless the transfer
36 will be unsafe.
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Comment [ET1]: Sections prior to Levels of Care include Purpose; Definitions; Program Requirements. Quality Programs, Program Scope, Formal transport plans and requirements will be in the Program Requirements

Comment [WU2]: Will need define

Comment [ET3]: This is in the national standards for MMD to be "board certified obgyn"

Comment [ET4]: At Mar PAC meeting

Comment [ET5]: On medical staff of hospital

- 38 (2) Supportive and emergency care delivered by appropriately trained personnel for
39 unanticipated maternal-fetal problems that occur until the patient is stabilized or
40 transferred.
- 41 (3) Ensure the ability to begin emergency cesarean delivery including ensuring the
42 availability of a physician with the training, skills, and privileges within a time
43 interval that best incorporates maternal and fetal risks and benefits with the
44 provision of emergency care.
- 45 (4) Ensure **adequate** surgical assistance for cesarean deliveries commensurate to
46 the complexity of the surgery.
- 47 (5) Ensure that a qualified physician or certified nurse midwife with appropriate
48 physician back-up is available to attend all **deliveries** or other obstetrical
49 emergencies.
- 50 (A) The primary provider caring for a pregnant or postpartum woman
51 who is a family medicine physician or physician specializing in
52 obstetrics and gynecology **or maternal fetal medicine**, or a certified
53 nurse midwife with appropriate physician back-up whose credentials
54 have been reviewed by the MMD and:
- 55 (i) Has completed continuing education annually, specific to the care
56 of the pregnant and postpartum woman, including complicated
57 conditions
- 58 (ii) Shall arrive at the patient's bedside within a timeframe
59 commensurate to the patient's condition; for an urgent request,
60 the timeframe may not be greater than 30 minutes and may be
61 shorter for more critical circumstances
- 62 (iii) If not immediately available to respond or is covering more than
63 one facility, shall have appropriate backup coverage available,
64 documented in an on call schedule and readily available to facility
65 staff; and the physician is providing backup coverage shall arrive
66 at the patient bedside within a timeframe commensurate to the
67 patient's condition; for an urgent request, the timeframe may not
68 be greater than 30 minutes and may be shorter for some
69 circumstances
- 70 (B) Certified nurse midwives who attend patients
- 71 i. Shall operate under guidelines reviewed and approved
72 by the MMD
- 73 ii. Shall have through formal arrangement, a physician
74 providing back-up and consultation, whose credentials
75 reviewed by the MMD and shall be able to arrive at the
76 patient's bedside within a timeframe defined in (5) (A)
77 (ii-iii)
- 78 (C) An obstetrician/gynecologist shall be available at all times

Comment [ET6]: From Perinatal Guidelines, 7ed, p24

Comment [ET7]: This is in national guidelines but doesn't specify in-house vs consultation and to come in if requested, etc

Some community level II's recommend keep as is (not board certified)

- 79 (D) An on-call schedule of providers, back-up providers, and provision for
80 patients without a physician should be posted on the labor and
81 delivery unit.
82 (E) During a delivery or cesarean, there will be separate provider
83 immediately available to attend to the resuscitation of the newborn
84 including intubation and administrative of medications if needed.
85 (F) Availability of appropriate anesthesia, laboratory, radiology,
86 ultrasonography and blood bank on a 24 hour basis as described in S
87 133.41(a), (h), and (s) of this title respectively.
88 (i) Ensure that the blood bank has the capability of to
89 provide ABO-Rh specific or O-Rh negative blood, fresh
90 frozen plasma and/or cryoprecipitate, and platelet
91 products at the facility at all times
92 (6) Anesthesia personnel
93 (A) with obstetrical experience or expertise shall be provided to
94 pregnant and postpartum women including labor analgesia and
95 surgical anesthesia, and available at all times
96 (B) A board certified anesthesiologist with special training or experience
97 in obstetric anesthesia is available at all times for consultation
98 (7) CT imaging available including interpretation on a 24 hour basis, and ideally MR
99 imaging
100 (8) Ultrasound availability. The facility will ensure:
101 (A) Basic ultrasonographic imaging for maternal or fetal assessment including
102 interpretation available on a 24 hour basis
103 (B) A portable ultrasound machine will be available in the labor and delivery
104 and antepartum unit for urgent bedside examination.
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106 (9) Special equipment shall be available to accommodate the care and services for
107 obese women
108 (10) Ensure the availability and interpretation of non stress testing and
109 electronic fetal monitoring
110 (11) Hospitals offering a trial of labor for patients with prior cesarean delivery
111 must have the immediate availability of anesthesia, cesarean delivery, and
112 neonatal resuscitation capability during the trial of labor.
113 (12) A registered pharmacist shall be available for consultation on a 24 hour
114 basis.
115 (A) If medication compounding is done by a pharmacy technician for
116 neonates/infants, a pharmacist will provide immediate supervision of the
117 compounding process.
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119 (B) If medication compounding is done for neonates/infants, the
120 pharmacist will develop checks and balances to ensure the accuracy of
121 the final product.

Comment [WU8]: FFP and/or cryoprecipitate
Level III blood bank director agrees with this

Comment [ET9]: This is in Perinatal Guidelines –
should include?

Comment [WU10]: Dr Hollier - advocate for
this; does not necessarily need to be onsite

Comment [ET11]: For urgent situations

Comment [ET12]: Mar PAC meeting

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- (13) Resuscitation – The facility shall have appropriately trained staff, policies and procedures for the stabilization and resuscitation of pregnant or postpartum women based on current standards of professional practice, including
 - (A) ensuring the availability of personnel who can stabilize pregnant or postpartum women until transfer is possible
 - (B) having at least one person on site at all times who can be immediately available to provide ACLS including intubation, cardioversion or defibrillation, and direct the administration of medications for cardiopulmonary arrest.
 - (C) Having current guideline or protocols specifically addressing the resuscitation of the pregnant woman, and ensure that resuscitation equipment for pregnant and postpartum women is readily available at the labor and delivery area, including
 - (i) Equipment for cardioversion and defibrillation
 - (ii) Resuscitation equipment and medications
 - (iii) Intubation equipment including fiber optic scopes for awake intubation
 - (14) Consultants available including
 - (A) a physician specializing in maternal fetal medicine shall be available by formal agreement or call schedule on site, by phone, or by telemedicine as needed.
 - (B) Medical and surgical consultants available onsite to stabilize obstetrical patients who have been admitted to the facility or transferred from other facilities
 - (15) The facility shall have written guidelines or protocols for various conditions that place the pregnant or postpartum woman at risk for morbidity and/or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:
 - (A) Massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, and including management of unanticipated hemorrhage and/or coagulopathy
 - (B) Obstetrical hemorrhage including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality.
 - (C) Hypertensive disorders in pregnancy including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality
 - (D) Sepsis and/or systemic infection in the pregnant or postpartum woman
 - (E) Venous thromboembolism in pregnant and postpartum women, and to assessment of risk factors, prevention, early diagnosis and treatment

Comment [ET13]: By formal agreement or call schedule per MAR PAC meeting

Comment [ET14]: National Guidelines

- 166 (F) The management of the morbidly obese pregnant and post partum
167 patient
- 168 (16) The facility shall have an adequate number of RN's with competence in
169 level II maternity care criteria and ability to stabilize and transfer high-risk
170 women and newborns who exceed their designation criteria
- 171 (17) The facility shall have nursing leadership and staff with formal training
172 and experience in the provision of perinatal nursing care and should coordinate
173 with respective neonatal services
- 174 (18) Shall have a QAPI process and policies aimed to reduce maternal
175 morbidity and mortality including:
- 176 (A) Measuring key outcomes and making improvements on outcomes that
177 are less than optimal;
- 178 (B) The facility will ensure that drills for high risk events such as shoulder
179 dystocia, emergency cesarean delivery, eclampsia, clinical coagulopathy,
180 respiratory failure, and maternal hemorrhage will occur at regular
181 intervals to help medical, nursing, and ancillary staff prepare for these
182 emergencies
- 183 (C) ensure regular team training on an ongoing basis in the perinatal areas to
184 promote staff communication and effectiveness in working together
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- 186 (19) Perinatal Education. A registered nurse with experience in maternity
187 care including moderately complex and ill obstetric patients shall provide the
188 supervision and coordination of staff education.
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- 190 (20) Ensures the availability and support personnel with knowledge and skills
191 in breastfeeding to meet the needs of mothers.
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- 193 (21) Social services and pastoral care shall be provided as appropriate to meet
194 the needs of the patient population served, including bereavement services.

Comment [ET15]: This is in national guidelines

Comment [ET16]: Shoulder Dystocia deleted per Mar PAC meeting

Comment [WU17]: Should guidelines and OR table and bed for morbidly obese

Comment [WU18]: High risk and low frequency events, moved from separate categories