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Maternity Care Policy

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Associated Documentation: Safeguarding Policy (Children, Young People and Adult at Risk) Domestic Abuse Management Guidance JRCALC UK Ambulance Clinical practice Guidelines NICE Obstetric Guidelines Female Genital Mutilation: Management Guidance Resuscitation Policy Assessment, Conveyance and Referral of Patients Policy				

Staff Summary

Even the slightest doubt must make the clinician consider if any abdominal pain or vaginal bleeding may be pregnancy related in any patient who can become pregnant.
If a midwife is on-scene, they will assume the role of senior clinician regarding the decisions relating to maternity care and may choose to manage the birth on scene. YAS clinicians should work under the direction of the midwife. Once the baby is born then the YAS clinician will assume clinical responsibility for the care of the newborn. 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/Delivery Suite. Unless normal birth is imminent with the head advancing, or other time sensitive interventions are required then the patient should be transported immediately. If the birth is considered imminent but does not progress, then the patient should be transported immediately. The booked Delivery Suite is the most appropriate destination but will be dependent on the distance, clinical care required and urgency of the situation. For patients residing in Yorkshire a pre-alert to the booked Delivery Suite is mandatory, although a decision may be made to divert to an alternative unit due to travel, capacity, or clinical reasons. Patients who are not resident in Yorkshire should be transported to the nearest appropriate birthing centre with a pre alert made.
Care for patients who are pregnant is in accordance with JRCALC and Trust guidance, available on the JRCALC Plus App.
Pregnant patients in cardiac arrest should be immediately and rapidly transported to the nearest emergency department irrespective of the presenting arrest rhythm or cause of arrest. Patients who are unequivocally dead should not have futile resuscitation attempts made; however, normal care of the deceased processes apply. When dealing with a pregnant patient, the well-being of the patient is essential to the survival of the foetus and therefore the resuscitation of the patient must always be the priority. Maternal resuscitation should not be terminated in the pre-hospital environment unless there are signs that are incompatible with life as listed in the JRCALC guidance.
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 Domestic Abuse: Management Guidance.
It is known that Black and Asian patients and those patients with a disability have adverse outcomes in pregnancy and staff must be aware of the additional or tailored support that may be required for this patient group to achieve equality of care.
Staff should indicate during their appraisal whether they require update training in obstetric emergencies. This can be facilitated via the clinical leadership programme or 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 maternity care across the Trust.

1.2 This policy applies to the management of all patients who are pregnant.

1.3 This policy applies to staff working in patient facing and remote assessment in both 999 and 111.

1.4 The care for all obstetric patients will be delivered in accordance with national best practice guidance, from such bodies as JRCALC, National Institute for Clinical Excellence (NICE), Royal College of Obstetrics and Gynaecology, or 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 (Children, Young People and Adult at Risk)
- Domestic Abuse Management Guidance
- Resuscitation Policy
- Assessment, Conveyance and Referral of Patients Policy.

2.0 Purpose/Scope

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

3.1 Delivery of Care

3.1.1 Pregnancy should be considered in any patient who is capable of becoming pregnant, particularly where they present with abdominal pain or gynaecological signs or symptoms.

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

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

3.1.4 Guidelines

- Maternity Care (including Obstetric Emergencies Overview)
- Birth Imminent: Normal Birth and Birth Complications
- Care of Newborn
- Haemorrhage During Pregnancy (Including Miscarriage and Ectopic Pregnancy)
- Maternal Resuscitation

- Pregnancy Induced Hypertension (including Eclampsia)
- Trauma in Pregnancy
- Vaginal Bleeding: Gynaecological Causes

3.1.5 Algorithms

- Maternity pre-hospital screening tool
- Breech Birth: Pre-hospital maternity emergency management
- Cord Prolapse: Pre-hospital maternity emergency management
- Eclampsia: Pre-hospital maternity emergency management
- Haemorrhage During Pregnancy: Pre-hospital maternity emergency management
- Normal Birth: Pre-hospital maternity emergency management
- Post-partum Haemorrhage: Pre-hospital maternity emergency management
- Shoulder Dystocia: Pre-hospital maternity emergency management
- Newborn Life Support.

3.2 Normal Delivery and Delivery Complications

3.2.1 Ordinarily, birthing patients will be conveyed to the nearest obstetric unit. In time critical situations patients may be conveyed to the nearest ED as set out in the YAS maternity screening tool which is available on the JRCALC app. Parent and baby should where clinically appropriate be conveyed to the same destination.

3.2.2 In maternity cases where birth is not imminent and there are no complications it may be appropriate to contact the maternity unit for advice, prior to making transport arrangements. 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 patient to the most appropriate unit.

3.2.3 If a midwife is on-scene they will assume the role of senior clinician regarding the decisions relating the pregnancy and labour and may choose to manage the birth on scene. YAS clinicians should work under the direction of the midwife, unless there is an overriding non-obstetric condition requiring emergency management.

3.3 Transport of Pregnant Patients

3.3.1 Conveyance of patients must be to an appropriate destination as per the YAS maternity screening tool. Manual displacement of the uterus or conveyance in the left lateral tilt should be considered in all patients who are being conveyed who are known or thought to be beyond 20 weeks gestation whether their condition is obstetric in nature or not.

3.3.2 A pre-booked birthing unit may have been previously chosen by the patient. Where appropriate this should be the conveyance destination. There may be cases where the destination is inappropriate due to birthing complications or lack of specialist obstetric services. For instance, a birthing unit may be midwife led and lack anaesthetic or obstetric services. The conveyance destination is a clinical decision based on the needs of the patient primarily and foetus secondarily.

3.3.3 It is out of scope for ambulance clinicians to care for patients during water births. Guidance is available in JRCALC to support such circumstances but in all cases where there is no midwife present the patient must be asked to leave the birthing pool to receive care.

3.4 Transport of Postnatal Patient

3.4.1 Obstetric units can provide care for patients up to six weeks post-partum. A clinical conversation with units can support appropriate decision making but this should not delay transfer of patients who are critically unwell.

3.5 Resuscitation

3.5.1 Pregnant patients in cardiac arrest should be immediately and rapidly transported to the nearest emergency department irrespective of the presenting arrest rhythm or cause of arrest. Patients who are unequivocally dead should not have futile resuscitation attempts made; however, normal care of the deceased processes apply.

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

3.5.3 A mechanical chest compression device may be used to facilitate effective chest compressions during transport where one is immediately available.

3.5.4 Maternal resuscitation should not be terminated in the pre-hospital environment unless there are sign that are incompatible with life as listed in the JRCALC guidance.

3.6 Equality of care.

3.6.1 Patients with a hidden disability such as ADHD or Autism, learning difficulties, or a physical disability may need additional support in any episode of care but even more so in pregnancy as their disability can impact on the care they might need. Patients with a disability may respond to pregnancy and childbirth in a unique way and if staff are made aware of the patent's disability, then they must ensure the patient receives the support appropriate for them so they can receive the best possible care.

3.6.2 Staff should be aware that patients with a sensory disability are less likely to have seen a healthcare professional before 12 weeks gestation which may have an impact on their early pregnancy which may result in a call to the ambulance service.

3.6.3 It has been established that mortality rates in black and Asian babies are significantly higher than for white babies and that black babies are 3 times more likely to die than white babies (9per 1000 births vs 3 per 1000 births). Additionally black women are 3.7 times more likely to die in pregnancy or childbirth than white women and Asian women are 1.7 times more likely to die. These figures can be even higher in deprived areas. Staff must be aware of these facts when providing care to those from ethnic minority backgrounds, with an understanding of how staff bias, misunderstanding or language barriers could and do lead to harm and even death. Consequently, staff must understand how pregnancy related conditions and signs and symptoms can be displayed differently in and on Black or minority ethnic patients and infants.

3.6.4 Patients from some religions, beliefs or cultures are less likely to have access to antenatal care or may require a chaperone if being treated by male identifying staff. Consent should be obtained sensitively, and care taken to treat pregnant patients as their customs would require. When managing pregnant patients from different religions, beliefs or cultural backgrounds, care must be taken when examining patients with an understanding of why they may not have sought antenatal care or their customs when being treated by male identifying staff.

3.6.5 In the rare occasion staff treat a pregnant Trans Male, care should be taken with language and understanding of gender dysphoria. The patient may still be taking testosterone which needs to be considered if showing with abdominal pains in early pregnancy. If testosterone has been stopped to achieve pregnancy or after learning of a pregnancy, this may lead to increased feelings of gender dysphoria and should be considered by staff as part of their care. More information on treating Trans patients can be found in the Trans Guidance for Staff and Patients.

3.7 Safeguarding Children and Adults at Risk.

3.7.1 Working Together to Safeguard Children (HM Gov, 2018) includes the imperative to protect the unborn. 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 Safeguarding Policy (Children, Young People and Adult at Risk) and YAS Domestic Abuse Management Guidance.

3.7.2 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.

3.7.3 Occasionally pregnancy may be concealed or denied until labour commences. In both situations there may have been no ante-natal care. Some concealments may also result in the birth occurring in secret. YAS clinicians must remain vigilant and be aware of the consequences of concealment and that concealment should be considered across all age groups but with special attention to those under the age of sexual consent. Concerns should be raised using the YAS policy for safeguarding.

3.7.4 Pregnancy should be a consideration in a patient who is physically capable and of reproductive age, particularly where their condition may be as a result or complication of pregnancy. Patients may not wish to disclose this information in the presence of others. Appropriate questioning around the potential for pregnancy should always be in confidence away from others including parents, escorts, and chaperones. If this is not possible a balanced decision needs to be taken about the value of such information to the care of the patient at the time. JRCALC guidance sets out the process for assessing the abdomen for signs of pregnancy.

3.7.5 Staff should be aware of the signs of Female Genital Mutilation (FGM) as set out in JRCALC guidance. Any incidental findings of FGM should be reported to the police directly with a safeguarding referral made as per the YAS Female Genital Mutilation: Management Guidance. During labour, complications associated with FGM can be catastrophic and the priority for staff is to provide immediate care to patients with safeguarding referrals made following care has been handed over. Trans Men could also need to be safeguarded under the FGM safeguarding process if circumstances apply.

3.8 Investigation of complaints and incidents involving maternity patients

3.8.1 Investigations form a vital part of informing and improvement across YAS. Understanding why things go wrong and learning from these cases influences the safety and quality of care provision across the Trust. Following a complaint or submission of

an incident through the Datix system, the incident will be reviewed in accordance with current Trust policies.

3.8.2 In addition, the Health Services Safety Investigations Body (HSSIB) will investigate cases notified by the hospital of intrapartum stillbirth, early neonatal deaths and severe brain injury diagnosed in the first seven days of life, when the baby:

- was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); or
- was therapeutically cooled (active cooling only); or
- had decreased central tone and was comatose and had seizures of any kind.

3.8.3 As part of their investigations, any contact with the ambulance service will be considered to identify any system-wide learning.

4.0 Training expectations for staff

4.1 All staff responding to emergency or urgent calls involving maternity patients will receive the relevant level of maternity 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 maternity 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 and managed through the Clinical Portfolio Governance Group.

4.3 Whenever there is a major change in clinical practice guidelines information will be cascade via clinical updates, and clinical refresher training. The methods used will be dictated by the nature or complexity of the changes.

4.4 Staff should indicate during their appraisal whether they require update training in obstetric emergencies.

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.

5.2 The policy will inform all clinical educational material and will be cascaded via investment days, CPD days, and NQP investment days.

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 Education Portfolio Governance board 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 Education Portfolio Governance board. Staff requiring update training will be coordinated and added to the OLM database by the Clinical Education Coordinator and reported via the Clinical Education Portfolio Governance board. 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 Clinical Education Portfolio Governance board, 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.

7.0 Appendices

7.1 This Policy includes the following appendices:
Appendix A - Roles & Responsibilities

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

Quality and clinical practice
The Quality and Clinical Practice directorate will ensure clinical best practice is implemented, and work with the YAS Academy ensuring best practice and current evidence-based practice is utilised in the training of obstetric care.

Clinical Directorate
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 core training requirements regarding obstetric care.

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

The YAS Academy will monitor and evaluate all core education/training activities and report the findings through the Clinical Education Portfolio Governance board. Any training delivered outside of the YAS academy structure e.g. PROMPT training will be monitored by the clinical education portfolio governance board.

They will implement changes in line with best practice following discussions or direction from the Quality and Clinical Practice 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 into the Quality and Clinical Practice 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, Advanced Paramedics-Clinical Lead and Team Leaders, to ensure that the dissemination of changes in clinical practice pertaining to obstetric care are managed appropriately.

Remote Patient Care Directorate (999/111)

To ensure clinical staff receive appropriate remote assessment training in relation to obstetric and maternity care in conjunction with the academy.

To ensure auditing is conducted for maternity, pregnancy related calls to ensure safe and appropriate remote care is delivered and an appropriate service response.

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 patients.

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.

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 Director for Quality and Clinical Practice/Chief Paramedic
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. They may devolve some duties to other roles within the 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

Will 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 maternity care policy is adhered to within their area of responsibility.

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