

# MATERNAL AND NEWBORN SERVICE

## HOSPITAL LICENSURE PRE-SURVEY QUESTIONNAIRE

Hospital: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Instructions: Please complete data for the most recent full year for each hospital campus**

INDICATE REPORTING DATES: \_\_\_\_\_ to \_\_\_\_\_

- \_\_\_\_\_ 1. Total Number of Births
- \_\_\_\_\_ 2. Number of Vaginal Births
- \_\_\_\_\_ 3. Number of Vacuum Assisted Births
- \_\_\_\_\_ 4. Number of Vaginal Births After C-Section
- \_\_\_\_\_ 5. Total Number of C-Sections
- \_\_\_\_\_ 6. Number of Primary C-Sections
- \_\_\_\_\_ 7. Total Number of deliveries of multiple births
  - \_\_\_\_\_ two newborns
  - \_\_\_\_\_ three newborns
  - \_\_\_\_\_ four or more newborns
- \_\_\_\_\_ 8. Number of Deliveries 35 - 0 weeks Gestational Age or over
- \_\_\_\_\_ 9. Number of Deliveries between 34-0 and 34-6 weeks
- \_\_\_\_\_ 10. Number of Deliveries between 32-0 and 33-6 weeks
- \_\_\_\_\_ 11. Number of Deliveries before 32 weeks
- \_\_\_\_\_ 12. Average length of stay (vaginal birth mothers)
- \_\_\_\_\_ 13. Average length of stay (C-section mothers)
- \_\_\_\_\_ 14. Average infant length of stay, well newborn nursery, as applicable
- \_\_\_\_\_ 15. Average infant length of stay, continuing care nursery, as applicable
- \_\_\_\_\_ 16. Average infant length of stay, special care nursery, as applicable
- \_\_\_\_\_ 17. Average infant length of stay, neonatal intensive care unit, as applicable

- \_\_\_\_\_ 18. Level II only: Number of newborns treated with Continuous Positive Airway Pressure (CPAP), if applicable
- \_\_\_\_\_ 19. Number of early maternal discharges (under 48 hours following vaginal birth or under 96 hours following C-Section)
- \_\_\_\_\_ 20. Level I or II only: Total number of maternal transfers from your hospital to another hospital
- \_\_\_\_\_ Number before delivery
- \_\_\_\_\_ Number after delivery
- \_\_\_\_\_ 21. Level III only: Total number of maternal retro-transfers
- \_\_\_\_\_ Number before delivery
- \_\_\_\_\_ Number after delivery
- \_\_\_\_\_ 22. Level I or II only: Total number of newborns transferred from your hospital to another hospital
- \_\_\_\_\_ 23. Level III only: total number of newborns retro-transferred
- \_\_\_\_\_ 24. Number of maternal deaths (death of woman while pregnant or within 90 days of delivery)
- \_\_\_\_\_ 25. Number of fetal deaths (death of fetus 20 weeks gestation or greater)

**GENERAL ADMINISTRATION**

**Level of Care (130.601 Definitions)**

Yes  No  1. Does the hospital's criteria for the management of maternal conditions include gestational age?

Yes  No  2. Are these criteria identified in a written policy?

**Perinatal Advisory Committee (130.616 A)**

Yes  No  1. Does the hospital have a perinatal advisory committee?

2. List member names and their title in the hospital or role in the community (or attach)

_____	_____
_____	_____
_____	_____

3. What is the frequency of meetings per hospital policy? \_\_\_\_\_

4. What are the dates of the last 3 meetings? \_\_\_\_\_

Yes  No  5. Are minutes available?

**Written Collaboration and Transfer Agreements (130.616 B)**

Yes  No  1. Does the hospital have a written agreement(s) for Maternal Services with other hospitals?  
*If yes, please complete attached form (see page 12).*

Yes  No  2. Does the hospital have a written agreement(s) for Newborn Services with other hospitals?  
*If yes, please complete attached form (see page 12).*

Yes  No  3. Level II Services only: Does the hospital employ nurse practitioners to provide on-site delivery room and/or special care nursery services?

Yes  No  4. Does the primary level III collaboration agreement include provisions for the Level II nurse practitioners rotation to the Level III unit?

Please submit copies of each agreement.

**Data Collection and Reporting Systems (130.628)**

Yes  No  1. Does the hospital have policies and procedures for collecting and reporting maternal and newborn data?

Yes  No  2. Is a person(s) assigned to assure compliance with maternal and newborn services data collection and reporting requirements?

Please list on attached sheet:  
Name, title, and data for which the individual is responsible (for example, birth information, fetal deaths, maternal deaths)

Yes  No  3. Level III Services only: Does the hospital participate in the Vermont Oxford Network's Very Low Birth Weight Database?

**Patient and Family Services (130.615)**

1. How does the hospital meet the Maternal-Newborn education needs of limited English proficient patients?

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2. What are the major languages of the hospital's population identified as a result of the language needs assessment conducted in accordance with 105 CMR 130.1103 (A)?

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Reference:

130.1103: Interpreter Service - Coordinator

In connection with its provision of emergency department service each acute care hospital shall designate a coordinator of interpreter services who shall be responsible for:

(A) conducting an annual language needs assessment of the service area which includes input from community-based organizations, and which includes identification of those languages for which notices shall be posted.

**Administrative Policies (130.616 C)**

1. Does the hospital have written policies and procedures regarding the admission and/or placement of antenatal patients presenting for:

Yes  No  a) Diagnostic and testing procedures

Yes  No  b) Pregnancy related conditions

Yes  No  c) Non-pregnancy related medical and surgical conditions

2. Yes  No  Does the hospital have written policies and procedures regarding the use of licensed obstetric services beds for patients admitted for gynecological services?

**Patient Care Policies (130.616 D) (130.395)**

- Yes  No  1. Does the hospital have written policies and procedures regarding infant identification and security?

- Yes  No  2. Does the hospital have written policies regarding the disposition of the remains of a fetus following the death of the fetus (other than by abortion)?

**Quality Assurance and Education Program (130.616 E)**

- Yes  No  1. Does the maternal and newborn service have an ongoing quality assurance program?

- Yes  No  2. Is the program plan described in writing?

3. Please attach a list of persons (name, profession and title) who routinely participate in the maternal and newborn quality assurance activities.

- Yes  No  4. Does the program include an annual review of transfer cases, management of cases, and educational programs and protocols among facilities that transport maternal and neonatal patients to one another pursuant to collaboration/transfer agreements?

- Yes  No  5. Are outcome statistics including neonatal and perinatal mortality, as well as appropriateness of neonatal and maternal transfers, compiled in a standardized manner and reviewed at a minimum on a quarterly basis by the hospital perinatal advisory committee? Date of last review by committee: \_\_\_\_\_

- Yes  No  6. Are neonatal and maternal deaths after transfer or discharge from the facility (within first 28 days of delivery) included in the statistics?

**NURSING AND LACTATION SERVICES**

- Yes  No  1. Is a registered nurse designated to provide maternal and newborn staff education and training to update and maintain staff knowledge, competencies and skills?

If more than one nurse educator is provided for the maternal and newborn service, please list each separately (or attach) and include area(s) of responsibility.

Name of designated nurse educator: \_\_\_\_\_

Nurse educator's qualifications: \_\_\_\_\_

Nurse educator's area(s) of responsibility: \_\_\_\_\_

Hours per week nurse educator dedicated to maternal and newborn service staff education: \_\_\_\_\_

Others (Name/Qualifications/Responsibilities/Hours): \_\_\_\_\_

2. Does the in-service education program include the following (**please check if yes**):

- (a) Evaluation of the condition of the mother, fetus and newborn.
- (b) Assessment of risk during the labor, delivery, recovery and postpartum periods.
- (c) Fetal assessment modalities including use of electronic fetal monitor, auscultation tools, interpretation of fetal heart-rate patterns and initiation of appropriate nursing interventions for non-reassuring patterns (for nurses caring for pregnant women).
- (d) Nursing management of emergency situations that specifies communication and decision-making responsibilities and chain of command.
- (e) Adult and newborn resuscitation.
- (f) Immediate care and assessment of the newborn.
- (g) Family-centered care that is culturally and linguistically appropriate.
- (h) Support of the normal processes of labor and birth.
- (i) Mother and infant security.
- (j) Initiation and support of lactation.

3. How often do nursing staff receive retraining in adult and neonatal cardiopulmonary resuscitation?

\_\_\_\_\_

How often are mock code drills conducted? \_\_\_\_\_

**Lactation Care and Services (130.616 G)**

**Yes**  **No**  1) Does the hospital provide mothers and infants requiring advanced lactation support with ongoing consultation during the hospital stay from an International Board Certified Lactation Consultant (IBCLC) or an individual with equivalent training and experience?

If more than one individual is providing consultation, please list each separately (or attach)

Name of Individual: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Hours per week employed/contracted for lactation consultation and support: \_\_\_\_\_

Others (Name/Qualifications/Hours per week): \_\_\_\_\_

\_\_\_\_\_

Please check the following, **if yes**:

- 2) Are breastfeeding policies and procedures evidence based and in writing?
- 3) Does the educational program of lactation support include the following:
  - The nutritional and physiological aspects of human lactation.
  - Positioning of mother and infant to promote effective sucking, milk release and production.
  - Practices to avoid, recognize and treat common breastfeeding complications.
  - Nutritional needs of the mother during lactation and monitoring the nutritional needs of the infant.
  - Safe techniques for milk expression and storage of milk.
  - Information about community support services available to the family after discharge.
  - Cultural values related to breastfeeding.

**Nurse Staffing**

**Yes**  **No**  1) Are nurse staffing plans developed and in effect for both the maternal and newborn services?

**Yes**  **No**  2) Are all staff positions in the plan budgeted? If no please explain on attached sheet.

3) What is the basis of the nursing staffing plan? (For example, is it based on a minimum registered nurse to patient ratio, a hospital developed acuity-based patient classification system, a nationally recognized patient classification system, a combination, etc.) \_\_\_\_\_

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**STAFFING: MATERNAL SERVICE**

**Key Staff Contacts: Maternal Service**

(Please list name, title and qualifications, including Board certification status of physicians)

**Medical**

Medical Director Obstetrics Service

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Nursing**

Nursing Director Maternal Service

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Nursing Manager Maternal Service

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Anesthesia**

Director of Obstetrical Anesthesia Service

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Respiratory Care Services**

Director/Manager of Maternal Respiratory Care Services

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Maternal Social Work Services**

Director/Manager of Maternal Social Work Services

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Maternal Nutrition Services**

Director/Manager of Maternal Nutrition Services

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Quality Assurance**

Director/Coordinator of Maternal QA Program:

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**ON-SITE AND ON-CALL MATERNAL SERVICE STAFF COVERAGE**

**On-site:** Check one or more that applies to your hospital’s Maternal Service coverage. Who is available **on-site** and responsible for coverage for the Maternal Service 24 hours a day, 7 days a week?

- 1. Family Practitioner
- 2. Obstetrician
- 3. Nurse Midwife
- 4. Other \_\_\_\_\_
- 5. None of above are on-site 24/7

**On-call:** Check one or more that applies to your hospital’s Maternal Service coverage. Who is available **on-call** and responsible for coverage for the Maternal Service 24 hours a day, 7 days a week?

- 1. Family Practitioner
- 2. Obstetrician
- 3. Nurse Midwife
- 4. Other \_\_\_\_\_

**STAFFING: NEWBORN SERVICE**

**Key Staff Contacts: Newborn Service**

(Please list name, title and qualifications, including Board certification status of physicians)

**Medical**

Medical Director *Well Newborn Service*

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Medical Director of Nurseries (as applicable):

Level IB: Medical Director, *Continuing Care Nursery*

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Level II: Medical Director, *Special Care Nursery*

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Level III: Medical Director, *Neonatal Intensive Care Unit*

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Nursing**

Nursing Director/Manager, *Well Newborn Service*

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Level IB: Nursing Director/Manager, *Continuing Care Nursery*

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Level II: Nursing Director/Manager, *Special Care Nursery*

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Level III: Nursing Director/Manager, *Neonatal Intensive Care Unit*

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

Nurse Educator

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Respiratory Care Services**

Director/Manager of Newborn Respiratory Care Services

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Newborn Social Work Services**

Director/Manager of Newborn Social Work Services

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Newborn Nutrition Services**

Director/Manager of Newborn Nutrition Services

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**Quality Assurance**

Director/Coordinator of Newborn QA Program

Name: \_\_\_\_\_

Qualifications: \_\_\_\_\_

**ON-SITE AND ON-CALL NEWBORN SERVICE STAFF COVERAGE**

**On-site:** Check one or more that applies to your hospital's Newborn Service coverage. Who is available **on-site** and responsible for the Newborn Service 24 hours a day, 7 days a week?

- 1. Family Practitioner
- 2. Pediatrician
- 3. Neonatologist
- 4. Nurse Practitioner
- 5. Other \_\_\_\_\_
- 6. None of above are on-site 24/7

**On-call:** Check one or more that applies to your hospital's Newborn Service coverage. Who is available **on-call** and responsible for the Newborn Service 24 hours a day, 7 days a week?

- 1. Family Practitioner
- 2. Pediatrician
- 3. Neonatologist
- 4. Nurse Practitioner
- 5. Other \_\_\_\_\_

## TRANSFER AGREEMENT(S)

### NEWBORN SERVICES

Hospital	Primary collaborating hospital	Agreement Date	Includes guidelines for patient transfer?	Includes a contingency plan, if resources are not available for transfer?	Includes provisions for monitoring quality of care and outcomes of transferred newborns?	Includes guidelines for retro-transferring newborns back to the transferring hospital when it is medically appropriate?
	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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### MATERNAL SERVICES

Hospital	Primary collaborating hospital	Agreement Date	Includes guidelines for patient transfer?	Includes a contingency plan, if resources are not available for transfer?	Includes provisions for monitoring quality of care and outcomes of transferred maternal patients?	Includes guidelines for retro-transferring maternal patients back to the transferring hospital when it is medically appropriate?
	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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