NHS
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NHS Trust

Obstetric Care Policy (Excluding NHS 111)

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V 2.2		Steven Dykes	D	Amended to include Operational, Training, and Clinical issues
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Document Author = Deputy Medical Director
Associated Documentation: ▪ Policy and Procedure for Safeguarding Children and Young People ▪ Policy for the management of Domestic Abuse ▪ Policy for Identifying and Acting Upon National Clinical Guidance ▪ JRCALC UK Ambulance Clinical practice Guidelines ▪ NICE Obstetric Guidelines: ▪ Resuscitation Policy ▪ Policy for the Conveyance and Non-Conveyance of Patients ▪ Paediatric Care Policy

Staff Summary

All females of childbearing age may be pregnant, and unless there is a history of hysterectomy, even the slightest doubt must make the clinician consider if any abdominal pain or vaginal bleeding may be pregnancy related. Pregnancy is timed from the first day of the last period, and from that date lasts up to 42 weeks

When dealing with a pregnant woman, the maternal well-being is essential to the survival of the foetus and therefore the resuscitation of the mother must always be the priority.

For both uncomplicated and complicated cases, time must not be spent on scene awaiting a midwife to attend. There should be no delay in transporting these patients to the nearest Obstetric Unit. Unless birth is imminent (head, buttocks or feet present) then the patient should be transported immediately. If the birth is imminent but does not progress, then the patient should be transported immediately.

In maternity cases where delivery is not imminent and there are no complications, the mother may be transported to the unit in which she is booked. If the patient is booked into a unit that is not within a reasonable distance or travelling time, clinicians should base their judgements on the maternal assessment, and take the mother to the most appropriate unit.

If a midwife is on-scene they are the senior clinician regarding the decisions relating to obstetric care, and may choose to manage the birth on scene. YAS Clinicians should work under the direction of the midwife.

Sick pregnant women should be transported in the left lateral position, left lateral tilt or with the uterus manually displaced. Uncomplicated labouring women should be transported in the most comfortable position, but must avoid lying flat.

Pregnant women in cardiac arrest are an indication for rapid transfer to hospital regardless of cause of arrest or initial rhythm. Transport to hospital should be initiated immediately once safe to do so. They should be transported to the nearest Emergency Department with a pre-alert call.

Maternal resuscitation should not be terminated in the pre-hospital environment.

Working Together to Safeguard Children (DCSF 2010) includes the imperative to protect unborn children. The protection of children from harm is the responsibility of everyone. It is essential that whenever an individual has concerns about whether a child is suffering, or is at risk of suffering significant harm, that they share their concerns using the YAS Policy for Safeguarding Children and Young People or the YAS Policy on management of domestic abuse.

Staff should indicate during their personal development review (PDR), whether they require update training in obstetric emergencies. This can be facilitated via the clinical leadership programme or if new skills are needed via YAS Academy.

1.0 Introduction

1.1 This policy details the processes by which Yorkshire Ambulance Service NHS Trust (YAS) will effectively implement and manage the provision of obstetric care across the Trust.

1.2 This policy applies to the management of all women who are pregnant. Pregnancy is timed from the first day of the last period, and from that date lasts up to 42 weeks

1.3 This policy does not apply to staff working in NHS 111

1.4 The care for all obstetric patients will delivered in accordance with national best practice guidance, from such bodies as JRCALC, NASMeD, National Institute for Clinical Excellence (NICE), Royal College of Obstetrics and Gynaecology, The Royal College of Midwives

1.5 This policy is designed to be read in conjunction with other Trust policies which are relevant to obstetrics, including:

- Safeguarding Policy
- Domestic Abuse Management Guidance
- Policy for Identifying and Acting Upon National Clinical Guidance
- Procedure for the management of JRCALC guidance
- Procedure for the management of NICE guidance
- Resuscitation Policy
- Policy for the Conveyance and Non-Conveyance of Patients
- Paediatric Care Policy

2.0 Purpose

2.1 The purpose of this policy is to ensure the delivery of safe and effective care to obstetric patients.

2.2 To ensure that all staff are trained appropriately in the delivery of care to obstetric patients.

3.0 Process

Delivery of Care

3.1 All females of childbearing age may be pregnant, and unless there is a history of hysterectomy, even the slightest doubt must make the clinician consider if any abdominal pain or vaginal bleeding may be pregnancy related.

3.2 When dealing with a pregnant woman, the maternal well-being is essential to the survival of the foetus and therefore the resuscitation of the mother must always be the priority.

3.3 Recognition of obstetric emergencies involves the identification of a number of key signs affecting the patients airway, breathing, circulatory or neurological systems. If these signs are present, the patient must be regarded as time critical. Following the Maternity pre-hospital screening tool (Appendix B) provides guidance to clinician in the situation management of the mother and baby .

3.4 Staff will follow the assessment, diagnosis and treatment regimes as described in the JRCALC UK Ambulance Clinical Practice Guidelines covering the following areas:

- Maternal Assessment
- Delivery Procedure
- Managing Complications of Labour
- Haemorrhage during Pregnancy
- Pregnancy induced Hypertension (pre-eclampsia)
- Managing pregnancy-related emergencies
- The effects of Pregnancy on Maternal Resuscitation
- Vaginal Bleeding, Gynaecological causes (Including abortion)

Normal Delivery and Delivery Complications

3.5 The YAS Maternity Care Pathway for Yorkshire and Humber (appendix 1) supports YAS clinicians to make decisions in maternity cases. Regardless of whether the case is uncomplicated or complicated, time must not be spent on scene awaiting a midwife to attend. There should be no delay in transporting these patients to either their planned or the nearest obstetric unit, unless birth is imminent (head, buttocks or feet present). If birth is imminent but does not progress, the patient should be transported immediately.

3.6 In maternity cases where delivery is not imminent and there are no complications, the mother may be transported to the unit in which she is booked. In situations where the booked unit is not within a reasonable distance or travelling time, clinicians should base their decisions on the maternal assessment and take the mother to the most appropriate unit.

3.7 If a midwife is on-scene they are the senior clinician regarding the decisions relating to obstetric care, and may choose to manage the birth on scene. YAS clinicians should work under the direction of the midwife.

Transport of Pregnant Women

3.8 Sick pregnant women should be transported in either the left lateral position or with the uterus manually displaced. Women with uncomplicated labour should be transported in the most comfortable position for them, but must avoid lying flat.

Resuscitation

3.9 Pregnant women in cardiac arrest must be rapidly transported to hospital regardless of the cause of the arrest or the initial presenting rhythm. Transport to the nearest Emergency Department must be initiated immediately once safe to do so. The baby will need to be delivered by emergency caesarean section in order to facilitate resuscitation of the mother.

3.10 Pregnant women in cardiac arrest must be transported supine with the uterus manually displaced to the left.

3.11 A mechanical chest compression device (i.e. autopulse) may be used to facilitate effective chest compressions during transport where one is immediately available.

3.12 Maternal resuscitation should not be terminated in the pre-hospital environment.

Safeguarding Children and Vulnerable Adults

3.13 Working Together to Safeguard Children (DCSF 2010) includes the imperative to protect unborn children. The protection of children from harm is the responsibility of everyone. It is essential that whenever an individual has concerns about whether a child is suffering, or is at risk of suffering significant harm, that they share their concerns using the YAS Policy for Safeguarding Children and Young People or the YAS Policy on management of domestic abuse.

3.14 Domestic abuse often begins or may escalate during pregnancy and is associated with increased rates of miscarriage, premature birth, foetal injury or foetal death. YAS clinicians should remain vigilant to the signs of domestic abuse and should follow the YAS guidance for managing Domestic Abuse.

3.15 Occasionally pregnancy may be concealed or denied until labour commences. In both situations there may have been no ante-natal care. These patients are incredibly vulnerable and may have associated mental health problems or issues with drug and/or alcohol dependence. Some concealments may also result in the birth occurring in secret. YAS clinicians must remain vigilant and be aware of the consequences of concealment Concerns should be raised using the YAS policy for safeguarding adults.

4.0 Training expectations for staff

4.1 All staff responding to emergency or urgent calls involving obstetric patients will receive the relevant level of obstetric training on their core training course as outlined in the course learner outcomes, awarding body objectives or module indicative content. These are held by YAS Academy and dictate the programme of education for all core courses.

4.2 All staff who will attend obstetric patients as part of their normal range of duties will receive training which meets the standards set in the Training Needs Analysis (TNA) for both core and refresher/updating training requirements,

4.3 Staff will receive refresher/update training which will be monitored through the completion of a clinical competency portfolio and signed off by a Clinical Supervisor and quality assurance checked by the Clinical Development Manager.

4.4 Whenever there is a major change in clinical practice guidelines information will be cascade via clinical updates, a Clinical Supervisor or Clinical Development Manager or may form part of update training. The methods used will be dictated by the nature or complexity of the changes.

4.5 Staff should indicate during their personal development review (PDR), whether they require update training in obstetric emergencies. This can be facilitated via their Clinical Supervisor or Clinical Development Manager or if new skills are needed via YAS Academy.

4.6 A database will be maintained by YAS Academy highlighting which staff have received obstetric training. This database will be populated by the clinical education coordinator and used to report the numbers of staff attending training in obstetrics.

5.0 Implementation Plan

5.1 The latest approved version of this policy will be posted on the YAS intranet for all members of staff to view. New members of staff will be signposted to this guidance as part of their trust induction.

6.0 Monitoring compliance with this policy

Standard	Monitor
Process for monitoring the organisational duties	Organisational and individual duties have been assigned Monitoring and compliance of duties will be via the Clinical Governance Group Deficiencies in the applications of and/or adherence to this policy will be reported to the Clinical Governance Group who will note them in their minutes together with any corrective action(s) that need to be taken to ensure compliance. Progress of these actions will be reviewed at subsequent meetings.
Process for managing obstetric care	All staff trained to national guidelines monitored via the OLM (Oracle Learning Management) staff database Monitored through the Clinical Case Review (CCR) process via the Clinical Governance Group Obstetric care management to be monitored through Patient Care Record (PCR) completion Actions to address any identified deficiencies will be noted in the minutes of the Clinical Governance Group and reviewed at subsequent meetings.
Process for managing the organisations expectations in relation to staff training as identified in the training needs analysis	All staff identified as requiring obstetric training will undergo initial training linked to course learner outcomes agreed with the Clinical Directorate or awarding body All staff undertaking core training with obstetric care as an element will be added to the OLM data base which will be monitored by the Clinical Education Coordinator and reported through the

	Clinical Governance Group Staff requiring update training will be coordinated and added to the OLM database by the Clinical Education Coordinator and reported via the Clinical Governance Group. Ongoing monitoring of compliance will be via the Clinical Leadership Framework system and monitored through the achievement of operational competencies, and recorded on the OLM system Any required update training will be via the YAS Academy
Process for monitoring the minimum standards of obstetric care training which reflect national guidelines	This will be monitored through the Clinical Leadership Framework system and the achievement of observed practice and achievement of operational competencies held on the OLM system
Process for monitoring compliance with all of the above	A workforce compliance report will be presented to the Clinical Governance Group on a monthly basis, monitoring the compliance of set standards. Actions to address any identified deficiencies will be noted in the minutes of the Clinical Governance Group minutes and reviewed at subsequent meetings.

Appendices

Appendix A - Roles & Responsibilities

Trust Board

The Trust Board have overarching accountability for all aspects of the obstetric policy and will be required to gain assurance that all aspects are implemented and adhered to.

Clinical Directorate

The Clinical Directorate will ensure best practice is observed and implemented, and work with the YAS Academy ensuring best practice and current evidence based practice is utilised in the training of obstetric care.

The Clinical Directorate will be responsible for ensuring that the care provided to pregnant women is audited.

YAS Academy

The YAS Academy will oversee and provide all training requirements regarding obstetric care.

They will develop all learner outcomes and implement them for all obstetric care courses or obstetric elements of core courses delivered within YAS.

The YAS Academy will monitor and evaluate all education/training activities and report the findings through the Clinical Governance Group.

They will implement changes in line with best practice following discussions or direction from the Clinical Directorate or Clinical Governance Group.

Operations Directorate

The operations directorate will ensure that mechanisms are in place to monitor all clinical operational staff, ensuring that they deliver the appropriate levels of care to obstetric patients.

They will link in to the clinical directorate and YAS Academy, highlighting any areas of concern regarding obstetric care. They will ensure that staff remain appropriately trained to provide high quality, safe and effective care to pregnant women.

They will ensure that effective communication processes are in place between Consultant Paramedics, Clinical Development Managers and Clinical Supervisors, to ensure that the dissemination of changes in clinical practice pertaining to obstetric care are managed appropriately.

Clinical Governance Group

The Clinical Governance Group will monitor and sign off any changes to practice or implementation of new practices or equipment used in obstetric care management.

Support Services Directorate

The support services directorate will ensure that front-line clinicians are appropriately equipped to care for pregnant women.

The support services will work collaboratively with the clinical directorate to review the minimum equipment list for compliance on a yearly basis.

The relevant equipment procurement groups will coordinate the assessment and any subsequent roll-out of new equipment as directed by the clinical directorate.

Individual Duties

Chief Executive

The Chief Executive is responsible for ensuring that resources and mechanisms are in place for the overall implementation, monitoring and review of this policy.

Executive Medical Director

Has overall responsibility for the implementation of this policy in accordance with the JRCALC guidance and for ensuring that all staff delivers care in accordance with this policy.

The Executive Medical Director may devolve some duties to other roles within the Clinical Directorate.

Head of YAS Academy

Is responsible for ensuring that each core course has an appropriate level of obstetric education embedded within the syllabus, to meet the area of responsibility for that role. Some of this responsibility will be devolved to the Education Assurance manager within YAS Academy.

Will ensure that learner outcomes are derived from best practice in line with Clinical Practice Guidelines

To liaise with the clinical directorate regarding changes in best practice or implementation of additional/new elements to be covered in the syllabus, and paediatric equipment to be issued or carried by the Trust or on Trust vehicles or premises.

Ensuring all tutors and personnel under their supervision are competent in all aspects of obstetric care up to their level of responsibility of practice.

To evaluate and review all taught educational material on a regular basis to ensure it meets; current best practice, Trust requirements and is appropriate for its purpose.

Communicate information on the correct selection, usage and maintenance of obstetric care equipment to staff, particularly relating to actions taken, post incident reports or as part of a “lessons learned” process.

Clinical Staff

Ensure that they maintain their obstetric assessment, diagnosis and treatment skills (as appropriate) in line with their training, and skill level.

Actively manage obstetric patients appropriate to their skills, training and scope of practice. If the management of an obstetric patient is beyond their skills, competence or knowledge, they should promptly consider seeking advice or the attendance of a clinician with more advanced skills.

Ensure that the obstetric care policy is adhered to within their area of responsibility.

Ensure incidents involving obstetric care failure are reported to their line manager and through DATIX promptly and accurately.

Appendix B -

YAS Maternity Pre-hospital screening tool: Yorkshire and the Humber

Pre-hospital Maternity Screening and Action Tool

NHS Yorkshire Ambulance Service NHS Trust

Manage Haemorrhage Immediately

Antepartum Haemorrhage (APH)

<20 weeks: consider

- Referred pain to shoulder: Ectopic, Miscarriage
- Time Critical? Immediate transfer with pre-alert to the nearest ED
- Oxygen and vascular access en-route

≥20 weeks: consider

- Constant abdominal pain / back pain: Placental abruption, Placenta praevia
- Time Critical? Immediate transfer with pre-alert to the nearest Obstetric Unit
- Left lateral position or manual uterine displacement
- Oxygen and vascular access en-route

Postpartum Haemorrhage (PPH) immediately after birth

Consider 4 T's: Tone, Trauma, Tissue, Thrombin

(Uterine muscle tone, Vaginal Tear, Retained Placenta, Clotting Problems)

Placenta Insitu

- Misoprostol oral/sublingual/rectal (unless contraindicated)
- Time Critical: Immediate transfer with pre-alert to nearest Obstetric Unit
- Oxygen and vascular access and 1g TXA en-route

Placenta Delivered

- Uterine massage and offer Entonox
- Misoprostol oral/sublingual/rectal (unless contraindicated)
- Time Critical: Immediate transfer with pre-alert to nearest Obstetric Unit
- Oxygen and vascular access and TXA en-route
- Internal manoeuvre (bi-manual compression) **only if trained to do so**

Vaginal Trauma

- Apply direct external pressure to tears
- Time Critical: Immediate transfer with pre-alert to nearest Obstetric Unit
- Oxygen and vascular access and TXA en-route

24hrs – 12 weeks postnatal: consider

- Could this be retained placenta? Sepsis?
- Time Critical? Immediate transfer with pre-alert to the nearest ED
- Oxygen and vascular access en-route
- Treat RED FLAG sepsis where appropriate

Primary Maternal Assessment

	Clinical Assessment		Red Flags: May indicate deterioration
Looks Unwell?		NO	YES
A	Respiratory Rate	11 – 20	0 – 10 OR ≥21
B	Oxygen Saturations	≥95%	≤94%
C	Pulse Rate	50 – 99	≤49 - ≥100
	Systolic BP	100 – 149	≤99 - ≥150
	Diastolic BP	40 – 90	≤39 - ≥91
D	Conscious Level	Alert	Responsive only to voice, pain or unresponsive Fitting, twitching Visual disturbance
E	Temperature	36° – 37.9°	≤35.9° - ≥38°
	Bleeding	None or spotting	YES >50mls Soaked sanitary towel Blood on the floor
	Membranes / fluid	Intact, clear ≥37 weeks	<37weeks, blood stained Meconium present Offensive smell
F	Uterine Fundus	Soft contractions ≥37 weeks in labour	Contraction <37weeks Constant pain Tender / rigid
	Foetus	Document last reported movements	
G	Load and Go	<20 weeks or ≥20 weeks – consider plan	Early extrication and interventions en-route >20weeks: left lateral position or manual uterine displacement

Consider appropriate pain relief

Maternity RED FLAGS?

Convey immediately where any ONE red flag present:

<20 weeks	Pre-alert nearest Emergency Department
≥20 weeks	Pre-alert nearest Obstetric Unit
	Consider maternal position: left lateral/manual displacement

Maternity Delivery Complications?

Cord Prolapse	Pre-alert nearest Obstetric Unit
Breech / Malpresentation	Oxygen and vascular access enroute
Shoulder Dystocia	Consider appropriate maternal position

No Red Flags or Delivery Complications

<20 weeks	Convey to nearest Emergency Department
≥20 weeks	Contact / Convey to booked Maternity Unit
≥37 weeks - In Labour	Contact / Convey to nearest Maternity Unit

Use SBAR tool to handover in hospital

S	**Situation** State your name and role Describe your concern and the red flag
B	**Background** State the reason for admission Summarise the relevant history State the risk of the woman
A	**Assessment** Report the results of the A-F assessment Summarise the interventions you have done State what you think is happening
R	**Recommendation** Explain what you need and be specific

Pre-Hospital Maternity Screening and Action Tool v2 (Updated 2018)

Maternity Prehospital screening action tool