Maternal and Perinatal Serious Incident Review Sub-Committee

Learnings Summary: January – June 2025

This document provides a summary of learnings arising from the Maternal and Perinatal Serious Incident Review Sub-Committee meetings. We encourage facilities to review the learnings to determine local relevance and possible action. Human Factors play a part in all clinical situations and should be considered within each of the learnings. While the resources are relevant to several learning areas, they are listed a single time.

Fetal Heart Rate (FHR) monitoring

- FHR monitoring is a screening tool to assess fetal wellbeing and must be used as part of a comprehensive, clinical assessment of the woman and fetus.
- When utilising continuous cardiotocography (CTG) for FHR monitoring, the clinical tools provide an opportunity to stop and review the full clinical picture.
- The clinical tools require a contemporaneous second clinician review to provide a secondary independent review. This measure assists clinicians to maintain situational awareness.
- The FHR clinical tools support a physiological approach to interpretation, which in turn supports accurate assessment of the full clinical picture.

NSW Health resources

- Maternity – Fetal Heart Rate Monitoring (GL2025_004)
- Recognition and management of patients who are deteriorating (PD2025_014)

CEC resources

- Perinatal Safety Education
- Maternal and Perinatal Serious Incident Review Sub- Committee publications: Maternal and Perinatal Lessons and Learnings – Emergency Caesarean Sections

Postpartum Haemorrhage (PPH):

- A comprehensive labour assessment includes consideration of existing and emerging risks for PPH.
- Early identification of risk factors for PPH, reduce adverse outcomes for women.
- As part of PPH care, CERS activation should occur to ensure there is a multidisciplinary response

NSW Health resources:

- Postpartum Haemorrhage (GL2025_007)

CEC resources:

- Between the Flags

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Vaginal Birth after Caesarean Section (VBAC):

- An in-person review for women in early labour assists identification of additional risk factors and inform decision making around the most appropriate place for early labour care.
- When a woman is in early labour, it is important to review antenatal care plans to support informed decision making.
- When a woman is in labour, it is important to inform the most senior obstetric medical officer to support comprehensive care planning as well as establish whole team communication pathways.
- Senior obstetric oversight for women attempting VBAC supports timely and appropriate action if there are complications.

NSW Health resources:

- Maternity – Supporting Women in their Next Birth after Caesarean Section (NBAC) (GL2014_004)
- Maternity and Neonatal Service Capability (GL2022_002)

CEC resources:

- Safety Fundamentals for Teams
- Maternal and Perinatal Serious Incident Review Sub- Committee publications: Maternal and Perinatal Watch – Uterine Rupture

Documentation:

- Clinicians must review all available documentation to gain a complete picture and not miss vital information
- Use of the copy and paste function in the Electronic Medical Record (EMR) can result in the transfer of incorrect information, compromising patient safety.
- A comprehensive review of documentation in the birthing environment should include any previous telephone consultations leading to the presentation/ admission.

NSW Health resources:

- Health Care Records – Documentation and Management (PD2025_035)
- Clinical Handover (PD2019_020)

CEC resources

- CEC Safety Alert Broadcast system (SAB): Maternity Telephone Consultations
- Clinical handover

Discharging women:

- Discharge information should include guidance that meets the woman's health literacy needs to ensure understanding, particularly for women with risk factors.
- The discharge process should include assessment of the full clinical picture and plans for ongoing care so that safe, informed care continues to be provided, including for women who discharge against medical advice.

NSW Health resources:

- Maternity – National Midwifery Guidelines for Consultation and Referral (PD2020_008)
- Patient Discharge Documentation (GL2022_005)
- Statewide Health Literacy Hub
- Quick guide for maternity staff: Integrated trauma-informed maternity care
- Trauma informed care
- Interpreting services

CEC resources:

- Safety Fundamentals for Person Centred Communication
- Partnering with patients, carers, and families
- Health Literacy

Complex care needs:

- When care is being provided to a pregnant woman from multiple teams, senior obstetric oversight is essential to co-ordinate care and support decision making.
- Pregnant women with complex care needs should have continuity of care from a designated obstetric medical officer in order to ensure care is comprehensive and meets the individual needs of the woman.
- All pregnant and postpartum women who present to the Emergency Department must have observations recorded on the Standard Maternal Observation Chart (SMOC) to appropriately identify signs of deterioration.
- Assessment of pregnant and postpartum women in the Emergency Department should include a maternal and fetal wellbeing assessment undertaken by the maternity team.
- When a woman presents with decreased fetal movements, utilising the Care Pathway for Women Concerned about Fetal Movements guideline will ensure a standardised approach supporting comprehensive management and timely decision-making regarding birth.

NSW Health resources:

- Care Pathway for Women Concerned About Fetal Movements (GL2021_019)

- Connecting, Listening and Responding: A Blueprint for Action - Maternity Care in NSW (IB2023_006)
- Tiered Networking Arrangements for Perinatal Care in NSW (PD2023_035)

Caring for the neonate:

- Following orogastric and nasogastric tube placement, it is important to monitor for early warning signs of deterioration such a desaturation, colour change and apnoea.
- Ensure correct orogastric and nasogastric tube placement is confirmed using chest Xray or pH testing of aspirate, to reduce harm.
- When a neonate is showing signs of deterioration following birth, prompt CERS activation is critical to ensure a timely response from clinicians who are trained in neonatal resuscitation.
- CERS processes alert the broader team and contribute to high quality communication, supporting clinicians to maintain situational awareness and respond appropriately.

NSW Health resources:

- Nasogastric and Orogastric Tube Insertion and Management in Neonates, Infants and Children (GL2025_012)
- Neonatal Resuscitation (GL2025_003)

CEC resource:

- Neonatal resuscitation equipment checklist

Medication safety:

- When a woman has an epidural in place, it is essential to maintain a clearly labelled closed line system to avoid medication errors and reduce the risk of contamination.
- Medication safety checks in the operating theatre must have a standardised process to avoid unintentional errors such as the wrong drug being administered.

NSW Health resource:

- Medication Handling (PD2022_032)

CEC resource:

- Medication Safety

We value your feedback. If you have any questions or comments about this report, please email CEC-PatientSafety@health.nsw.gov.au