Guidelines for a Working Relationship Between the Department of Obstetrics and Gynecology and the Department of Family Medicine at the University of North Carolina at Chapel Hill; and Between Physicians and Nurses in the UNC Women's Hospital Labor and Delivery Unit

(Amended January 27, 2016)

Preamble

Rendering healthcare to pregnant women and their newborn infants is an honor and a sacred duty for healthcare providers who are privileged to participate. It provides the opportunity to share some of the most significant moments in the lives of patients and their families. It requires unique knowledge, skills and attitudes of those delivering the care and it demands sensitivity to the emotional and physical needs of both mothers and their babies.

By design, the Labor and Delivery Unit of UNC Hospitals is a site for delivering maternal and child care to members of the community and for training healthcare providers of the future. UNC Hospitals sponsors training programs in both Obstetrics and Gynecology and in Family Medicine, whose residents are required to receive obstetrics training to be eligible for board certification. To fulfill residency training requirements, both the Department of Obstetrics and Gynecology and the Department of Family Medicine must employ and privilege faculty capable of providing care to pregnant women and their children. In addition, UNC Hospitals offers clinical privileges through these departments to physicians and nurse midwives in the community who also provide these services. It is the expressed goal of all of these healthcare providers to provide the highest possible standard of care for their patients.

Obstetrical care is sometimes complicated and frequently requires utilization of procedures or technology that not all providers are qualified to perform. Some situations require urgent intervention to save the lives of women and/or their children. In order to provide excellent care, it is necessary to coordinate the efforts of obstetricians, family physicians and nurse midwives who practice on the Labor and Delivery Unit. Toward that end, the following guidelines have been ratified by both clinical departments.

Principles:

The following principles provide a basis for the guidelines between obstetricians, family physicians and nurse midwives (collectively referred to as "providers") in any clinical unit of the UNC Healthcare System, including the Labor and Delivery Unit:

1. Excellence in patient care is the highest priority for all providers. A goal of all providers is to continuously strive to improve the quality of care offered at UNC Hospitals.
2. Interactions between providers in any venue must be guided by civility, open dialogue, and acknowledgement of colleagues as members in good standing of the UNC Hospitals Medical Staff or as physicians in training.
3. Clinical privileges are granted by the Department of Obstetrics and Gynecology and the Department of Family Medicine in accordance with Medical Staff by-laws and Medical Staff Policies on appointment. Many surgical and/or bedside procedures are performed on behalf of patients in Labor and Delivery. For that reason, each practitioner who seeks privileges to practice in the Labor and Delivery unit should identify those specific procedures for which s/he requests privileges. Accordingly, each department must have a Privilege Request Form that includes a listing of the procedures performed in Labor and

Delivery, and a place for the applicant to indicate precisely which procedures s/he requests privileges to perform. The Chair of the Department of Family Medicine should provide a copy of the privileges recommended for new and reappointed faculty members to the Obstetrician-Gynecologist in Chief, UNC Women's Hospital. The Obstetrician-Gynecologist in Chief will review the recommendations and at h/her discretion will review individual recommendations with the Chair of Family Medicine. The Chair of Family Medicine will forward the recommendations to the Credentials Committee.

4. As a courtesy, the Vice Chair for Obstetrics in the Department of Obstetrics and Gynecology and the Chair of the Department of Family Medicine will each notify the other, as well as the nurse manager of Labor and Delivery, as new faculty or fellows join the Medical Staff.
5. An essential part of the mission of both departments is to train physicians capable of providing obstetric care for citizens of North Carolina. Toward that end, guided by recommendations set forth by the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians, the departments have developed these guidelines for mutual interaction in rendering care to pregnant women and their infants.
6. Providers who attend to patients on the Labor and Delivery Unit acknowledge that each group possesses qualities and skills used in the delivery of care to pregnant women.
7. Family physicians and nurse midwives provide a valued patient referral base for UNC's Department of Obstetrics and Gynecology.
8. The willingness of UNC obstetricians to provide consultation for patients in Labor and Delivery makes it possible for family physicians and nurse midwives to practice on the Labor and Delivery Unit.
9. Family physicians and nurse midwives will seek consultation in accordance with clinical situations, with the paramount concern being the safety and well being of the patient(s) involved. Obstetrical consultation is indicated for certain medical conditions and/or clinical situations, as outlined in the body of this document. For those conditions or situations, family physicians and nurse midwives are expected to request consultation. To that end, the Ad Hoc Group recognizes item #20 from the Rules and Regulations of the Medical Staff, the relevant excerpt of which reads as follows: *"The patient's physician is responsible for requesting consultations when indicated. It is the duty of the Medical Staff through its Chiefs of Service and Executive Committee to make certain that members of the Staff do not fail in the matter of requesting consultations when needed."*
10. The Chairs of the Departments of Obstetrics and Gynecology and Family Medicine will work with their Chiefs of Service and the Chief of Staff to ensure that members of the Medical Staff do not fail in the matter of requesting needed consultations, as delineated in these guidelines.
11. The Department of Obstetrics and Gynecology and the Department of Family Medicine will develop formalized joint procedures to monitor and improve the care of patients managed on Labor and Delivery.
12. Because the obstetric attending covering labor and delivery is responsible for accepting any maternal transports from outside facilities and also for any procedures requiring the operating rooms, it is essential for him/her to have an understanding of all patients on the board. In that spirit, any provider working on the unit should recognize that responsibility and communication any relevant patient information to the obstetrical attending.

Definitions:

1. Consultation: A consultation is a request from one provider to another for an advisory opinion or to perform a procedure.
2. Consultation with Follow-up: A consultation with follow-up is a request from one provider to another for ongoing advice regarding management of a patient for a specific condition or through a specified period of time.
3. Referral: A referral is a process by which one provider requests that another provider assume responsibility for management of a patient: a) for a specific period of time; or b) until resolution of the condition; or c) for continuing management of the condition.
4. Labor and Delivery Board: The labor and delivery board is a status board containing the names of all patients admitted to labor and delivery. It details medical information about the pregnancy, the patient's status in labor, any existing complications and their treatments. It is intended as a reference for physicians and nurses who need an overview of everything happening on the Labor and Delivery Unit.
5. Senior Obstetrics Resident is the PGY 3 or PGY4 resident who is on call for the Labor and Delivery Unit.
6. Partogram: A partogram is a graph showing the dilation of a patient's cervix and the descent of the fetal presenting part over time.

Guidelines on Communication

These guidelines provide a framework for communication between all healthcare providers who have patients admitted to the UNC Labor and Delivery Unit. They cover appropriate and necessary communication between services and detail three levels of consultation on patients. Examples of conditions are given for each level, but are not intended to be exhaustive lists. Quality patient care, appropriate resident training, patient safety and patient preferences are all important considerations in the use of these guidelines. Specific points are as follows:

1. All patients admitted to the Unit should be listed on the Labor and Delivery Board and have their relevant clinical data noted. In addition, the Senior Obstetrics resident or Obstetrics Attending On Call should be given a brief "FYI presentation" of the patient by her healthcare provider(s) to allow a process of clear and concise communication upon admission to Labor and Delivery. Once notified, the Senior Obstetrics Resident or Attending may contact the primary physician and request to review the patient's medical record. If, after reviewing the record, the obstetrician wishes to provide consultative input, the obstetrician will communicate this to the provider. The provider will receive the input, promptly review the clinical situation and determine whether to request formal consultation.
2. The Labor and Delivery Board should be updated by the provider for all patients as their labors progress. All ensuing complications and treatments should be noted in a timely fashion.
3. Consultation with an obstetrician should be obtained whenever a managing provider feels that it might be beneficial for the patient and the patient agrees. When such consultation is desired, the provider will contact either the available Senior Obstetrics Resident or the Obstetrics Attending on call. When a consult is urgent, the Family Medicine attending should request the consultation of the Obstetric attending. When possible, the Obstetric attending and chief resident will provide consultation simultaneously, but we recognize that, in the case of urgent consultations, the obstetric attending must take sole or concurrent responsibility unless other emergencies on the unit require his or her presence.
4. All providers are invited and encouraged to participate in the Department of Obstetrics and Gynecology's Labor and Delivery morning and evening sign-out rounds. However, it is recognized that other services operate on different rounding and coverage schedules.

Guideline for Vaginal Birth after prior Cesarean Section (VBAC)

In the case of a patient attempting vaginal delivery after prior cesarean section (VBAC), all providers will keep an up-to-date partogram on the Labor and Delivery board. The provider will ensure that a current VBAC consent form has been signed by the patient and is on the chart. All available operative note(s) and/or documentation of review of previous uterine surgeries shall be readily available on the chart.

Guideline for Vacuum Delivery

In the case of a Family Medicine patient for whom vacuum delivery is contemplated at or below +2/5 station, the family physician or nurse midwife will notify nursing personnel of the anticipated instrumented delivery and the potential need for specific back-up. The physician or midwife will also notify the Senior OB Resident or Obstetrics Attending of said procedure to ensure ready availability of obstetrical consultation should that be requested. If the physician or midwife feels it is unsafe to leave the bedside s/he may ask the nurse to assist in locating the obstetrician. It is the responsibility of the attending provider caring for the patient to clearly define his or her expectations for the obstetrician's involvement.

Guidelines for Family Medicine Consultation with Obstetricians for Procedures, Advice or Management of Patients

There are three levels of consultation for Family Medicine patients. Level 1 is Consultation. Level 2 is Consultation with Follow-up. Level 3 is Referral. When <u>any</u> level of consultation is made, the following principles will be followed:

1. The requesting service will document the consultation in writing with a clear statement of the question being asked or what procedure is being requested. Requests should be accompanied by relevant medical information. The response of the consultant should also be in writing and should address the request.
2. The requesting provider uses professional judgment and the preferences and values of the patient in deciding whether or not to act on the consultant's recommendation.
3. If the requesting provider disagrees with the consultant's recommendation, a clear statement of the rationale should be written in the patient's chart.
4. The patient will be aware of the consultation and have a clear understanding of the consultation process. The patient may accept or decline the consultant's recommendation(s).
5. If the patient chooses to decline the consultation or the recommendations given by the requesting and the consulting service, the requesting service will document this in the record.
6. In the event there is disagreement between a Family Medicine resident and an Obstetrics resident over the appropriateness of consultation in a given situation, either resident may request immediate attending-to-attending communication; such communication will take place as quickly as possible. The Family Medicine Attending also has the option to request the opinion of the Maternal Fetal Medicine Physician on "back up" call after notification of the in-house attending generalist obstetrician or Maternal Fetal Medicine fellow. Final decisions on patient management rest with the patient's attending physician.

Specific Conditions and Indications For Three Levels of Consultation

Level 1 - Consultation:
A Level 1 consultation is a request for the consulting service to evaluate a patient and give an advisory opinion on the condition or to perform a specific procedure. If a procedure is done, the consulting service manages the patient during the procedure and returns the patient to the care of the requesting service when the procedure is completed. Consultation is indicated for, but not limited to:

- External cephalic version
- Amniocentesis
- Obstetric Ultrasound
- Forceps delivery
- Vacuum delivery above +2/5 station
- Gestational Diabetes requiring medication
- Polyhydramnios with AFI >30
- Trial of Labor after Cesarean (Low Risk)
    - One prior cesarean
    - Spontaneous labor
    - Category 1 FHR tracing
    - Normal progress of labor (no dystocia or arrest of labor progress after 6 cm)

Level 2 – Consultation with Follow-Up
A level 2 consultation is a request to the consulting service for ongoing advice regarding management of the patient for a specific condition or through a specified period of time. Both services should develop a plan of management that details the responsibilities of each service (e.g. which service will write what orders). The patient will remain the primary responsibility of the requesting service, which will write progress notes. The consulting service should also write notes in the patient's record when appropriate. Any healthcare provider seeing a patient in consultation should seek approval from the requesting service for treating or further referring any other condition. Consultation with follow up is indicated for, but not limited to:

- Severe preeclampsia
- Preterm labor at less than 34 weeks gestation
- Preterm premature rupture of membranes at less than 34 weeks gestation
- Possible need for an instrumented vaginal delivery of a fetus above a +2 station
- Prolonged second stage >5 hours in nulliparous patient and >3 hours in multiparous patient
- Vaginal bleeding requiring admission
- Biophysical profile score ≤4/8 or ≤4/10
- Trial of Labor after Cesarean (High Risk)
    - Induction
    - Augmentation (prior to initiation of Pitocin)
    - Category 2 FHR tracing not responsive to intervention
    - Dystocia or arrest of labor
    - History of >1 prior cesarean

Level 3 – Referral
A referral is a process by which the requesting services ask to have the consulting service assume responsibility for management of the patient: a) for a specific period of time; or b) until resolution of the condition; or c) for continuing management of the condition. Referral is indicated for, but not limited to:

- Cesarean section
- Multifetal gestation
- Eclampsia

Guideline for Addressing Nursing Concerns at the Point of Care

Collaboration between providers (doctors, nurse practitioners and midwives) and professional registered nurses caring for patients is essential for quality patient care. Generally this collaboration works very well locally and directly at the bedside between the nurse and the provider. In the event a registered nurse is concerned about a patient's plan of care, the following steps outline the required communication channels. As long as patient safety does not require a different approach in a specific situation, these steps are to be followed in sequence. When a nurse moves to a given step it is understood that all preceding steps have been tried and that the situation is not yet resolved to the nurse's satisfaction. In accepting this process physicians recognize that the RN assigned to the patient, and the Charge Nurse, have a responsibility to pursue the communication channels until the RN believes a satisfactory patient plan of care has been reached.

Note that a nurse may choose to solicit guidance and collaboration with the L&D Charge Nurse at any step. In the event that the unit is extremely busy or it is an emergency situation, and the Charge Nurse is in patient care, the nurse may choose to contact the Nurse Manager or Supervisor for guidance. If any step in this communication plan is not possible or a given individual is unavailable, the Nurse and the Charge Nurse have the responsibility to proceed to the next step.

Steps

1. The RN caring for the patient privately discusses concerns with the provider directly (resident or midwife) in a confidential, respectful and timely manner. Most disagreements should be resolved at this step.
2. The RN speaks directly to the patient's Attending provider (Obstetrics or Family Medicine) about the clinical situation. It is expected that most issues not resolved at Step 1 will be resolved here.
3. The RN communicates the problem to the Charge Nurse of L&D. The Charge Nurse will assess the situation and talk with all nurses and providers involved, striving to reach an acceptable and mutually agreed upon patient plan of care.(If the patient is a Family Medicine patient continue with step 4; if OB patient, proceed to step 5)
4. The Charge Nurse collaborates with the Family Medicine Attending to discuss the case with the Obstetrical Attending on L&D (if previously uninvolved) to seek a mutually agreeable resolution. Optimally the Charge Nurse and Attending physician will do this together, but the Charge Nurse is responsible for communicating with the Obstetrical Attending. The Obstetrical Attending, if a generalist or MFM Fellow, may choose to consult the MFM back-up physician. The Charge Nurse will also discuss the situation with the Nurse Manager or Nursing Supervisor.
5. The Charge Nurse or Manager/Supervisor will contact the Medical Director of L&D or a designee to review and resolve the clinical situation. The Charge Nurse/Supervisor will also contact the Director of Nursing for Women's Hospital, if immediate assistance is needed.
6. The Medical Director or designee will discuss the case with the Obstetrician-Gynecologist in Chief, UNC Women's Hospital for final resolution of the patient plan of care. The Charge Nurse/ Director of Nursing / Supervisor may meanwhile contact the Chief Nurse or Associate Chief Nurse Officer for guidance. If a case reaches this step, the Senior Vice President for Women's Hospital will also be notified.

Guideline for Joint Review of Outcomes

All clinical departments of UNC Hospitals are required to review the care of their patients (e.g. departmental Quality Improvement Conferences). These processes will be augmented by a periodic joint review of patients managed on the Labor and Delivery Unit by an ongoing CQI committee, called the Quality for Women's and Infant's Performance Improvement Committee (QWIPIC). The QWIPIC will be a subcommittee of the Clinical Management Committee of the Medical Staff. In accordance with the bylaws, two representatives from either the Department of ObGyn, Family Medicine, or Neonatology will be appointed by the Chief of Staff to co-Chair this Committee.

Guideline for Rapid Review of Specific Cases

There may be instances in which a member of the Medical Staff or the Nursing Staff desires an expeditious, retrospective review of a case. Any physician, nurse midwife, nurse, or other employee who works on the Labor and Delivery Unit may complete a risk management incident report form or call legal/risk management and request a rapid review. Legal/risk management will convene a review committee composed of the Chief of Staff or designee, the Associate Chief of Staff for Clinical Outcomes and Effectiveness, the Nurse Manager for Labor and Delivery or designee, one physician from the Department of Obstetrics and Gynecology, one physician from the Department of Family Medicine, providers involved in the specific case, and representatives from legal/risk management. When clinically relevant, representatives from Anesthesiology and/or Neonatology may in specific instances be asked to participate as well.

Every attempt will be made to complete the review within 48 hours. The review committee's findings will be forwarded to the Obstetrician-Gynecologist in Chief, UNC Women's' Hospital, and to the Chief of Staff. The Obstetrician-Gynecologist in Chief will recommend appropriate action as follows -- identified systems issues in need of review or revision should be forwarded for additional evaluation to the Quality for Women's and Infant's Performance Improvement Committee; health care provider issues should be referred to the appropriate Department Chair or the Department of Nursing. The Chief of Staff will then make a final determination of the next steps to be taken. When appropriate, the findings will be promptly reported to the Chair of the relevant clinical department(s), the Clinical Director for Women's Hospital and Clinics, and the Senior Vice-President for Women's Services. Risk Management will also discuss the outcome of the review with the individual who requested the review.

Modification of the Guidelines

These guidelines are not intended to cover all known complications of obstetrics, or every conceivable patient problem that might arise on the Labor and Delivery Unit. They have purposely been written to specify a process of communication and consultation, rather than to dictate what actions should occur.

These guidelines should be reviewed as needed, by an ad hoc group appointed at the time by the Chief of Staff.

The service chiefs of Obstetrics Labor and Delivery and Family Medicine Maternal and Child Health and their designees will meet regularly to review and update this document.

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