Indiana Perinatal Hospital Standards

Frequently Asked Questions

2013-2015
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Standard I: Organization

Standard II: Obstetric Unit Capabilities

2.4 The hospital shall have genetic diagnostic and counseling services or policy for consultation referrals for these services in place.

Q1: To meet this requirement, do we need to have a written policy and a written agreement with someone who does provide these services?

This standard is optional for Level 1. It is expected for Levels II and III. If the hospital does not have its own genetic diagnostic and counseling services, there must be written policy to make such referrals and information on where genetic diagnostic and counseling services are available. A written agreement is not required.

Q2: Is this referring to inpatients or patients post delivery after a D&C?

This is referring to pregnant women with risk factors, post delivery and post D&C as needed.

If there is a need for counseling during normal prenatal care, this would be addressed in the physician office.

2.5 The hospital shall have a laboratory capable of performing fetal lung maturity tests.

Q1: Does this mean that the test results must be immediately available or do you just have to have the capability of performing?

This standard is optional for Level 1. It is expected for Levels II and III. Test results do not have to be available immediately.

Q2: Is it OK to send the test out?

Yes

Q3: If we have a written agreement with a lab outside of our hospital that is capable of performing these tests 24 hours a day would that be sufficient?

Yes

2.6 The hospital shall have a full range of invasive maternal monitoring available to the delivery area, including equipment for central venous pressure and arterial pressure monitoring.
Q1: Please clarify whether the lines have to be inserted or maintained?

This standard is optional for Levels I and II. It is expected for Level III. The standard refers to unit capabilities and does not specify who inserts and maintains the lines for invasive monitoring.

2.10: Hospitals offering a trial of labor for patients with a prior cesarean delivery must have immediately available appropriate facilities and personnel with the capacity for anesthesia, cesarean section, and neonatal resuscitation capability during the trial of labor.

Q1: What does the definition of “immediately available” mean particularly in the anesthesia area?
Immediately available means a resource available on site as soon as it is requested.

Standard III: Obstetric Personnel
3.1 At a minimum, each delivery hospital must have the following primary delivery providers available to attend all deliveries when a patient is in active labor:
   a) Obstetric provider (OB-GYN, Surgeon or Family Practice physician with additional training in obstetrics) with appropriate training and privileges to perform emergency cesarean delivery should be available to attend all deliveries.
   b) A provider board-certified or board eligible in obstetrics/gynecology or maternal-fetal medicine available at all times.
   c) A provider board-certified or board eligible in obstetrics/gynecology or maternal-fetal medicine onsite at all times

Q1: The OB clinic is next door to the Family Birthing Center and is literally less than one minute door to door. If, during normal clinic hours, the physician designated as the laborist saw patients in the clinic with the understanding the first priority was the Family Birthing Center, would that meet the standard for immediately available?
Immediately available means a resource available on site as soon as it is requested. Since the clinic and Birthing Center are co-located, it would appear it would meet the definition of immediately available. The laborist must meet the standards identified in 3.1(a), 3.1(b), and 3.1(c) for the level of care the hospital is providing.
3.2 A provider (or providers) board-certified or board eligible in maternal-fetal medicine shall be:

   a) Available for consultation on-site, by phone or by telemedicine as needed.
   b) Available at all times either onsite, by phone or by telemedicine with inpatient privileges
   c) Available at all times for onsite consultation and management

Q1: Would a written agreement with another facility that can provide this service be sufficient?
Standard 3.2a is expected for Levels I and II. An internal written guideline on when to obtain consultation and a written Memorandum of Understanding with a physician board-certified in maternal-fetal medicine or a hospital with a maternal-fetal medicine specialist on staff would be sufficient

Q2a: Does 3.2a mean that the MFM has to be in house or that the practicing OB has the ability to call the MFM 24 hours a day?
For Levels I and II, the practicing OB must have the ability to obtain consultation at all times.

For Level III standard 3.2b is expected as written. Standard 3.2b does not apply to Level IV as a Level IV hospital must adhere to Standard 3.2c. Standard 3.2c is required for Level IV and for Level III if the hospital is designated as a Perinatal Center.

Q2b: Or, if the patient is admitted at our facility, and the OB doctor has consulted by phone with the MFM, can an appointment be made for the patient to see the MFM as an outpatient?
The answer to this question depends on the condition of the patient and the result of the consultation between the OB physician and the MFM specialist.

Q3: Is it necessary for the hospital to have a maternal-fetal medicine physician on the medical staff in active practice and, if needed, in house within 30 minutes or could the consultation be by telephone?
It is expected for Level III and IV OB Units

Q4: While ACOG removed “in house within 30 minutes” the expectation for a level III and IV facility is that an MFM would need inpatient privileges for purposes of managing those patients, if their condition warranted it. If the expectation is that they do not need to manage the patient on-site, would arranging coverage with an MFM from another city meet the standard if the MFM had “inpatient privileges” but was a minimum of 2 hours away.
Note that standard 3.2b is optional for Level II. For Level III Hospitals wishing to be designated as a Perinatal Center and Level IV hospitals, it is expected that the MFM be available onsite at all times for immediate consultation and management as indicated in Standard III.2(c). If there is no MFM present these hospitals would need to refer the high risk pregnant woman to another appropriate level hospital or hire a locum tenens MFM to cover the MFM duties. Level III Perinatal Centers and Level IV hospitals must have obstetrical programs that provide subspecialty care for pregnant women and infants. Maternal care must include management of complex maternal complications and prematurity. As written, this standard intends to assure timely assessment and intervention for pregnant women with rapidly deteriorating clinical status related to underlying medical conditions that are not routinely encountered by board-certified OB/GYNs, such as cardiovascular collapse, respiratory failure and neurologic compromise.

For a Level III that is not a designated Perinatal Center, access at all times to an MFM with inpatient privileges onsite, by phone or by telemedicine is acceptable as indicated in Standard III.2(b)

3.7 REVISED
Anesthesia service should meet the needs of the patients served, within the scope of the service offered, in accordance with acceptable standards of practice, and under the direction of a qualified physician.

a) Anesthesia services should be available to provide labor analgesia and surgical anesthesia.

b) Anesthesia services should be available at all times to provide labor analgesia and surgical anesthesia.

c) Anesthesia services should be available at all times onsite to provide labor analgesia and surgical anesthesia.

d) A provider board-certified in anesthesiology with special training or experience in OB anesthesia should be available for consultation

e) A provider board-certified in anesthesiology with special training or experience in OB anesthesia shall be in charge of OB anesthesia services

Standard 3.7a is expected for Levels I. Standard 3.7b and 3.7d is expected for Level II. Standard 3.7c and 3.7e is expected for Levels III and IV.

Q1: What defines “readily available to the delivery area when a patient is in active labor? Readily available is defined in the standards as “A resource for consults and assistance available within a short time after it is requested.” In this situation, there must be a qualified
anesthesia provider who can come to the delivery room within a short time after he/she is requested.

Related:
Standard 2.1(c) The hospital shall demonstrate its capability of providing uncomplicated and complicated obstetrical care through written standards, protocols, guidelines and training including the following:
   c) Initiating an emergent cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care

This would mean that a level I hospital should also have a qualified anesthesia provider available for an emergent cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care.

Q. 2 The hospital only has a CRNA in the hospital at night. Is that sufficient for the hospital to be a level three. I gave the doc a copy of the standards and the ACOG bulletin. The hospital can use the CRNA but will need to have anesthesia services on site at all times as a back-up.

3.11 The hospital shall have appropriately qualified medical staff to perform basic interventional radiology, maternal echocardiography, computed tomography, magnetic resonance imaging and nuclear medicine imaging with interpretation, detailed obstetric ultrasonography and fetal assessment including Doppler studies available at all times.

Q1: Which types of procedures are being referred to? The specific procedures will not be identified in the standards. Examples include uterine artery embolization to control post-partum hemorrhage and abscess drainage. The physician will decide what is required according to the status of the patient.

Standard IV: Obstetric Support Personnel

4.1 The hospital shall have appropriately qualified pharmacy personnel in adequate numbers to meet the needs of each patient in accordance with the care setting including: IAC 15-1.5-7(3)
   (a) Registered pharmacist available for telephone consultation 24 hours per day and 7 days per week.
(b) Registered pharmacist available 24 hours per day and 7 days per week.
(c) Registered pharmacist with experience in perinatal/neonatal pharmacology available 24 hours per day and 7 days per week.

Q1: We have a pharmacist on-call during the hours that they are not in the hospital- is this okay?

For Level I hospital, the registered pharmacist must, at a minimum, be available for telephone consultation 24 hours per day and 7 days per week.

For a Level II hospital, a registered pharmacist must be available 24 hours per day and 7 days per week. This means the pharmacist must be on site as soon as requested in order to dispense any needed medication in an emergency without delay.

For a Level III hospital, a registered pharmacist must be available 24 hours per day and 7 days per week. And the standards specify that a registered pharmacist with experience in perinatal/neonatal pharmacology be available 24 hours per day and 7 days per week. The pharmacist must be on site in order to dispense any needed medication immediately in an emergency.

4.3 The hospital shall provide lactation support per AWHONN and ILCA recommendation:
   a) Level I: 1.3 FTE per 1000 deliveries per year
   b) Level II: 1.6 FTE per 1000 deliveries per year
   c) Level III and IV: 1.9 FTEs per 1000 deliveries

Q1: Is it really necessary for the hospital to provide lactation support per AWHONN and ILCA recommendations?
   Yes, the standard will stay as written because it reflects the most current AWHONN recommendations. The hospital may seek collaborative agreements with the local WIC program or other local resources.

Q2: This standard indicates I need 1.04 FTEs for lactation. I currently have a .5 FTE for lactation but also have availability for other staff members to help with lactation. The staff receives yearly education on lactation and help mothers when our lactation consult is not present. Do we have to employ 1.04 FTE’s plus have extra staff available or can we employ .5 FTE and include the staff we have available? Or can we send some of the RN’s already on staff to additional classes to help fill this need?
The hospital would be expected to show how it has met the FTE criteria. The hospital can use various sources such as WIC for lactation consultants.

Q3: How was the number of lactation consultants calculated?

The standard reflects the most current AWONN recommendations.

Q4: Is it a new state standard that we have an IBCLC staff member employed in our department?

Standard 4.3 addresses the recommended FTEs for lactation support. We realize it will take a number of years for all hospitals to reach this standard. Indiana AWHONN and WIC will assist Indiana in reaching this goal.

Q5: Our staff has been provided breastfeeding education and does that meet criteria or do we have to have a Lactation consultant as per Joint Commission guidelines?

If a hospital believes their current breastfeeding education is equivalent to the standards they will need to justify that in a request for consideration.

Standard V: Obstetric Equipment

5.2 The hospital will have the following equipment available and the capability to use as indicated.

n) Fiberoptic scopes for awake intubation

Q1: We do currently have a GlideScope® in our ER department that is accessible. Does this meet the criteria for what you are looking for?

Any fiberoptic scope used for awake intubation will meet this standard. Video-assisted laryngoscopy systems, such as GlideScope, can be used to facilitate traditional or fiberoptic intubation. By itself, without fiberoptic equipment, access to GlideScope alone would not satisfy this standard.

Standard VI: Obstetric Medications

6.2 The following medications shall be in the delivery area or immediately available to the delivery area:

a) Oxytocin (Pitocin)

b) Methylergonovine (Methergine)
c) 15-methyl prostaglandin F2-alpha (Carboprost, Hemabate, Prostin F2 Alpha)
d) Misoprostol
e) Prostaglandin E2 (Dinoprostone, Cervidil, Prostin E2)
f) Narcotics
g) Antibiotics
h) Magnesium sulfate
i) Naloxone
j) Lorazepam

Q1: What is 15-methyl prostaglandin F2?

15 methyl F2 alpha prostaglandin, also sold as Carboprost, Hemabate, and Prostin F2 Alpha, is used for the control of postpartum hemorrhage. This is critical for birthing units in case of emergency.

Q2: We carry Hemabate but don’t carry the 15-methyl prostaglandin F2 Prostin in our pharmacy

Hemabate is a form of 15-methyl prostaglandin F2-alpha and meets this standard.

Q3: Is Carboprost an appropriate substitute for Prostin?

Carboprost, Hemabate, and Prostin F2 Alpha are forms of 15-methyl prostaglandin F2-alpha used to control postpartum hemorrhage.

Dinoprostone, Cervidil and Prostin E2 are all forms of prostaglandin E2 which is used for cervical ripening and labor induction.

NEONATAL SECTION

Standard I: Organization

Definitions

Level II
Hospitals have neonatal programs that provide specialty care to infants, as described by these standards. These hospitals must have the ability to provide care for stable
or moderately ill infants ≥1,500 grams AND ≥32 0/7 weeks gestation with problems that are expected to resolve rapidly and not anticipated to need subspecialty-level services on an urgent basis. These hospitals must have the ability to provide assisted conventional ventilation or continuous positive airway pressure or both for brief durations, generally less than 24 hours. Level II nurseries must have the ability to stabilize infants born before 32 weeks gestation and weighing less than 1500 grams until transfer to a neonatal intensive care facility. Level II nurseries must have equipment and personnel continuously available to provide ongoing care as well as to address emergencies. These hospitals do not receive primary infant transports. The hospital shall have a written plan for accepting or transferring mothers or neonates as “back transports” for ongoing convalescent care, including criteria for accepting the patient and patient information on the required case. These neonatal units are supervised by a board-certified pediatrician, and have prearranged consultative agreements with a level III or IV center.

Q1: As a Level 2 Nursery, can I accept a transfer in from a Level 1 facility?

As stated above, Level II nurseries do not usually receive primary transports of ill newborns. However, after consultation with their affiliated Level III or Level IV center, they may receive transports from Level I of infants born at 32 weeks of gestation or later and weighing 1500 grams or more with problems that are expected to resolve rapidly and are not anticipated to need subspecialty service on an urgent basis.

Level III

Hospitals provide subspecialty care for infants as described by these standards. These hospitals provide acute and comprehensive NICU care for infants who are born at ≤32 weeks gestation and ≤ 1500 grams at birth, or have medical or surgical conditions regardless of gestational age or weight. Designation of Level III care should be based on clinical experience as demonstrated by large patient volume, increasing complexity of care, and availability of pediatric medical subspecialists and pediatric surgical specialists1. Pediatric surgical specialists (including

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1 According to the AAP policy statement “Although little debate exists on the need for advanced neonatal services for the most immature and surgically complex neonates, ongoing controversies exist regarding which facilities are qualified to provide these services and what is the most appropriate measure for such qualification. These issues are, in general, based on the need for comparison of facility experience (measured by patient volume or census), location (inborn/outborn deliveries, regional perinatal center, or children’s hospital) or case-mix (including stillbirths, delivery room deaths, and complex congenital anomalies).” There is an expectation that the next review of the AAP Levels of Neonatal Care policy statement will indicate appropriate patient volume for each level of neonatal care. The AAP Policy Statement on Levels of Neonatal Care, August 27, 2012. [www.pediatrics.org/cgi/doi/10.1542/peds.2012-1999](www.pediatrics.org/cgi/doi/10.1542/peds.2012-1999)
anesthesiologists with pediatric experience) should perform all procedures in newborn infants. Pediatric ophthalmology services and an organized program for the monitoring, treatment, and follow-up of retinopathy of prematurity should be readily available in Level III nurseries. The neonatal units are supervised by Board-certified neonatologists and offer continuous availability of neonatologists. Neonatal units provide a full range of respiratory support that may include conventional ventilation, and/or inhaled nitric oxide, and/or high-frequency ventilation if suitable equipment and properly trained personnel are available. Pediatric medical subspecialty services may be provided onsite or consultation may be provided at a closely related institution which allows for emergency transport within a reasonable time between institutions. Pediatric surgical and anesthesiology subspecialists may be on site or at a closely related institution to perform major surgeries. Neonatal care capability includes advanced imaging, with interpretation on an urgent basis that includes computed tomography, magnetic resonance imaging, and echocardiography. Level III perinatal hospitals accept risk-appropriate maternal and neonatal transports. The hospital shall have a written plan for accepting or transferring mothers or neonates as “back transports” for ongoing convalescent care, which includes criteria for accepting the patient and patient information on the required case.

Q.1: The Indiana Standards say, “Designation of Level III care should be based on clinical experience as demonstrated by large patient volume, increasing complexity of care, and availability of pediatric medical subspecialists and pediatric surgical specialists 5.” Does this mean someone will be monitoring our patient volume?

As the footnote states, “According to the AAP policy statement “Although little debate exists on the need for advanced neonatal services for the most immature and surgically complex neonates, ongoing controversies exist regarding which facilities are qualified to provide these services and what is the most appropriate measure for such qualification. These issues are, in general, based on the need for comparison of facility experience (measured by patient volume or census), location (inborn/outborn deliveries, regional perinatal center, or children’s hospital) or case mix (including stillbirths, delivery room deaths, and complex congenital anomalies).” There is an expectation that the next review of the AAP Levels of Neonatal Care policy statement will indicate appropriate patient volume for each level of neonatal care. The August, 2012 Levels of Neonatal Care Guidelines from the AAP do not include patient volume as a criteria for assigning level, nor do the Indiana Standards, at this time.

Q2: Will we lose our NICU III status if we do not have 24/7 in house coverage of OB, anesthesia/CRNA or a neonatologist? Can we look at quality data to show we are above quality measures with the resources we have now? All of physicians are on- call and
must be in house within 30 minutes. Most live within 10 minutes of the hospital. Do the providers have to be in house or can they be readily available?

Standard 8.1 states that “The hospital shall have appropriately qualified neonatal medical staff.” Standard 8.1 d) states that the hospital shall have prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, anesthesiologists with pediatric experience, and pediatric ophthalmologists at the site or at a closely related institution by prearranged consultative agreement. “This is required for a level III NICU. Readily available is defined as a resource for consults and assistance available within a short time after it is requested.

Standard 8.9 states that a board-certified provider or an active candidate for Board certification in neonatology shall be available to be present in-house within 30 minutes. This is a requirement for Level III and IV NICUs. Within 10 minutes would seem to meet both these requirements.

In certain situations there may be a need to allow variability from the standards such as when geographical coverage is necessary for a certain part of the state. These situations will be discussed during the application and site visit process. Hospitals will be expected to show that they meet relevant quality goals if there is a reason to vary from the Standards.

Q3: If we lose our level III NICU status, will we have to send our moms that might deliver to another hospital with a level III NICU?
Q.4 Can a hospital have a Level 2 OB and Level I NICU? That would mean the hospital could accept mothers > 32 weeks, but would not qualify to keep babies knowing that they would have to transfer all those babies out.

A hospital can have a higher level for their neonatal unit than for the OB unit. However a hospital cannot have a higher OB unit than neonatal unit. As stated in the Obstetrical Definitions on page 4 of the Revised Perinatal Hospital Standards(6-16-15), “These hospitals{Level II Obstetrical) may receive maternal referrals within the guidelines of their level. These hospitals provide delivery room and acute specialized care for infants ≥1,500 grams AND ≥ 32 0/7 weeks gestation. Maternal care is limited to term and preterm gestations that are maternal risk appropriate.’’ For Levels III and IV, the Obstetrical Definitions state on page 5, “In accepting maternal transports the level of neonatal care required for an anticipated delivery and care of the neonate must be in
place." Every effort should be made to send the mother-fetal dyad to the risk appropriate level of care for the pregnant woman and infant prior to delivery.

Standard VII: Neonatal Unit Capabilities

7.2 The hospital shall have equipment for performing interventional radiology services for neonatal patients.

Q.1: Please list the procedures an interventional radiologist would be expected to perform.

This standard is not applicable for Levels I and II, optional for Level III and expected for Level IV. The procedures will not be listed. They depend on the clinical situation and the physician’s assessment of what is required for the patient.

Standard VIII: Neonatal Personnel

8.1 The hospital shall have appropriately qualified neonatal medical staff personnel, available as listed below for each level of care.

(a) The hospital shall have consulting relationships in place with a pediatric cardiologist, a surgeon and an ophthalmologist who has experience and expertise in neonatal retinal examination.

Q1: Does this require a written plan/actual contracts with receiving physicians/facilities? We have 2 Pediatric groups and an independent practicing Pediatrician. One group uses primarily one hospital and the other group uses another hospital. They have good working relationships with those hospitals and have no issues with making referrals. Is this sufficient or do we need a written plan (and do you have an example of one)? Of course they always ask the patient if they have a preference before making arrangements.

This standard is optional for Level I and expected for Level II. It is not applicable to Level III or IV because they are expected to have these subspecialists at the site. It will be expected for Level II that there be a Memorandum of Understanding with these subspecialists that they will provide consultation services as needed for the hospital. This does not have to be a contract. This standard refers to pediatric subspecialists, not general pediatricians.

8.1(e) the hospital shall maintain a full range of pediatric medical subspecialists, pediatric surgical subspecialists and anesthesiologists with pediatric experience at the site.
Q.1: The level of care chart key states O = optional requirement for level of perinatal center. What is it referring to as a perinatal center? The nicu? We do not have this available at our hospital, but we have very easy access to subspecialists in our system.

If a hospital has self-declared as Level II or III nursery, maintaining a full range of pediatric medical sub-specialists and anesthesiologists with pediatric experience is optional. If the hospital was self-declaring at a Level IV, this would be an essential requirement.

8.5 The hospital shall have prearranged consultative agreements with a board certified neonatologist 24 hours a day.

Q.1 We currently have affiliation with another hospital that might be able to provide availability to have a neonatologist available if we need them. We currently do consult over the phone with the neonatologist before transferring our newborns that need further medical care or would they have to physically be available to see a newborn?

Standard 8.5 is expected for Levels I and II. The neonatologist does not have to be physically present; however, there should be a written agreement with the other hospital that a board certified neonatologist will be available for consultation 24 hours a day.

8.8 A Pediatrician who has completed pediatric residency training, a nurse practitioner or physician assistant with adequate NICU training and experience, with privileges for neonatal care appropriate to the level of the nursery, shall be physically present in-house 24 hours a day and assigned to the delivery area and neonatal units and not shared with other units in the hospital.

Clarification: Standard 8.8 is not applicable for Level I and optional for Level II. It is expected for Levels III and IV.

Q.1 Can this NP be a Family NP? Someone that has NICU experience and is granted privileges by the hospital. A NICU RN that returned to school for Family Nurse Practitioner?

According to GPC7, “Neonatal nurse practitioners manage a caseload of neonatal patients in collaboration with a physician, usually a pediatrician or neonatologist. Nurse practitioners caring for neonates in the NICU must demonstrate completion of a formal neonatal educational program and national certification as a neonatal nurse practitioner. Any advanced practice registered nurse caring for neonates must demonstrate completion of a formal neonatal educational program that includes a minimum of 200 neonatal-specific didactic hours and at least 600 supervised clinical hours in the care of the at-risk and
critically ill newborn in Level II, Level III, or level IV NICUs. Nurse practitioners who are not educated as neonatal nurse practitioners and are working as nursing practitioners in the NICU are functioning beyond their scope of practice. The NP must be granted appropriate privileges by the hospital medical staff.

8.9 A board-certified provider or an active candidate for board-certification in neonatology shall be available to be present in-house within 30 minutes.

Clarification: Standard 8.9 is not applicable for Level I and optional for Level II. It is expected for Levels III and IV.

8.12 The hospital shall have appropriately qualified neonatal personnel in adequate numbers to meet the needs of each patient in accordance with the care setting:

a) A readily available, in-house registered nurse with demonstrated training and experience in the assessment, evaluation and care of normal newborns at all times;

b) A registered nurse skilled in the recognition and nursing management of the neonate with complications on the unit at all times;

c) An Advanced Practice Nurse (A Clinical Nurse Specialist (CNS) or Nurse Practitioner (NP)) with perinatal experience is available to the staff to foster continuous quality improvement, supervise education and participate in administrative functions.

d) All nurses with neonates at high risk should have evidence of continuing education in neonatal nursing and special training and experience in the management of neonates with complex illnesses and neonatal complications.

Q.1 In standard “c” above, What is their specific role/function? Is the NNP to function as a CNS? Is there to be dedicated NNP or CNS that functions as a CNS? We have had an open NICU CNS position for over a year with no qualified candidates applying. Is this shortage why the above calls for a CNS or NNP?

Standard 8.12 c) is Expected for Levels III and IV nurseries, optional for Level II and not applicable for Level I

In general Guidelines for Perinatal Care, 7th Edition (GPC7) states “an advanced practice registered nurse should be available to the staff for consultation and support on nursing care issues (in the NICU)(pp32-33) The GPC7 includes in the category of advanced practice registered nurses: neonatal, perinatal, and women’s health clinical nurse specialist and the neonatal and women’s health nurse practitioner. An advanced practice registered nurse is prepared, according to nationally recognized standards, by the completion of an educational program of study and supervised practice beyond the level of basic nursing. As of January 1,
2000, this preparation must include the attainment of a master’s degree in the nursing specialty. Nurses without a graduate degree who entered the profession before the year 2000, but are credentialed advanced practice registered nurses or certificate-prepared (non-graduate) nurse practitioners, should be allowed to maintain their practice and are encouraged to complete their formal graduate education. Nationally recognized certification examinations exist for each category of advanced practice nursing. Credentialing is now required on a national level and is no longer governed by individual states.

In regard to 8.12 c), GPC 7 states that “the clinical nurse specialist is a registered nurse with a master’s degree who, through study and supervised practice at the graduate level, has become an expert in the theory and practice of neonatal, perinatal, and women’s health nursing. Responsibilities of the clinical nurse specialist include fostering continuous quality improvement in nursing care and developing and educating staff. The clinical nurse specialist models expert nursing practice, participates in administrative functions within the hospital setting, serves as a consultant external to the unit, and applies and promotes evidence-based nursing practice.”

Considering the role of the neonatal nurse practitioner (NNP) defined by GPC7 below, the NNP could function in the role of the CNS described in 8.12 c). However, the NNP could not manage a full caseload of patients and cover the responsibilities defined in 8.12 c

**Q.2** Can the NNPs who manage a full caseloads of patients cross cover for standard “c” above or do they need to be “dedicated” to a specific role?

Standard 8.12 d) is not applicable for Level I and Level II and expected for Levels III and IV. The GPC7 states that “a neonatal or women’s health nurse practitioner is a registered nurse who has the clinical expertise in neonatal or women’s health nursing, has a master’s degree or has completed an educational program of study and supervised practice in the specialty; and has acquired supervised clinical experience in the management of patients and their families. Using their acquired knowledge of pathophysiology, pharmacology, and advanced assessment, nurse practitioners exercise independent judgment in the assessment and diagnosis of patients and in the performance of certain procedures. They develop a plan of care, provide treatment, and evaluate outcomes, Similar to the clinical nurse specialist, a nurse practitioner also may be involved in education, administration, consultation, and research.

Considering the role of the neonatal nurse practitioner (NNP) defined by GPC7 above, the NNP could function in the role of the CNS described in 8.12 c). However, the NNP could not manage a full caseload of patients and cover the responsibilities defined in 8.12 c). The NNP would need to be dedicated to role in 8.12 c). One NNP could not be responsible for both roles. If there are enough appropriately qualified neonatal personnel in adequate numbers to meet
the needs of each patient in accordance with the Level III setting, it is optional to have an NNP in the patient care role.

Q. 3 A NNP works 32 hours a week; 24 hours of which is dedicated to managing a caseload of neonatal patients, and 8 hours (weekly) is dedicated to development of staff education, policy revisions, quality improvement initiatives, skill labs.....and it’s written into her job description as such, stating that in addition to managing a caseload of neonatal patients she will have x number of hours dedicated to development of staff education, and quality improvement initiatives ......would that meet this standard?

This question implies that the NNP is managing a caseload of neonatal patients and also fulfilling the duties of coordinating staff education as stated in Standard 8.21. Standard 8.21 is optional for levels I and II. It is expected for Levels III and IV. If the ratio of time available for patient care and staff education meets the needs of adequate patient care and staff education consideration will be given to this arrangement.

8.13 The hospital shall have respiratory therapists who are:
(a) Experienced in the delivery of continuous positive airway pressure and/or mechanical ventilation or both readily available.
(b) Skilled in neonatal ventilator care and management assigned to the NICU and not shared with other units when any patient is receiving assisted positive pressure ventilation, high-frequency ventilation, and/or inhaled nitric oxide 24 hours a day.

Q1: Does 8.13(b) include CPAP, SIPAP and BIPAP? Or does it refer to infants on the ventilator? We are trying to increase our respiratory FTE’s to fit a level 3 NICU so need to make sure we are reading the standard appropriately.

Q2: Will you please clarify the standard below as it relates to non-invasive positive pressure ventilation? Does this also count as meeting this standard 8.13.B and in so doing require RTs to be in NICU ‘and not shared with other units’?

‘Skilled in neonatal ventilator care and management assigned to the NICU and not shared with other units when any patient is receiving assisted positive pressure ventilation, high-frequency ventilation, and/or inhaled nitric oxide 24 hours a day.’

Standard 8.13 is expected for Levels II, III and IV
An RT skilled and experienced in all methods of the delivery of continuous positive airway pressure and/or assisted conventional mechanical ventilation or both, must be readily available. For Level II, this RT could be shared with other units. By definition a Level II nursery will only be providing assisted conventional ventilation or continuous positive airway pressure or both for brief durations, generally less than 24 hours.

Standard 8.13(b) is expected for Level III and IV
An RT skilled in all methods of the delivery of continuous positive airway pressure as well as neonatal ventilator care and management must be assigned to the NICU and not shared with other units when any patient is receiving assisted positive pressure ventilation (including CPAP, BPAP or SIPAP), high-frequency ventilation, and/or inhaled nitric oxide 24 hours a day. For infection control purposes if a baby is on any form of positive pressure ventilation, an RT dedicated to that unit must be assigned to that unit only. If the RT is also the one going on deliveries that would be acceptable because it is considered a function of the unit. The RT must not be someone who is rotating through different units of the hospital.

8.15 The hospital shall provide lactation support per AWHONN and ILCA recommendation:
   a) Level I 1.3 FTE per 1000 deliveries per year
   b) Level II 1.6 FTE per 1000 deliveries per year
   c) Level III and IV 1.9 FTEs per 1000 deliveries

Q.1 Is the above LC FTEs (in the neonatal standards section) in addition to the LC FTEs provided in OB?
No, the lactation consultant standard refers to the number of deliveries or number of maternal-infant dyads.

Q.2 If OB unit does 3,000 deliveries a year, the above would call for 5.7 FTEs for the OB area. Do these 5.7 FTEs also cover the NICU?
Yes

Q.3 If the 5.7 FTEs is for both areas, what is the allocation of FTEs to the NICU?
The allocation for the ICU would depend on the number of admissions to the ICU.

Q.4. Is there a reason why the recommended LCs for the NICU is not based on the NICU average daily census or admissions per year? Is there an opportunity to have this looked at and a recommendation made specific to NICU?
Standard 8.15 is based on the current recommendations of the International Lactation Consultant Association (ILCA) and Association for Women’s Health, Obstetric & Neonatal Nurses (AWHONN). The IPQIC will review standards on a regular basis and will accept specific recommendations for updates.

8.18 The hospital shall have Physical Therapist and/or Occupational Therapist, with additional Continuing Education Units in the area of neonatal care, as a member of the interdisciplinary care team.

Q.1: How many CEUs will be required?
The number of CEUs will not be prescribed.

Q2. The standard says they need “continuing education units in the area of neonatal care.” Our question is: are there a certain number of credits required each year?
This standard is not applicable for Level I, optional for Level II and expected for Levels III and IV. The number of CEUs will not be prescribed. Hospitals will be responsible to ensure staff is qualified.

8.19 The hospital shall have a Speech Therapist, with additional Continuing Education Units in the area of neonatal care, as a member of the interdisciplinary care team.

Q.1: How many CEUs will be required?
This standard is not applicable for Level I, optional for Level II and expected for Levels III and IV. The number of CEUs will not be prescribed, but should include evaluation and management of neonatal feeding and swallowing disorders. Hospitals will be responsible to ensure staff is qualified.

8.20 The hospital shall have qualified nursing leadership in accordance with the care setting:
   a) Nursing care should be under the leadership of a registered nurse (Expected for Level I, Not applicable for Levels II, III, and IV)
   b) Nursing care should be under the leadership of a registered nurse with demonstrated expertise in obstetric care, neonatal care or both (Optional for Level I, Expected for Level II, Not applicable for Levels III and IV)
   c) Nursing care should be under the leadership of a registered nurse, masters prepared or actively seeking a masters degree with experience and training in neonatal nursing, as well as in the care patients at high risk.
Q.1: If the director currently does not have an advanced degree, what time frame would he/she be given to be enrolled in a program and how long until completion would be required?

*Standard 8.20 refers to an administrative/management position. This is the type of situation that will require a request for consideration or corrective action plan.*

Q2: The CNO is the director and is about to obtain a BSN degree in a couple of months. The OB manager (myself) has an ASN degree with 17 years of experience in obstetrics and neonatal care. Neither the CNO nor I have a MSN degree. However, do we meet the credentials for a critical access hospital that you are looking for? What actions need to happen since obviously obtaining a MSN is not a quick thing to fix?

*This is the type of situation that will require a request for consideration or corrective action plan. The Indiana Hospital Perinatal Standards are the same for Critical Access Hospitals as they are for other delivering hospitals.*

8.21 A registered nurse who has been educated and masters prepared or actively seeking a masters degree, should be on staff to coordinate education.

Q.1: This standard appears to be inconsistent with Standard 8.20

*Standard 8.20 refers to an administrative/management position. It is optional for Levels I and II. It is expected for Levels III and IV. Standard 8.20 refers to an administrative/management position. It is optional for Level I and expected for Levels II, III, and IV.*

Q2: Please define what is meant by “a hospital perinatal program” which requires a registered nurse with advanced neonatal experience and a master’s degree identified for staff education as stated in section 8.21. What does the perinatal program refer to and, if more than 1 person is responsible for staff education, does having at least one of these members masters prepared meet the criteria??

*In general, the term “hospital perinatal program” refers to the administration and operation of hospital units which provide obstetrical and neonatal care. The Indiana Hospital Perinatal Standards were written with an Obstetrical and a Neonatal Section. In some standards, the term “hospital perinatal program” applies to either the Obstetrical or the Neonatal section*
such as in Standard 8.21, where “hospital perinatal program” refers to the hospital’s neonatal care unit. The standard indicates that at least one registered nurse with advanced neonatal experience and a master’s degree must be identified for staff education.

Q.3 Currently, we have one 0.8 Network educator FTE (32 hours week) for 3 hospitals (2 SCN, 1 NICU). Would this meet this standard? OR To meet this standard does the educator need to be on site/dedicated to the NICU staff for education? If so, is there a specified FTE required? Example specific number of educator hours/FTE per # of beds/nursing FTEs?

Standard 8.21 refers to an educational/training position. An FTE nurse educator is optional for Levels I and II. It is expected for Levels III and IV. The expectation is that one FTE will be dedicated to a Level III or Level IV nursery. If SCN means Special Care Nursery or a Level II nursery, the Full Time educational/training position is not necessary at Level II. There is no specified number of educator hours/FTE per # of beds or per nursing FTEs at this time. It would be appropriate for an FTE nurse educator assigned to a Level III to be available for education of Level II or Level I units assuming the educational/training needs of the Level III nursing staff are met.

Standard IX: Neonatal Support Personnel

9.1 Portable ultrasonography for newborns, with the services of appropriate support staff, shall be available to the neonatal units.

Q1: We do not currently do ultrasounds on infants except for abdominal ultrasounds. We have an affiliation with a larger hospital in Louisville that have pediatric radiologists that could read our ultrasounds if we are able to consult them when needed and would need to have an agreement with the hospital. Would that work to meet the expectation and availability?

Standard 9.1 is optional for Level I and expected for Levels II-IV. It is necessary to have the portable ultrasonography machine on site. It would be acceptable to have an agreement with a pediatric radiologist who could read the ultrasound immediately if it were sent electronically or using telemedicine technology.

9.5 The hospital shall have a pediatric cardiac catheterization laboratory and appropriate staff.

Q1: Is it truly expected that a hospital must have a pediatric cardiac cath lab to be considered Level III?
No, this standard is optional for Level III and expected for Level IV.

Standard X: Neonatal Equipment

10.2 The hospital shall have all of the following equipment and supplies immediately available for existing patients and for the next potential patient:
   a) O2 analyzer
   b) stethoscope
   c) intravenous infusion pumps with appropriate drug libraries
   d) radiant heated bed in delivery room and available in the neonatal units
   e) oxygen hood with humidity
   f) pediatric bag and masks capable of delivering a controlled concentration of oxygen to the infant
   g) orotracheal tubes
   h) aspiration equipment
   i) laryngoscope
   j) umbilical vessel catheters and insertion tray
   k) cardiac monitor
   l) pulse oximeter
   m) phototherapy unit
   n) Doppler blood pressure for neonates
   o) cardioversion/defibrillation capability for neonates
   p) resuscitation equipment for neonates
   q) individual oxygen, air O2 blended and humidified capability, and suction outlets for mothers and neonates
   r) emergency call system
   s) bowel bags

Q1a: What exactly do they want for Doppler blood pressures for neonates? We have the ability to take blood pressures on newborns but were not sure if this (standard) wanted more invasive monitoring to be available.

Q1b: We currently take blood pressures after delivery on all patients with a blood pressure machine. Does this meet the Doppler blood pressures you are looking for?

A Doppler blood pressure unit for neonates is a noninvasive device which automatically measures systolic BP, diastolic BP, mean arterial pressure, and heart rate; it displays the values on a lighted digital display and prints them on a recorder. The Doppler blood pressure measurement is more accurate, especially in small neonates. Doppler ultrasound is not the
same thing. The Doppler blood pressure unit is expected equipment for all levels of neonatal care.

To clarify, the Blood Pressure device(s) used for newborns is actually an oscillometric device(s). When the BP is low, Doppler technology can be used to detect a pulse and sometimes the systolic BP.

Q1c: As a level 2 nursery do I need to have a Doppler for blood pressure readings?

Q1d: Exactly what is needed to qualify for the Doppler Blood Flow Device for neonates?

The commonly used BP device(s) for newborns is an oscillometric device(s); these measure mean BP and extrapolate systolic and diastolic. When BP is low, doppler technology can be used to detect a pulse and sometimes the systolic BP.

Levels I, II, III and IV nurseries are expected to have an oscillometric device(s) to measure blood pressure in a neonate.

Levels III and IV nurseries are expected to have the ability to measure blood pressure continuously and directly through the use of electrical transducers and catheters.


Q2a: To what extent do we need cardioversion/defibrillation capabilities for neonates? I want to clarify what equipment is expected to be available at the Level 1 facilities to perform these procedures if the need arises.

Q2b: Also the Cardioversion/defibrillation capable on neonates’ requirement. We do not cardiovert or defibrillate any newborns. We only following the NRP guidelines in regards to resuscitation.

Levels I and II are expected to have equipment to implement the Neonatal Resuscitation Program (NRP). This would not include cardioversion or defibrillation equipment for newborns. Levels III and IV are expected in addition to have the necessary equipment to perform cardioversion or defibrillation on neonates.

Q3: What specifically is a bowel bag?

Bowel bags are used to protect the newborn's intestines in a case of Gastrochisis or Omphalocele, birth defects in the abdominal wall that allow the intestines and sometimes
stomach to sit outside of the abdomen. The bowel bag is a sterile bag that prevents
temperature loss, fluid loss and infection until the baby can receive surgery to correct the
defect. The lower half of the infant (including the intestine) is placed into a sterile bowel bag,
feet first, up to the level of the under-arms. This is a rare occurrence but there are a number
of cases in Indiana each year. All birthing units should be prepared for any problems that
could arise at labor and delivery. Each hospital should have at least 2 sterile bowel bags in
case of unforeseen birth problems.

Standard XI: Neonatal Medications

Standard XII: Universal Laboratory

Standard XIII: Universal Education

13.4 The Perinatal team member:
- Acquires knowledge and experiences that reflect current evidenced based
  practice in order to maintain skills and competence appropriate for his or her
  specialty area, role, and practice setting.
- Participates in and maintains professional records of educational activities
  required to provide evidence of competency.
- Maintains licensure and certification as mandated by state licensing boards,
  health care facilities and accrediting agencies.
- Maintains certification within the specialty area of practice as appropriate, as
  a mechanism to demonstrate special knowledge.
- Participates in lifelong learning, including educational activities related to
  evidence based practice, knowledge acquisition, safety and professional
  issues.
- Has knowledge of relevant practice parameters and guidelines of other
  organizations that focus on the delivery of health care services to women and
  newborns.
Q1: This standard states that the perinatal team will maintain certification within the specialty area of practice. It is not reasonable to expect 100% of the staff to be certified but certainly a percentage of the staff is reasonable. *Each hospital will be responsible to ensure staff is qualified.*

**Standard XIV: Performance Improvement**

**Standard XV: Policies and Protocols**

**General Questions:**

**Q1: Does a “prearranged consultative agreement” have to be written?**
A prearranged consultative agreement should be a written Memorandum of Understanding between the hospital and consultant that services will be provided as needed. It does not have to be a contract. With a few exceptions for emergencies, prearranged consultative agreements can be performed by using telemedicine technology and/or telephone consultation.

**Q2: Does a “closely related institution” mean within a certain geographical area?**
The relationship does not have to be geographic. If geographic constraints for land transportation exist, the Level III facility should ensure availability of rotor and fixed-wing transport services to quickly and safely transfer infants requiring subspecialty intervention. “Closely related” refers to a level of close affiliation or collaboration that assures achievement and maintenance of the appropriate level of care. There should be a written Memorandum of Understanding between the hospitals that the pertinent services will be provided as needed.

**Q3: What is the timeline to correct any deficiencies?**
There are at least two situations during the certification process where time to correct deficiencies may be granted. In the first case, if the application is not complete, the hospital will be given a stated time to complete the application. The exact time has not been determined by the ISDH yet. The second situation may occur after a site visit of the hospital does not meet the requirements for the level of care it applied for. A letter will be sent to the hospital asking for a revision or action plan to meet the required standard and the letter will state the timeline for revision.

**Q4. Can we be a Level III OB and a Level II Neonatal unit?**
A hospital can have a higher level for their neonatal unit than for the OB unit. However a hospital cannot have a higher OB unit than neonatal unit. As stated in the Obstetrical Definitions on page 4 of the Revised Perinatal Hospital Standards (6-16-15), “These hospitals (Level II Obstetrical) may receive maternal referrals within the guidelines of their level. These hospitals provide delivery room and acute specialized care for infants ≥1,500 grams AND ≥ 32 0/7 weeks gestation. Maternal care is limited to term and preterm gestations that are maternal risk appropriate.” For Levels III and IV, the Obstetrical Definitions state on page 5, “In accepting maternal transports the level of neonatal care required for an anticipated delivery and care of the neonate must be in place.” Every effort should be made to send the mother-fetal dyad to the risk appropriate level of care for the pregnant woman and infant prior to delivery.

Q5: Are any deficiencies allowed or do we have to meet every standard?
The expectation is that the hospital will meet the standards indicated for the level of care it applies for. In certain situations there may be a need to allow variability from the standards such as when geographical coverage is necessary for a certain part of the state. Hospitals will be expected to show that they meet relevant quality goals if there is a reason to vary from the Standards. These situations will be discussed during the application and site visit process.

Q6: What physicians sit on the committee recommending the changes?
The Task Force that developed the Indiana Perinatal Hospital Standards was made up of neonatologists, maternal-fetal medicine specialists, obstetricians, pediatricians, family physicians, hospital administrators, certified lactation consultants, women’s health nursing and representatives from the Indiana Hospital Association, Indiana Perinatal Network, Indiana March of Dimes, IU Center for Women’s Health and Indiana Family Health Council and the Indiana State Department of Health.

The Standards were accepted by the Governing Council of the Indiana Perinatal Quality Improvement Collaborative in February, 2013. Members of the Governing Council represent the Indiana Chapter American Academy of Pediatrics, Indiana Chapter American College of Obstetrics & Gynecology, Indiana Chapter Association of Women’s Health Obstetric & Neonatal Nurses, Indiana Academy of Family Physicians, Indiana Hospital Association, Indiana March of Dimes, Indiana Minority Health Coalition, Indiana Perinatal Network, Indiana Primary Health Care Association, Indiana Rural Health Association, Indiana State Medical Association, Indiana University School of Medicine, Department of Public Health, Indiana State Department of Health Maternal Child Health, Indiana State Department of Health Office of Primary Care, Indiana Department of Insurance, Indiana Office of Medicaid Policy & Planning, and a Consumer Member.
Q9: Please define what is meant by "a hospital perinatal program"
In general, the term "hospital perinatal program" refers to the administration and operation of the hospital units which provide obstetrical and neonatal care. The Indiana Hospital Perinatal Standards were written with an Obstetrical and a Neonatal Section. In some standards, the term "hospital perinatal program" applies to either the Obstetrical or the Neonatal section such as in Standard 8.21, where "hospital perinatal program" refers to the hospital's neonatal care unit.

Q10: If a level II nursery has a baby on a vent. for 18 hours, extubates and then a day later tires out and has to go back on a vent. or CPAP would the baby need to be transferred to a level III nursery at that time or does the "24 hour" positive pressure guideline for level II nurseries start over?
If the baby is failing extubation then it needs to be transferred. For a practice that wanted to trial extubation daily in these babies you could theoretically drag a new 24 hours out indefinitely. Moreover the infant likely would still exceed the CPAP and or oxygen limits to be improving by 24 hours.

Q11: Does your medical staff (section leaders) have the authority/accountability to set or define best practice?
Best practices are based on standards from national organizations not established by each hospital’s medical staff. Hospital staff can and should convey what are best practices that have been established by the relevant professional organizations.

Q12: Are all standards weighted the same? Must all be met to pass?
Yes, all standards that apply to the level of care that a hospital is applying for must be met to pass. There are certain standards that pertain more to safety than others. Ex. FTEs for lactation consultants vs. 24/7 coverage. The plan is to look at processes. There will be no waivers, but alternatives to achieve outcomes will be considered. There will be an appeals process.

Q13: We have a 2 hospital system – one plans to be a Level 3 and one plans to be a Level 2 – how will we be surveyed?
Each hospital will be surveyed separately. Two hospitals = two surveys. We would expect them to share binder information that is applicable to both places.
Q14: Will Level 3s be limited by geography and if so, how will that be determined?  
Each hospital will apply for whatever level of care they wish to pursue. The ISDH will place no restrictions on a hospital’s level of care application.

Q15: For Level 1 hospitals, will patients that don’t meet definition of “low risk” be transferred out to higher level hospital (including smokers, high blood pressure, etc)?  
The goal is for women and babies to receive service in a risk appropriate hospital. This is where Perinatal Center support will come in as well. If Level 1 can manage circumstances through consultation, that will work.

Q16: How are you addressing the standard of affiliation with a perinatal center for hospitals on state borders that don’t transfer to Indy?  
There is no expectation that all transfers will go to Indianapolis. (ex. Border hospitals that transfer to Louisville, Cincinnati, Chicago). Indiana has no control over hospitals in other states. The ISDH nurse surveyors will look at agreements Indiana hospitals make with out of state hospitals to ensure their appropriateness for the safety and quality of care for the newborn.

Q17: If we apply as Level 1, but we meet the criteria for a Level 2, will the survey reflect that?  
All hospitals receive a detailed report that reflects which standards are met and what level they qualify for. E

Q17: Will hospitals be assigned to a perinatal center?  
All hospitals will need to be aligned with a perinatal center but it won’t be assigned. Hospitals will decide which perinatal center with which to align. They may have agreements with more than one. We know Indiana’s structure will be more systemic or network-based than geographical.

Q18: Does anyone have sample contracts or MOUs between the various levels?  
The responsibilities that will need to be addressed in the contract/agreement were identified in the Perinatal Center Document. The Systems Implementation committee purposely did not develop a template contract or MOU since all hospital systems will need to negotiate the details and personalize for their system. We know some have designed their own already. The nurse surveyors report that hospitals have been willing to share what they have developed.

Q19: Have you seen common gaps in the volunteer surveys so far that can be shared?  
The following are common gaps in Obstetrics Standards:
• **Standard II: Obstetrical Unit Capabilities**
  - Written plan for accepting level-based maternal transports
  - Genetic diagnostic & counseling services or policy for consultation/referrals

• **Standard III: Obstetric Personnel**
  - Board-certified or board eligible OB/GYN or MFM onsite at all times (Level III OB’s)
  - Nursing Leadership: Perinatal Directors & Educators being masters prepared or actively seeking masters. (Level III facilities)
  - Advanced practice nurses (CNS or NP) for Level III facilities

• **Standard IV: Obstetrical Support Personnel:**
  - Lactation support per AWHONN and ILCA recommendations

• **Standard XV: Policies & Protocols:**
  - Written plan for accepting or transferring neonates as “back transports.”

The following are common gaps in Neonatal Standards:

• **Standard VIII: Neonatal Personnel**
  - Consulting relationships in place with pediatric cardiologist, a surgeon and an ophthalmologist. (Level II nurseries)
  - 24/7 “in-house” neonatal coverage (Level III nurseries)
  - Prearranged consultative agreements with neonatologists 24/7 (Level I & II nurseries)
  - RT not shared with other units when any patient is receiving assisted PPV, HFOV, and/or NO 24 hrs a day
  - Nursing Leadership: Perinatal Directors & Educators being masters prepared or actively seeking masters
  - Advanced practice nurses (CNS or NP) for Level III facilities

• **Standard XV: Policies and Protocols**
  - Written plan for accepting or transferring neonates as back transports.

**Q20:** Some facilities use “manager” and others use “director” to describe responsibility. Will this be considered when gauging standard attainment?

*The term itself is not the issue. Surveyors will look for oversight responsibility and will understand organizational chart for clarification related to the standards.*

**Q21:** Do critical access hospitals need to go through the levels of care certification process?

*All hospitals offering obstetric services will need to go through the certification process.*