Maidstone and Tunbridge Wells NHS
NHS Trust

NHS
Maidstone and
Tunbridge Wells
NHS Trust

Ref: FOI/GS/ID 5275

Please reply to:
FOI Administrator
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net

19 February 2019

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to pregnancy and labour policies.

You asked:
I would be grateful if you would please provide your:
1. Protocols/policies surrounding management of normal/low risk pregnancy to include all monitoring guidelines.
2. All guidelines and policies relating to monitoring foetal heart rate during labour (intermittently or CTG).
3. Policies and guidelines surrounding management and intervention during labour (including any polices or guidelines relating to instrumental intervention during labour).
I would be grateful if you would please supply all policies/guidelines in force on or before 15 November 2015.

Trust response:

Please see the following policies and guidelines.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Antenatal Booking Appointments

Requested/
Required by: Women's & Children's Directorate

Main author: Matron for Community & Outpatient's Midwifery (AM)

Other contributors:	Maternity Community Team Leads, Supervisor of Midwives (SP) Midwife (TC)
Document lead:	CNST Maternity Co-ordinator (AC) **Contact Details:** ext 33514
Supersedes:	Antenatal Booking Appointments, (November 2009, v1.0)
Approved by:	Delivery Suite Forum **Date:** 26th September 2011
Ratified by:	Clinical Risk Management Group **Date:** 6th October 2011
Review date:	October 2014

Document History

Requirement for document:	• 2011/12 Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards; Standard 4, Criterion 1 • To ensure the maternity booking process within the Trust complies with current recommendations and provide an excellent service to women
Cross References / Associated Documents:	**Associated Documents:** Maidstone & Tunbridge Wells NHS Trust Maternity. (2011) *Antenatal Clinical Risk Assessment Including Referral to Consultant Led Care.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines.

	Maidstone & Tunbridge Wells NHS Trust Maternity. (2010) Children's *Safeguarding Policy and Procedure.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines. Maidstone & Tunbridge Wells NHS Trust Maternity. (2011) *Diabetes in Pregnancy.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines. Maidstone & Tunbridge Wells NHS Trust Maternity. (2011) *Patient Information and Discussion Guideline.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines. Maidstone & Tunbridge Wells NHS Trust Maternity. (2011) *Training Strategy.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines. Maidstone & Tunbridge Wells NHS Trust Maternity. (2011) *Maternal Antenatal Screening Tests.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines. Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Care of the Obese Woman in Pregnancy*. Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines. Maidstone & Tunbridge Wells NHS Trust Maternity. (2011) . *Record Keeping and Management of Health Records.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines. Maidstone & Tunbridge Wells NHS Trust Maternity. (2011) Venous *Thromboemolism in Pregnancy & the Puerperium guideline.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines. **Cross References:** Confidential Enquiry into Maternal and Child Health. (2009). *Perinatal Mortality 2007.* London: RCOG Press. Available at: www.cmace.org.uk Confidential Enquiry into Maternity and Child health. (2007). Saving *Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003-2005.* London: CEMACH. Available at: www.cemach.org.uk Confidential Enquiries into Maternal Deaths in the United Kingdom. (2001). *Why Mothers Die 1997-1999.* London: CEMD. Available at: www.cemach.org.uk Confidential Enquiry into Maternity and Child Health. (2004). *Why Mothers Die 2000-2002.* London: RCOG Press. Available at: www.cemach.org.uk Maternity Care Working Party. (2006). *Modernising Maternity Care* –

	A Commissioning Toolkit for England (2nd Edition). London: The National Childbirth Trust, The Royal College of Midwives, The Royal College of Obstetricians and Gynaecologists. Available at: www.rcog.org.uk National Institute for health and Clinical Excellence. (2008). *Antenatal care: Routine care for the healthy pregnant woman.* London: NICE. Available at: www.nice.org.uk National Institute for Health and Clinical Excellence. (2010). *Pregnancy and Complex Social Factors: A Model for Service Provision for Pregnant Women with Complex Social Factors*. London: NICE. Available at: www.nice.org.uk Wolfson Institute of Preventive Medicine (2008) *Antenatal Screening for Down's Syndrome.* London UK National Screening Committee. (2008). *Screening tests for you and your baby.* Leeds: National Screening Committee

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	Referral for Consultant led Care	November 2007
2.0	Document revised and previous guideline incorporated	November 2009
3.0	Revised and amended to include service reconfiguration changes	October 2011

Policy Statement for

Antenatal Booking Appointments

Maidstone and Tunbridge Wells NHS Trust recognises the need for a process that ensures pregnant women have their first full booking visit and hand held maternity record completed within approved time scales.

This will allow opportunities for:
Early identification of high risk pregnancies
Antenatal screening within recognised timeframes
Identification of Concern and Vulnerability issues
Dietary and lifestyle advice appropriate for a healthy pregnancy

1.0 Introduction and Scope of Procedural Document

- This document applies to all midwives and obstetricians undertaking antenatal care
- This procedure is to ensure that women have access to early antenatal care and are appropriately risk assessed and referred
- This guideline should be read in conjunction with MTW Guideline (referenced on page 2) '*Antenatal Clinical Risk Assessment Including Referral to Consultant Led Care'*

The Maternity Service provided to women by Maidstone & Tunbridge Wells NHS Trust (MTW) was reconfigured in September 2011. Inpatient services for high risk women were transferred to the Tunbridge Wells Hospital at Pembury (TWH) with the Neonatal Unit also based at TWH.

Women are offered the following:

- Low risk women may choose to give birth at TWH, at home or the new midwife-led Birth Centre at Maidstone
- A range of outpatient maternity services including Antenatal Clinics, Obstetric Ultrasound and a Maternity Day Unit, continue to be offered at both TWH and Maidstone Hospital. These will be accessed, as appropriate by both high and low risk pregnant women in each geographical area.

2.0 Definitions

- **Low Risk** – women who are identified by risk assessment as suitable for midwifery led care during their pregnancy

- **High Risk** – women who are identified by risk assessment as having a condition or problem that require them to have additional care during their pregnancy
- **Euroking** – Electronic maternity record collecting data obtained at the booking interview
- **Patient Centre** – Electronic record of patient inpatient & outpatient activity, including hospital records management.
- **Full booking visit** – First antenatal appointment to include full assessment of medical, obstetric and social history
- **BMI** – Internationally accepted formula for measuring obesity
- **Combined screening test** - Antenatal screening performed between 10 & 13 weeks of pregnancy to identify the risk of Downs Syndrome in the fetus. Consists of combination of blood test and nuchal translucency ultrasound scan
- **Concern & Vulnerability** - Mechanism for identifying mothers and babies potentially at risk

3.0 Duties

It is the registered professional's responsibility to deliver care that is based on current evidence, always acting in the woman's best interests.

The midwife's duties to include:

- Bookings, ideally to take place within the specified time frame (see 5.2.2)
- Appropriate completion of documentation, Euroking (Maternity IT system), hand held records and referral to maternity unit of choice and other professionals or agencies as necessary

4.0 Training / Competency Requirements

Registered midwives and medical staff caring for obstetric patients have a professional responsibility to maintain their competence.

No specific training required for implementation of this guideline. However, midwives and obstetricians have mandatory annual updates on antenatal screening and care of vulnerable clients.
Refer to: MTW Maternity Guideline: (referenced on page 2)

- Training Strategy

5.0 Procedure for Antenatal Booking Appointments

5.1 Responsibilities of relevant staff groups

5.1.1 Midwives responsibilities (Including those based in Ante-natal clinic who may have responsibilities for out of area bookings)

To ensure that women are seen and full antenatal booking visit carried out within agreed time scales i.e. between 6-10 weeks gestation

To ensure that appropriate referral is made for either high risk or low risk care

To ensure that data obtained from booking assessment is uploaded onto Euroking system by 12 completed weeks of pregnancy

5.1.2 Obstetric responsibilities
To ensure that women referred for high risk obstetric care are seen and assessed appropriately

To ensure that women with underlying medical conditions are seen by appropriate professional e.g. diabetic women

5.1.3 Teenage pregnancy midwife
If, on initial contact, it is apparent that the woman is less than 19 years old, she should then be directly referred to the Teenage Pregnancy midwife who will arrange the antenatal booking appointment

5.2 Process for ensuring that women have their first full booking visit and hand held maternity record completed by twelve completed weeks of pregnancy

5.2.1 Process for organising first antenatal booking appointment
The first antenatal booking appointment with a midwife can be made either by direct contact with the midwife or via the pregnant woman's GP surgery.

Out of area women are referred by their GP or local community midwife and will be contacted via the Antenatal Clinics at TWH or Maidstone Hospital (as geographically appropriate) to arrange a booking appointment. Contact will be either by telephone or letter, as appropriate to individual circumstances and necessary timeframes.

This antenatal booking appointment should be carried out between 6-10 weeks of pregnancy thereby ensuring that all available antenatal screening can be completed within specified time frames

The duration of this first booking appointment is expected to be no less than 1 hour

5.2.2 Booking Appointment

At the booking appointment ensure all women have information regarding an appropriate place of delivery for them, ie Tunbridge Wells Hospital at Pembury, Maidstone Birth Centre or home delivery. For distance reasons some women may choose to be referred to an alternative maternity unit outside of Maidstone and Tunbridge Wells NHS Trust.

This first Antenatal Booking Appointment consists of the following:

1. **Full demographic details** for entering into Patient Centre/Euroking

2. **Full medical, obstetric and social history and any significant medical history** of woman's family and partner taken using the Euroking (Maternity IT system) antenatal questionnaire

This information may initially be collected manually and then transferred to Patient Centre/Euroking as soon as possible, **but at the latest by 12 completed weeks of pregnancy**

Antenatal screening information is supported by giving each woman a copy of the UK National Screening booklet "Screening tests for you and your baby" (available to download in 18 different languages)

3. **Antenatal Screening for Down's syndrome – The Combined Test**

It must be ensured that the woman fully understands the implications of Combined Screening and makes an informed decision to consent or decline.

Should the woman decline the Combined Test she may still request an 11-14 week ultrasound scan.

Maidstone site

- The request form for 11-14 week scan with or without combined test is given to the woman by the midwife and needs to be signed prior to arrival for Nuchal Ultrasound scan
- The woman is also given the purple 'Wolfson' form for the combined screening blood tests to bring along to her nuchal appointment
- This information is faxed to the antenatal clinic so that an appointment for combined screening test may be made
- Leaflet given Antenatal Screening for Down's Syndrome – The Combined Test

Pembury site:

- The request form for 11-14 week scan with or without combined test will be completed by the mother and sent together with the Wolfson form direct to the Ultrasound Department by the midwife for an appointment to be allocated for Nuchal Scan
- Leaflet given Antenatal Screening for Down's Syndrome – The Combined Test

Refer to MTW Guideline: (referenced on page 2)

- Maternal Antenatal Screening Tests

4. **Family Origin Questionnaire** completed – Top copy sent to laboratory with Full Blood Count sample, pink copy to patient notes, yellow copy to ANC for filing with medical records

5. **Dietary and lifestyle advice** to include:
   a. Dietary advice – foods to avoid etc
   b. Advice on smoking and referral to smoking cessation service if the woman is a smoker
   c. Advice on alcohol consumption

6. **Healthy weight advice**:

● Document booking BMI.

● If BMI >35 refer to Healthy Weight Clinic as well as obstetrician and arrange Glucose Tolerance Test (GTT).

● Also arrange GTT if any other risk factors present as detailed below

Refer also to MTW Guidelines: (referenced on page 2)

- Diabetes in Pregnancy
- Care of the Obese Woman in Pregnancy

RISK FACTORS FOR SCREENING FOR GDM

- BMI above 30 kg/m^2
- Previous macrosomic baby weighing 4.5 kg (equivalent to 10 lbs) or above
- Previous gestational diabetes
- First degree relative with diabetes
- Family origin with a high prevalence of diabetes:
  - South Asian (specifically women whose country of family origin is India, Pakistan or Bangladesh)
  - Black Caribbean
  - Middle Eastern (specifically women whose country of family origin is Saudi Arabia, UAE, Iraq, Jordan, Syria, Oman, Kuwait, Lebanon or Egypt)
- Previous unexplained stillbirth

- Macrosomia in current pregnancy
- Polyhydramious in current pregnancy
- Persistent glycosuria on 2 or more occasions in current pregnancy

7. Antenatal classes:
Information regarding availability and process for booking

8. Additional leaflets/information given:
NHS Pregnancy book (as available or alternative suitable publication)
FW8 form completed
Individual team profile booklet
Current available leaflets regarding diet/lifestyle, health pregnancy etc
Healthy Start application form – midwife to sign if applicable

9. **Identify any Concern & Vulnerability/Safeguarding Children** issues:
Make any urgent referral to Social Services if necessary
Complete Concern and Vulnerability form after discussing with the woman the reason for this. Consider completion of a CAF (Common Assessment Framework) if appropriate.
Refer to MTW Guideline: referenced on page 2

- Children's Safeguarding Policy and Procedure

10. **Family Background Questionnaire:**
Complete regarding other children of this mother or her partner (Appendix 8). If Concern and Vulnerability form necessary this form should be attached. If Family Background Questionnaire does not identify any concerns it should be sent to the Antenatal Clinic with the other booking documents for filing in the main hospital notes.

11. **GP and Health Visitor Notification of Booking**
Complete form and send to GP surgery and relevant health visitor team, ensuring effective multi-disciplinary information sharing. (See Appendix 7)

12. Blood tests

It is recommended that all pregnant women are offered screening for rubella, syphilis, hepatitis B and HIV. Consent or decline of each of these should be clearly indicated on the request form. If women decline screening for any or all of these infections, the midwife should sensitively enquire as to the reasons for decline and explain the benefits of screening for both mother and baby. If women decline screening for infectious diseases at booking, it should be offered again at 28 weeks.
Discuss with woman and obtain consent for taking these blood tests. It is the midwife's responsibility to take all booking bloods.
Booking bloods: -

- Group, Rhesus factor and Antibody screen – ensure result copied to GP surgery and Antenatal clinic
- Full blood count with Family Origin Questionnaire

- Haemoglobinopathies (HPLC/Electrophoresis) if indicated by Family Origin Questionnaire
- HIV
- Hepatitis B
- Syphilis
- Rubella

Refer to MTW Guideline: (referenced on page 2)
- Maternal Antenatal Screening Tests

13.Midstream urine specimen
To be sent to laboratory

14. Height(m), weight (kg)
Calculate BMI- if over 35 refer to Healthy Weight Clinic and Obstetric Consultant

15. Blood pressure

16. Calculate Estimated Date of Delivery (EDD)

17. Assess thromboembolic risk utilising flow chart on Antenatal Thromboprophylaxis Risk Assessment and Management form, and refer accordingly if elevated risk identified. Completed flow chart to be included in woman's maternity notes.

Refer also to MTW Guideline (referenced on page 2)
- Venous Thromboemolism in Pregnancy & the Puerperium

18. Antenatal Clinic Referral
Refer to appropriate site and professional as required, using information obtained from medical, obstetric and social questionnaire to decide on low risk midwifery care or high risk obstetric care. See Referral for Consultant Led Care (Appendix 5).

Maidstone site:
Complete antenatal booking referral form, indicating whether high or low risk and fax to Antenatal Clinic. Antenatal Clinic will arrange Combined Test appointments with Ultrasound Department. If the woman is High Risk she will be sent an antenatal clinic appointment. Antenatal Euroking to be completed at a later date

Pembury site:
Antenatal Euroking completed. Clinic referral form and Ultrasound request form are generated by Euroking. These forms are sent to Antenatal Clinic and Ultrasound Department in order to generate scan appointments. The Euroking form will also contain a High or Low Risk category box for the midwife to indicate whether or not the woman needs consultant referral

5.2.3 Hand Held Records

Explain to the woman that her maternity notes consist of hand held records which she must bring to every antenatal clinic or hospital attendance. She will receive the completed set of notes with the Euroking summary once this information has been entered by the community midwives. If not completed at time of booking, the maternity notes are returned to the GP surgery reception by the midwife for collection by the woman, as arranged.

5.2.4 Follow up Appointments

Inform woman regarding pattern of antenatal care appointments.
Arrange for her to return at 16 weeks gestation in order to:

- Document blood results, and Downs screening results (if applicable)

in hand held notes

- Arrange Anti D appointment at 28 weeks if Rhesus negative
- Listen to fetal heart
- Routine antenatal check
- Ensure Antenatal Clinic appointment has been received if appropriate
- Ensure anomaly scan appointment has been received if requested

5.3 Process for late antenatal bookings

Pregnant women of more than 12 weeks gestation must be seen by their named midwife as soon as possible, but within 2 weeks of referral and the process for booking followed as outlined above in 5.2.2 - 5.2.4. The date of the woman's referral for care should be documented in her maternity notes.

5.4 Process for ensuring that women who have not previously had a full medical examination in the United Kingdom have a medical history taken and clinical assessment made of their overall health

These women should be seen by a GP at the surgery where they are registered

If this has not been done, the midwife should ensure that an appointment is made as soon as possible for a full medical examination and explain to the woman the reason for this. In the interim, this should not delay the initial booking appointment. Details of the appointment request should be documented in the woman's notes.

The midwife should document in the woman's maternity notes when this medical examination has been undertaken and consider whether any findings will be likely to impact upon her initial pregnancy plan of care.

It is important to remember that these women may not be eligible for NHS care. If unclear refer to midwifery matron who will clarify the situation.

5.5 Process for identifying for which women health records from previous pregnancies are required for review by clinicians.

The booking midwife identifies women as high or low risk. When a booking referral is received by the Antenatal Clinic clerks all women booked as high risk will have their hospital notes requested, via Patient Centre, from Medical Records Department at Paddock Wood. These hospital notes will be stored at the Tunbridge Wells Hospital at Pembury for the duration of pregnancy.

Where a woman has received care in previous pregnancy outside of MTW, the Obstetric Consultant will, with the woman's consent, write to his or her colleague at the identified Trust and request a copy of the relevant information, which will be stored in the main MTW hospital notes.

5.6 Process for arranging the availability of health records for women for which health records from previous pregnancies are required for review by clinicians.

High Risk Women
As above, all hospital notes for high risk women are available at The Tunbridge Wells Hospital at Pembury, once received from Medical Records as soon as possible following the booking appointment. Hospital notes for women booked to deliver at The Tunbridge Wells Hospital, but receiving antenatal care at Maidstone Hospital, will be stored at The Tunbridge Wells hospital. These notes will be transferred to Maidstone Hospital for booked Antenatal Clinic appointments ensuring that they are always available for review by clinicians. Following a booked Antenatal Clinic appointment at Maidstone hospital notes will be transferred back to Tunbridge Wells ensuring their availability should an antenatal admission become necessary.

Low Risk Women
Hospital notes for low risk women booked to deliver at The Tunbridge Wells Hospital at Pembury are requested from Medical Records by the Antenatal Clinic clerks when women are 36 weeks pregnant. They will be stored on the Delivery Suite until after delivery and the episode of care is closed.

6.0 Monitoring and Audit – Elements of this guideline will be audited using the tool attached (Appendix 4)

Monitoring Table – Booking Appointments						
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Action Lead(s)**	**Change in practice and lessons to be shared**
Responsibilities of midwives and obstetricians in relation to booking appts are undertaken as at 5.1	Matron for Community and Outpatients/ designated person	1% of maternity records will be reviewed using the audit tool at Appendix 4	Annual	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.
All women have had their first booking visit by 12 weeks	Matron for Community and Outpatients/ designated person	1% of maternity records will be reviewed using the audit tool at Appendix 4	Annual	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.
All women have their maternity notes available for collection by 12 weeks	Matron for Community and Outpatients/ designated person	1% of maternity records will be reviewed using the audit tool at Appendix 4	Annual	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements	Action Lead(s)	Change in practice and lessons to be shared
All women who present for booking after 12 weeks are seen within 2 weeks	Matron for Community and Outpatients/ designated person	1% of health & maternity records of women who on referral are already twelve or more weeks pregnant will be reviewed using the audit tool at Appendix 4 (identified by Euroking electronic system)	Annual	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.
All women who have not previously had a full medical examination in the UK are seen by their GP in early pregnancy	Matron for Community and Outpatients/ designated person	1% of maternity records of women who have not previously had a full medical examination in the UK are seen by their GP in early pregnancy will be reviewed using the	Annual	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.

		audit tool at Appendix 4 (identified by Euroking electronic system)				
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting Arrangements**	**Action Lead(s)**	
Hospital Notes, containing previous health & pregnancy records will be requested from Medical Records for all women classified as High Risk	Matron for Community and Outpatients/ designated person	1% of maternity records of High Risk women will be reviewed using the audit tool at Appendix 4	Annual	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.
Hospital Notes, containing previous health & pregnancy records for all High Risk women will be available for clinician's review for both booked ANC appointments & emergency antenatal admissions	Matron for Community and Outpatients/ designated person	1% of maternity records of High Risk women will be reviewed using the audit tool at Appendix 4	Annual	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.

APPENDIX ONE

Process Requirements

1.0 Implementation and Awareness

1.1 Once approved this policy/procedural document will be published on the Trust intranet by the CNST Maternity Co-Ordinator or Maternity Secretary (as appropriate).
1.2 A monthly publications table will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust intranet) under "Trust Publications", and notification of the posting will be included on a bi-weekly notification email circulated Trust wide by the COMMS team.
1.3 On receipt of the Trust wide Bulletin board notification, all managers should ensure that their staff members are aware of the new publications.
1.4 On publication of any Maternity document, the CNST Maternity Co-Ordinator will ensure that an email is sent to all Maternity staff and other stakeholders, as appropriate.
1.5 Women & Children's Clinical Governance Newsletter (Quarterly publication)
1.6 Dissemination from staff team meetings
1.7 Delivery Suite Notice Boards or Guideline Folders (as appropriate)

2.0 Review

2.1 It is essential that Trust Policy/procedural documents remain accurate and up to date; this policy/procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure. It is the responsibility of the Document Lead for this policy/procedure to ensure this review is undertaken in a timely manner.
2.2 The Document Lead should review the policy/procedure and, even when alterations have not been made, undertake the consultation process as detailed in **Section 5.5 Consultation** of MTW Policy and Procedure '*Production, Approval and Implementation of Policies and Procedures*'.

3.0 Archiving

3.1 The Trust Intranet retains all superseded files in an archive directory in order to maintain document history.

3.2 Old paper guideline copies pre-dating Datix are stored at:
Chatham Archive & Storage document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634 826665

APPENDIX TWO

CONSULTATION ON: Antenatal Booking Appointments

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: CNST Maternity Co-ordinator.

By date: ***13th September 2011*** *(all documents must undergo a minimum of two weeks consultation)*

Name: *List key staff appropriate for the document under consultation.*	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Consultant Obstetricians	30/08/11			
Consultant Paediatricians	30/08/11			
Consultant Anaesthetists (Obstetric Leads)	30/08/11			
Head of Midwifery / Associate Director of Nursing	30/08/11	Oct 2011	Y	Y
Supervisors of Midwives	30/08/11			
Matron for Maternity Inpatient Services	30/08/11			
Clinical Manager for Governance & Risk	30/08/11			
Maternity Clinical Risk Manager	30/08/11			
Consultant Midwife	30/08/11			
Midwifery Staff via Drafts for Comments on Datix	30/08/11	Sept 2011	Y	Y
Maternity Team Leads including Antenatal Clinic and Maternity Day Unit	30/08/11	Aug 2011	Y	Y
Clinical Governance Assistant	30/08/11			
Local Counter Fraud Specialist	30/08/11			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Antenatal Booking Appointments
What are the aims of the policy or practice?	To outline a consistent & appropriate process for ensuring pregnant women have their first full booking visit and that hand held maternity records are completed within approved timescales.
Identify the data and research used to assist the analysis and assessment	See Page 2 of this document
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	NO
People of different ages	NO
People of different ethnic groups	NO
People of different religious beliefs	NO
People who do not speak english as a first language	Translators can be arranged on request. Leaflets available in different languages
People who have a physical disability	NO
People who have a mental disability	NO
Women who are pregnant or on maternity leave	N/A
Single parent families	NO
People with different sexual orientations	NO
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	NO
People in deprived areas and people from different socio-economic groups	NO
Asylum seekers and refugees	NO
Prisoners and people confined to closed institutions, community offenders	NO
Carers	NO
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	With review of this guideline, as a minimum every three years
Where do you plan to publish the results of your Equality Impact Assessment?	As an appendix of this guideline on Datix Guidelines (Trust intranet)

APPENDIX FOUR

Audit Tool for Booking Appointments

Hospital Number: ……

Criteria		**Comments** **Eg reason why recommendations not met**
Responsibilities of staff groups		
Woman has been seen by **midwife** and full antenatal booking carried out between 6-10 weeks	**Yes/No**	
Appropriate referral has been made by **midwife** for high or low risk care	**Yes/No**	
Data obtained from antenatal booking has been uploaded to Euroking by 12 completed weeks of pregnancy by **midwife**	**Yes/No**	
Women referred for high risk obstetric care are seen and assessed appropriately by **obstetrician**	**Yes/No**	
Women with underlying medical conditions are seen by appropriate professional as determined by **obstetrician**	**Yes/No**	
Women who are identified as less than 19 years old on initial contact are booked by Teenage pregnancy **midwife**	**Yes/No**	
Criteria		
Gestation at Booking Appointment		
		Continued overleaf ……

Gestation when Maternity Notes available		
If booked after 12 weeks, seen within 2 weeks of referral	**Yes/No/Not applicable**	
If medical exam required, arranged in early pregnancy	**Yes/No/Not applicable**	
If High Risk, hospital notes, containing previous health and pregnancy records are requested from notes storage facility following booking	**Yes/No/Not applicable**	
If High Risk, and received previous pregnancy care out of area, health and pregnancy records as appropriate are requested from relevant Trust	**Yes/No/Not applicable**	
If High Risk, hospital notes containing previous health and pregnancy records are made available for clinician's review at both booked ANC appts and emergency antenatal admissions	**Yes/No/Not applicable**	

APPENDIX FIVE

Referrals for Consultant Led care /Factors to consider when planning place of birth

The following tables are intended to assist practitioners in assessing individual pregnancy risk, both at booking and at all subsequent pregnancy contacts with the maternity service. The tables are integral to **MTW Guideline 2011 Clinical Risk Assessment (Antenatal)** and practitioners are advised to familiarise themselves with the contents of this guideline.

In Summary:

Low Risk women are identified by risk assessment as suitable for midwifery led care during their pregnancy.

High Risk women are identified by risk assessment as having a condition that requires them to have additional care during their pregnancy which will be Consultant led. In certain circumstances, women referred for consultant led care utilising the high risk indicators identified below, may be returned to midwifery care having received individual obstetric assessment, and in consideration of their desired place of birth.
Depending on the condition, consultant care visits should be planned on an individual basis, with women empowered to make informed decisions and choices. An individualised care pathway should be formulated and documented. Advice may be sought from the Antenatal Clinic team.

General health & pre-existing medical conditions	Specific condition (s)	Gestation at which ANC appt is likely to be offered or other consultation undertaken
Maternal age	Teenage pregnancy 40 or over	Referred to Teenage Pregnancy Midwife for booking, seen in ANC as appropriate Refer to ANC. Appt as appropriate
Additional needs	Assessment of risk should reflect the challenges of women with communication problems or learning difficulties	High risk referral will depend on individual circumstances
Body Mass Index (BMI)	Less than 18 kg/M_2 35 kg/M_2 or more	20/40 20/40 Additionally for referral to Healthy Weight in Pregnancy Midwife
Congenital		First trimester appt

abnormality		with Screening Co-ordinator
Family history of genetic Disorder		First trimester appt with Screening Co-ordinator
Previous gynaecological history	Myomectomy or major gynaecological surgery including to pelvic floor, hysterotomy or perforation of the uterus Previous cervical suture Cone biopsy or large loop excision of the transformation zone Fibroids	20/40 12/40 12/40 20/40 after ultrasound scan
Cardiovascular	Confirmed cardiac disease Requiring or not requiring treatment or antibiotics in labour. Hypertensive disorders	12/40 or other dependent upon individual circumstances 12/40
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic fibrosis	16/40 First trimester
Endocrine	Hyperthyroidism or Hypothyroidism Pre-existing Diabetes History of Gestational Diabetes	16/40 with TFT results 8/40 with advice from Diabetic Specialist Nurse 18/40 GTT
Renal	Abnormal renal function Renal disease requiring renal specialist Supervision	Upon diagnosis First trimester
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident Other neurological deficits	12/40 12/40 12/40 Dependent upon individual circumstances
Gastrointestinal	Liver disease associated with or without current abnormal liver function tests	First trimester or as appropriate

		depending upon individual circumstances
	Crohn's disease or Ulcerative colitis	Dependent on individual circumstances
Haematological	Haemoglobinopathies: sickle-cell disease, Beta-thalassaemia major	8-10/40 appt with Screening Co-ordinator
	History of thromboembolic disorders Increased VTE risk	8-10/40
	Persistent anaemia	Depending upon individual circumstances
	Immune Thrombocytopenia purpura or other platelet disorder or platelet count below 100,000	20/40
	Von Willebrand's disease or other clotting disorder	20/40
	Atypical antibodies which carry a risk of haemolytic disease of the newborn.	Following antibody titre levels from Tooting. Will be seen within 2 weeks
	Atypical antibodies which do not put newborn at risk of haemolytic disease	As appropriate dependent upon individual circumstances
	Identification of women who will decline blood and blood products	As appropriate dependent upon individual circumstances
Infective	Risk factors associated with Group B Streptococcus whereby antibiotics in labour would be recommended	As appropriate dependent upon individual circumstances
Infective (cont)	Hepatitis B or C carrier	12/40 appt with Screening Co-Ordinators

	Carrier of/infected with HIV	12/40
	Toxoplasmosis – women receiving treatment	12/40 with Screening Co-Ordinator or following diagnosis if infected during pregnancy
	Current active infection of chicken pox/rubella/first episode of genital herpes	12/40 with Screening Co-ordinator or following diagnosis if infected during pregnancy
	Tuberculosis under treatment	First trimester
Cancer		Dependent upon individual circumstances
Skeletal	Spinal abnormalities	20/40
	Previous fractured pelvis	20/40
Psychiatric & Social issues increasing vulnerability in pregnancy	Psychiatric disorder requiring current inpatient care	Emergency referral
	Personal history of psychosis/puerperal psychosis/bipolar disorder or schizophrenia	12/40
	Family history of bipolar disorder or puerperal psychosis	12/40
	Any identified factors that may make a woman more vulnerable in pregnancy including women on medication for depression or a personal history of self-harm	Appt depending upon individual circumstances
	Issues that have been raised in the pregnancy for example lack of social support, suspected domestic violence, issues raised on Concern & Vulnerability form when consultant input or opinion is felt appropriate	Appt depending upon individual circumstances
Previous anaesthetic problems		May require anaesthetist input during pregnancy. Dependent upon

		individual circumstances
Previous pregnancy complications		
Pregnancy loss	Women with significant pregnancy loss including: Recurrent miscarriage (3 or more) mid trimester loss, stillbirth, IUD, NND, previous death related to intrapartum difficulty or morbidity	Placed under Consultant care and management plan made according to individual circumstances
Neonatal concern	Previous term baby with jaundice requiring exchange transfusion	20/40
Hypertensive related disorders	Pre-eclampsia requiring preterm birth Eclampsia HELLP syndrome	20/40 20/40 20/40
Placental abruption		20/40
Uterine	Uterine rupture Caesarean section	20/40 20/40 (referral as appropriate to Birth Options Clinic prior to ANC appt)
Third stage related	Primary post partum haemorrhage (more than 1litre or any amount requiring additional treatment or transfusion) Retained placenta requiring manual removal in theatre.(*May be considered for home or birth centre birth if placenta removed from vagina or 3rd stage mismanagement a contributory factor*)	20/40 20/40
Previous delivery problems	Including shoulder dystocia, difficult or traumatic delivery	20/40
Previous baby more than 4.5 kg		28/40 GTT Consultant input as appropriate
Previous extensive vaginal,		20/40

cervical or third or fourth degree perineal trauma		

Factors relating to current pregnancy		**Gestation at which ANC appt is likely to be offered or alternative consultation undertaken**
Grand multiparity	4 or more previous births	20/40
Multiple birth		20/40 MCMA at 16/40 following ultrasound
Placenta praevia		34/40 after USS
Hypertensive disorders	Pre-eclampsia or pregnancy induced hypertension	Will be reviewed by on-call team at diagnosis and individual plan of care made
Preterm	Preterm labour Preterm pre-labour rupture of membranes	With Consultant input as inpatient ANC as appropriate following inpatient admission. Individual plan of care formulated
Mal-presentation	Breech or transverse lie after 36 weeks of pregnancy	Following diagnosis
Anaemia	Haemoglobin less than 10 g/dl at onset of labour	Consultant input as inpatient
Induction of Labour		Appt as appropriate in ANC to discuss depending on individual circumstances
Unbooked in this pregnancy		Placed under Consultant Care upon presentation. ANC follow up if prelabour
Onset of		Following diagnosis.

gestational diabetes		Initial appt will be with Diabetes Nurse Specialist
Lifestyle factors/ Substance misuse, drug or alcohol dependency requiring assessment or treatment		Placed under consultant care and plan of care formulated depending upon individual circumstances
Confirmed intrauterine death		Placed under Consultant care at diagnosis and individual management plan formulated
Fetal indications	Small for gestational age in this pregnancy or slowing in growth – refer for prompt USS assessment of growth, liquor and Doppler studies if SFH 3 cms or more **below** expected for gestation	Placed under Consultant care following diagnosis of restricted growth or oligohydramnios. Clinician reviewing ultrasound results will formulate appropriate plan of ongoing care.
Fetal indications (cont)	SFH 3cms or more **above** expected for gestation on 2 occasions. Refer for prompt USS of growth and liquor volume Large or small fetus identified on scans undertaken privately	Placed under Consultant care following diagnosis of polyhydramnios and/or fetal growth on 95th centile or above. Clinician reviewing ultrasound results will formulate appropriate plan of ongoing care Following review of scan results by midwife in community-led clinics
Recurrent Antenatal Admissions Recurrent non-	Women self-referring for example to Triage or MDU for assessment three or more times, and then discharged as NAD. Refer to MTW Guideline Missed	Seen in ANC as appropriate Seen in ANC as

attendance at CMW appts for low risk women	Antenatal Appts (2011).	appropriate
Abnormal fetal heart rate or Doppler studies		On diagnosis. Will require urgent same day review in Triage or Maternity Day Unit
Fetal Abnormality		At diagnosis. Individual plan of care formulated
Request from woman or midwife for consultant clinic review		As appropriate depending upon individual circumstances

Antenatal Thromboprophylaxis-Risk Assessment & Management

Tick the risk factors on the left and tick the action plan on the right. Document plan for thromboprophylaxis in notes - this tool to be completed at **Booking, Antenatal Admission, Within 24 hours of Admission, and if Any Change in Clinical Circumstances as an In-patient.**
Please check for contraindications to Anticoagulation and TEDS on Appendix 8.

Name of patient: …….. **Hospital Number: .....** **DOB: .....**
Date: … / … / …… **Time of Assessment: ……** **Booking:** ☐
At admission ☐ (Complete Form); **Within 24 hours** ☐ Any Change: Yes ☐ No ☐
If any change in 24 hours-complete a new form and document the plan clearly in the notes.

- Single previous VTE + ☐
  -thrombophilia or family history
  -Unprovoked/estrogen related
- Previous recurrent VTE ☐

→ **High Risk** ☐
Requires antenatal prophylaxis with LMWH + TEDS ☐
Refer To trust nominated thrombosis in pregnancy expert/team if in doubt, refer to full guideline

- Single previous VTE with no family history or thrombophilia ☐
- Asymptomatic Thrombophilia (Inherited or acquired and no VTE) ☐
- Prolonged hospital admission ☐
- Current Medical Co-morbidity: heart or lung disease, SLE, cancer, inflammatory conditions, nephrotic syndrome, sickle cell disease, intravenous drug user ☐
- Current/Recent Surgical procedure

→ **Intermediate Risk** ☐
Consider AN prophylaxis with LMWH + TEDS ☐
Seek advice from trust nominated thrombosis in pregnancy expert/team if in doubt

- Age > 35 years ☐
- Obesity (BMI > 30 kg/m^2) ☐
- Parity 3 or> 3 ☐
- Smoker ☐
- Gross varicose veins ☐
- Current systemic infection ☐
- Immobility (≥3 days), paraplegia, long distance travel (> 4 hours),SPD ☐
- Pre-eclampsia ☐
- Dehydration, Hyperemesis ☐
- OHSS ☐
- Multiple pregnancy ☐

→ 3 or more risk factors ☐
2 or more risk factors if admitted ☐

→ < 3 risk factors ☐

→ **Lower risk** ☐
Mobilisation and avoidance of dehydration

Appendix 7

Maidstone and Tunbridge Wells NHS
NHS Trust

ANTENATAL BOOKING NOTIFICATION

NAME
ADDRESS POSTCODE CONTACT PHONE NUMBER DOB EDD
Dr……MIDWIFE……

Dear GP/Health Visitor for your records:

The above patient has been booked for antenatal care.

She has been booked for:

MIDWIFERY LED CARE / CONSULTANT SHARED CARE
(Delete as appropriate)

AT MAIDSTONE / PEMBURY HOSPITAL/OTHER UNIT
(Delete as appropriate)

She is currently weeks pregnant.
I have arranged all routine scans at 12 and 20 weeks. I will continue to undertake all further antenatal and postnatal care.

Comments/Relevant information

If you are aware of any further medical, past obstetric or social history that you feel could be of relevance to her care could you please fax this information to the Midwifery Liaison Office, 01892 633718 or discuss with the relevant community midwife.
Thank you

Signature ……Community Midwife
Midwifery Liaison Office - Maidstone 01892 638158 Pembury 01892 633488

APPENDIX EIGHT

FAMILY BACKGROUND QUESTIONNAIRE

MIDWIVES – Please ensure that these questions are asked at an appropriate time during the booking interview. If any of the questions reveal significant information concerning the woman or her partners background, then a Concern & Vulnerability form must be completed. This form should be attached to the Concern & Vulnerability form.
For all women copies of this form should be placed in the woman's hospital notes (send it in with the booking paperwork), and to the health visitors at 20/40 along with their information sheet.

Woman's name and hospital number:-

1.	What is your partner's name & date of birth? Is he the father of the baby? If not please include the fathers details as well.	
2.	Do you live at the same address? If not what is his address?	
3.	Do you or your partner have any children together?	
4.	Does your partner have any children with a previous partner?	
5.	Do they live with you? Do you or your partner have contact with them. If not, is there a reason for this?	
6.	What are their names and date of birth of your partner's other children? (if known)	Name D.O.B
7.	If these children do not live with you, with whom do they live?	
8.	Have you or your partner ever had any contact with Social Services including as a child?	

9.	Do either you or your partner have any learning difficulties? If so, how does this affect you?	

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Antenatal Clinical Risk Assessment Including Referral to Consultant Led Care

Requested/ Required by: Women's and Children's Directorate

Main author: Lead Midwife, Antenatal Clinic (BA)

Midwife (TC)

Other contributors: Matron for Community & Outpatient's Midwifery (AM)
Consultant Obstetrician (MM)
Maternity Community Team Leads
Postnatal Manager/Supervisor of Midwives (SP)
Maternity Day Unit Sister (LH)

Document lead: CNST Maternity Co-ordinator (AC)

Contact Details: ext 33514

Supersedes: Antenatal Clinical Risk Assessment (2009); Version 1.0 and Referral for Consultant Led Care

Approved by: Delivery Suite Forum **Date:** 26th September 2011

Ratified by: Clinical Risk Management Group **Date:** 6th October 2011

Review date: October 2014

Document History

Requirement for document:	To ensure that clinical risks are identified and individual management plans are developed appropriately for women who require them. 2011/12 Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards; Standard 4, Criterion 3.
Cross References / Associated Documents:	**Associated Documents:** Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Antenatal Booking Appointments.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). Care *of the Obese Woman in Pregnancy.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Care of Women in Labour (incorporating Clinical Risk Assessment in Labour)*. Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines Maidstone & Tunbridge Wells NHS Trust Maternity. (2010). Children's *Safeguarding Policy & Procedure.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Criteria for Giving Birth in the Birth Centre or at Home*. Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Diabetes in pregnancy.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines MTW publication 'Having your baby: Choosing the right care for you' (2011) Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Maternity Training Strategy & Training Needs Analysis.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Mental Health Problems in pregnancy.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines

Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Missed Antenatal Appointments*. Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines

Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Obstetric Haemorrhage*. Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines

Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Operational Policy for Birth Centre*. Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines

Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). Record Keeping and management of health records. Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines

Maidstone & Tunbridge Wells NHS Trust Maternity. (2008). *Schedule of antenatal visits in low risk women.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines

Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Vaginal birth after caesarean section.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines

Maidstone & Tunbridge Wells NHS Trust Maternity. (2011). *Venous thromboembolism (VTE) in pregnancy. Prophylaxis, Diagnosis and Management.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines

Maidstone & Tunbridge Wells NHS Trust Maternity. (2008). *Women who decline blood or blood products.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines

Cross References:

Confidential Enquiry into Maternal and Child Health. (2007). *Saving Mothers' Lives. Reviewing maternal deaths to make motherhood safer – 2003-2005*. London: CEMACH available at www.cemace.org.uk

Confidential Enquiry into Maternal and Child Health. (2004). Why Mothers Die 2000-2002. London: RCOG Press. Available at: www.cemace.org.uk

Confidential Enquiry into Stillbirths and Deaths in Infancy**.** (2001) *8th Annual Report*. London: CESDI. Available at : www.cemace.org.uk

National Institute for Health and Clinical Excellence (2008). *Antenatal care: routine care for the healthy pregnant woman.*

London: NICE. Available at www.nice.org.uk

National Institute for Health and Clinical Excellence (2007). *Intrapartum care: Care of healthy women and their babies during childbirth.* London: NICE. Available at www.nice.org.uk

National Institute for Health and Clinical Excellence (2010). *Pregnancy and complex social factors. A model for service provision for pregnant women with complex social factors.* London: NICE. Available at www.nice.org.uk

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists. (2004). *Thromboprophylaxis during pregnancy, labour and after vaginal delivery*. London: RCOG. Available at: www.rcog.org.uk

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	First version of document	August 2009
2.0	Revised and updated to take account of service reconfiguration changes and include the guideline for Referral to Consultant Led Care	October 2011
2.1	Inclusion of new form for Antenatal Risk Assessment for Low Risk Care	November 2013

Policy Statement for

Antenatal Clinical Risk Assessment Including Referral to Consultant Led Care

Women with high risk factors or potential complications should be offered and advised on the referral pathways available to them

All risk assessments should be documented

Maidstone & Tunbridge Wells NHS Trust recognise that women should be offered a choice on place of birth. However consideration should be given to all risk factors that could affect the advice given to women when making this decision

Antenatal Clinical Risk Assessment, including Referral for Consultant Led care

Contents

Seven	

5.0 Introduction and Scope of Procedural Document

This guideline applies to all midwifery and obstetric staff caring for antenatal women.

Risk Assessment must be ongoing and reviewed at each antenatal visit.

This document is produced to ensure that women are appropriately risk assessed for maternity care, that risk is reviewed at each contact and an individual management plan is developed for women in whom risks are identified.

The Maternity Service provided to women by Maidstone & Tunbridge Wells NHS Trust was reconfigured in September 2011. Inpatient services for high risk women were transferred to the Tunbridge Wells Hospital at Pembury (TWH) with the Neonatal Unit also based at TWH.

Women are offered the following:

Low risk women may choose to give birth at TWH, at home or the new midwife-led Birth Centre at Maidstone

A range of outpatient maternity services including Antenatal Clinics, Obstetric Ultrasound and a Maternity Day Unit, continue to be offered at both TWH and Maidstone Hospital. These will be accessed, as appropriate by both high and low risk pregnant women in each geographical area.

6.0 Definitions

Low Risk – women who are identified by risk assessment as suitable for midwifery led care during their pregnancy

High Risk – women who are identified by risk assessment as having a condition or problem that require them to have additional care during their pregnancy

7.0 Duties

It is the registered professional's responsibility to deliver care that is based on current evidence, always acting in the patient's best interests.

The midwife and obstetrician have a duty to assess risk throughout the antenatal period and modify care plans accordingly

8.0 Training / Competency Requirements

No specific training required for implementation of this guideline. However, midwives and obstetricians have mandatory annual updates on antenatal screening and care of vulnerable clients.

Refer to MTW Guideline: (See page 2 for full reference)
●Maternity Training Strategy & Training Needs Analysis Matrix

9.0 **Procedure**

5.1 Timing of Risk Assessment:

The initial risk assessment is carried out at the booking appointment by discussion with the woman about her medical, obstetric and social history.
The Euroking questionnaire and hand held maternity records are used to record this information and helps to identify any risk factors.

All contacts between a pregnant woman and the maternity service require a further assessment of risk to occur. At the end of each consultation the next appointment is planned according to this risk assessment.
Refer also to MTW Guideline: (referenced on page 2)

- Antenatal Booking Appointments

5.2 Factors to be Considered when Assessing Risk

The following factors should be considered:

- Medical conditions, including anaesthetic history
- Factors from previous pregnancies
- Lifestyle and psychiatric history

See 'Referals for Consultant Led care/Factors to consider when planning place of birth' table at Appendix 4 for list of conditions for which referral should be considered, together with the potential timing of an initial obstetric (or other suitable professional) opinion. The most appropriate timing for each referral will be planned according to a woman's individual circumstances.

5.2.1 Special cases

- When women have **additional needs** such as communication problems or learning difficulties assessment of their risk must reflect these challenges
- Women must be identified at booking who will **decline blood or blood products** and Consultant referral made to ensure that the risks are discussed and understood and the woman's decision documented

Refer to: MTW Guidelines: (referenced on pages 2 and 3)

- Obstetric Haemorrhage
- Women who decline blood or blood products

5.3 Risk Assessment for Appropriate Place of Birth

Discussion about the woman's choice regarding place of birth will begin at the booking appointment. She should be informed about her options in relation to her individual risk factors and appropriate supporting literature issued, which may include MTW publication 'Having your baby: Choosing the right care for you'. These risks

may change during the course of the pregnancy and may alter the professional's advice about the suitability of each birth place option.

All discussions about choice of place of birth should be documented in the woman's hand held maternity record.

Low risk women booked to deliver with Maidstone & Tunbridge Wells NHS Trust (MTW) should be offered the choice of planning birth at home, at the midwifery- led Maidstone Birth Centre or the obstetric unit at Tunbridge Wells Hospital at Pembury (TWH). TWH offers both low risk midwifery-led and high risk obstetric-led care. NICE guidelines (2007) for Intrapartum care (referenced on page 2) provide comprehensive tables for identifying increased risk factors when discussing place of birth. These risk factors have been incorporated within the 'Referrals for Consultant Led care/Factors to consider when planning place of birth' table at Appendix 4.

If a woman opts to have a planned home birth, her midwife will arrange to visit at home to discuss the arrangements and to complete the Antenatal Risk Assessment Form for Low Risk Care pro-forma at booking, and then again at 36 weeks. (See Appendix 5). A woman is entitled to request a home birth, however where risk factors have been identified, the midwife must discuss the potential risks with the woman and document this clearly in the woman's Pregnancy Hand Held Record. The midwife should recommend the woman has a further joint discussion with a consultant obstetrician or consultant midwife or supervisor of midwives (see Pathway for Risk Assessment in Pregnancy at Appendix 6). If the woman requests to give birth at home against medical advice full support must be given to those midwives who will be providing care. A case management discussion should take place involving community midwife, consultant midwife, supervisor of midwives and obstetrician to ensure a plan is made and available to all staff likely to be involved.

If a woman wishes to deliver at the Birth Centre, her community midwife will complete the Antenatal Risk Assessment Form for Low Risk Care pro-forma at booking and notify the Birth Centre with a copy of this form. The same Antenatal Risk Assessment Form is completed again by the community midwife at the 36 week antenatal check and a copy sent to the Birth Centre. The completed form will be reviewed by the Birth Centre Manager/Consultant Midwife as an extra check regarding suitability for birth in the Birth Centre. A woman with pregnancy complications/risk factors will not be able to give birth in the Birth Centre.

Out of area women wishing to deliver at the Birth Centre will be invited to attend the Centre for their routine 36 week antenatal check. This check will be combined with the completion of the Antenatal Risk Assessment Form for Low Risk Care to ensure each individual fits the criteria for birthing at the Centre.

A copy of the completed Antenatal Risk Assessment Form for Low Risk Care, with details of the discussion and decisions made, is placed in the:

- Maternal hand held maternity notes
- Home birth folder on Triage at TWH for planned home births in the Tunbridge Wells community area and a further copy in the home birth folder in the TWH Community Midwives' office
- Home birth folder in the Community Midwives' office at Maidstone Birth Centre for planned home births in the Maidstone community area

so that this information is available to any midwife who may care for the woman in labour and to the midwives who may give advice when the mother makes contact at the onset of labour.

For further guidance regarding issues raised in this section (5.3) refer also to MTW Guidelines (referenced at pages 2 and 3)

- Operational Policy for Birth Centre
- Criteria for Giving Birth in the Birth Centre or at Home
- Care of Women in Labour (incorporating Clinical Risk Assessment in Labour)

5.4 Development of an Individual Management Plan for Women in Whom Risks are Identified

- Depending on the condition, consultant care visits should be planned on an individual basis, with women empowered to make informed decisions and choices

- CEMACH (2007) states that all women should receive care that is embedded in the local maternity network, ensuring they have an individualised care pathway.

- The Individual Management Plan formulated for any woman where risks have been identified should be discussed and agreed with her during a consultation.

- The appropriate MTW guidelines should be accessed via the DATIX system if required.

- The Individual Management Plan should be documented in the woman's maternity notes and confirmation obtained that it is understood by the woman

- If the woman **declines** to proceed with the recommended Individual Management Plan, it is important that it is clearly documented what has been recommended, with the rationale, and then clear documentation is made of what alternative Plan has been arranged

- It is recommended that an Individual Management Plan for women who **decline to follow recommended care** is circulated to relevant staff, to ensure that appropriate preparation can be arranged where necessary and to ensure that there is no conflict of advice.

5.5 Process for Referral in Pregnancy following clinical risk assessment

5.5.1 Process for referral following midwifery booking

- The booking form printed by Euroking and sent to the Antenatal Clinic (ANC) following booking, contains an area for the midwife to complete the risk

assessment and to request the appropriate referral e.g. consultant ANC (the majority of medical problems), teenage pregnancy midwife, healthy weight in pregnancy clinic midwife or other appropriate professional.

- When the booking form is received at ANC, the ANC midwife will review the risk assessment and confirm that the appropriate referrals are made for the appropriate gestation

See'Referals for Consultant Led care/Factors to consider when planning place of birth' at Appendix 4 for table of conditions for which referral should be considered.
Refer also to MTW Guideline: (referenced at page 2)

- Antenatal Booking Appointments (2011)

Woman Identified as Low Risk-

- Booking appointment (ideally between 6-10 weeks)
- Community Midwife based antenatal care

Woman Identified as High Risk

- Booking appointment (ideally between 6-10 weeks)
- Additional care may be provided in the consultant ANC or midwifery based care services, e.g. healthy weight in pregnancy clinic, teenage pregnancy service, screening coordinators, midwifery clinics or with the consultant midwife

5.5.2 Process for referral following GP consultation

- If a woman attends her GP for confirmation of the pregnancy, a referral is made to the community midwife in the community base.
- If the woman has a known medical problem (e.g. diabetes) the GP may send a written referral to the hospital, but all of these are directed to the ANC. The ANC will contact the community midwife to arrange the booking and the above referral route can then occur

5.5.3 Process for referral during pregnancy

- During pregnancy, any signs of deviation from normal identified by the midwife or GP should be referred to the appropriate grade of medical staff either via the on-call bleep or via an appointment in the consultant antenatal clinic (depending on the severity and nature of the risk identified)

- Advice can always be sought from the ANC or Triage/Delivery Suite staff

Referrals can be

- G.P. to Consultant (especially in early pregnancy)
- Midwife referral either by letter, by telephone or by entry into the maternity notes to consultant or middle grade obstetrician
- Obstetrician to another professional, e.g. cardiologist, psychiatrist, obstetrician in previous pregnancy
- Midwife / GP / obstetrician to: Smoking cessation team
  Teenage pregnancy midwives
  Healthy weight in pregnancy clinic team
  Specialist ultrasound clinic

Physiotherapist
via appropriate Referral Proformas
MTW Maternity Guidelines may be accessed via the Datix Guidelines system on the Trust intranet. Each Guideline will outline the referral requirements for a particular condition or risk.

5.6 Referral Back to Midwifery Led Care when appropriate
When a woman has been referred for obstetric opinion and the assessment of the risk changes to low risk she may be referred back to midwifery led care. See also 'Pathway for Risk Assessment in Pregnancy' at Appendix Six extracted from the Operational Policy for Birth Centre.

This change of risk and care plan should be documented by:

- Use of maternal hand held maternity notes
- Letter to Community midwife / GP if necessary

The mother will be informed of the assessment and advised to make an appointment with her midwife at the appropriate time.
Refer also to MTW Guideline: (referenced on page 3)

- Operational Policy for Birth Centre

5.7 Documentation of all of the above: all risk factors, related discussions and individual management plans must be documented in the maternity records where clinically relevant.
Refer to MTW Guideline: (referenced on page 3)

- Record Keeping and management of health records

10.0 Monitoring and Audit

Key elements of this guideline will be audited by the Directorate using the Audit Tool at Appendix Seven

Monitoring Table – Antenatal Clinical Risk Assessment

Element to be monitored	Lead for monitoring	Tool and role of the multidisciplinary team	Frequency	Reporting arrangements	Action Lead(s) for change	Change in practice and lessons to be shared
Appropriate documented risk assessment at booking and during pregnancy considering factors as outlined in this guideline including ●medical conditions ●anaesthetic history ●psychiatric history ●factors from previous pregnancies ●lifestyle history	Lead midwife, Antenatal clinic/ designated person	1% of maternity notes will be reviewed by a team of midwives and obstetricians using the Audit Tool at Appendix Seven	Annual	Feedback to Community team leads meeting reporting to Delivery Suite Forum reporting then to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.

●identification of women who will decline blood and blood products						
Risk Assessment for appropriate place of birth undertaken and documented	Lead midwife, Antenatal clinic/ designated person	1% of maternity notes will be reviewed by a team of midwives and obstetricians using the Audit Tool at Appendix Seven	Annual	Feedback to Community team leads meeting reporting to Delivery Suite Forum reporting then to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.
Individual management plan made and documented for women in whom risks are identified	Lead midwife, Antenatal clinic/ designated person	1% of maternity notes of high risk women will be reviewed by a team of midwives and obstetricians using the Audit Tool at Appendix Seven	Annual	Feedback to Community team leads meeting reporting to Delivery Suite Forum reporting then to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.

Appropriate referral made and documented for women in whom risks are identified	Lead midwife, Antenatal clinic/ designated person	1% of maternity notes of high risk women will be reviewed by a team of midwives and obstetricians using the Audit Tool at Appendix Seven	Annual	Feedback to Community team leads meeting reporting to Delivery Suite Forum reporting then to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.
Process followed for referral back to midwifery led care if appropriate	Lead midwife, Antenatal clinic/ designated person	1% of maternity notes will be reviewed by a team of midwives and obstetricians using the Audit Tool at Appendix Seven	Annual	Feedback to Community team leads meeting reporting to Delivery Suite Forum reporting then to Clinical Risk Management Group (CRMG)	Matron for Community and Outpatients/ designated person	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.

APPENDIX ONE

Process Requirements

4.0 Implementation and Awareness

4.1 Once approved this policy/procedural document will be published on the Trust intranet by the CNST Maternity Co-ordinator or Maternity Secretary (as appropriate).
4.2 A monthly publications table will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust intranet) under "Trust Publications", and notification of the posting will be included on a bi-weekly notification email circulated Trust wide by the COMMS team.
4.3 On receipt of the Trust wide Bulletin board notification, all managers should ensure that their staff members are aware of the new publications.
4.4 On publication of any Maternity document, the CNST Maternity Co-ordinator will ensure that an email is sent to all Maternity staff and other stakeholders, as appropriate.
4.5 Women & Children's Clinical Governance Newsletter (Quarterly publication)
4.6 Dissemination from staff team meetings
4.7 Delivery Suite Notice Boards or Guideline Folders (as appropriate)

5.0 Review

5.1 It is essential that Trust Policy/procedural documents remain accurate and up to date; this policy/procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure. It is the responsibility of the Document Lead for this policy/procedure to ensure this review is undertaken in a timely manner.
5.2 The Document Lead should review the policy/procedure and, even when alterations have not been made, undertake the consultation process as detailed in **Section 5.5 Consultation** of MTW Policy and Procedure '*Production, Approval and Implementation of Policies and Procedures*'.

6.0 Archiving

3.1The Trust Intranet retains all superseded files in an archive directory in order to maintain document history.

3.2 Old paper guideline copies pre-dating Datix are stored at:
Chatham Archive & Storage document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634 826665

APPENDIX TWO

CONSULTATION ON: Antenatal Clinical Risk Assessment, including Referral to Consultant Led Care

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: CNST Maternity co-ordinator.

By date: 3rd October 2011 **(**all documents must undergo a minimum of two weeks consultation)

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Consultant Obstetricians	21/09/11	Sept 11 Oct 11 (MPM & SA)	Y	Y
Consultant Paediatricians	21/09/11			
Consultant Anaesthetists (Obstetric Leads)	21/09/11			
Head of Midwifery/Associate Director of Nursing	21/09/11	Oct 11	Y	Y
Supervisors of Midwives	21/09/11			
Matrons for Maternity Inpatient and Outpatient Services	21/09/11			
Clinical Manager for Governance & Risk	21/09/11			
Maternity Clinical Risk Manager	21/09/11			
Consultant Midwife	21/09/11			
Midwifery Staff via Drafts for Comments on Datix	21/09/11			
Maternity Team Leads including Antenatal Clinic and Maternity Day Unit	21/09/11	Sept 11	Y	Y
Clinical Governance Assistant	21/09/11			
Local Counter Fraud Specialist	21/09/11			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Antenatal Clinical Risk Assessment, including Referral to Consultant Led care
What are the aims of the policy or practice?	To ensure best practice care for women receiving antenatal care
Identify the data and research used to assist the analysis and assessment	See Cross references on page 2
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no).
Males or Females	Applies to women only
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	No
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	When the policy is reviewed which as a minimum is every three years
Where do you plan to publish the results of your Equality Impact Assessment?	As an appendix of this guideline on Datix Guidelines (Trust intranet)

APPENDIX FOUR

Referrals for Consultant Led care /Factors to consider when planning place of birth

The following tables are intended to assist practitioners in assessing individual pregnancy risk, both at booking and at all subsequent pregnancy contacts with the maternity service. The tables are integral to **MTW Guideline 2011 Clinical Risk Assessment (Antenatal)** and practitioners are advised to familiarise themselves with the contents of this guideline.

In Summary:

Low Risk women are identified by risk assessment as suitable for midwifery led care during their pregnancy.

High Risk women are identified by risk assessment as having a condition that requires them to have additional care during their pregnancy which will be Consultant led. In certain circumstances, women referred for consultant led care utilising the high risk indicators identified below, may be returned to midwifery care having received individual obstetric assessment, and in consideration of their desired place of birth.
Depending on the condition, consultant care visits should be planned on an individual basis, with women empowered to make informed decisions and choices. An individualised care pathway should be formulated and documented. Advice may be sought from the Antenatal Clinic team.

General health & pre-existing medical conditions	Specific condition (s)	Gestation at which ANC appt is likely to be offered or other consultation undertaken
Maternal age	Teenage pregnancy 40 or over	Referred to Teenage Pregnancy Midwife for booking, seen in ANC as appropriate Refer to ANC. Appt as appropriate
Additional needs	Assessment of risk should reflect the challenges of women with communication problems or learning difficulties	High risk referral will depend on individual circumstances
Body Mass Index (BMI)	Less than 18 kg/M2 35 kg/M2 or more	20/40 20/40 Additionally for referral to Healthy Weight in Pregnancy Midwife
Congenital		First trimester appt

abnormality		with Screening Co-ordinator
Family history of genetic Disorder		First trimester appt with Screening Co-ordinator
Previous gynaecological history	Myomectomy or major gynaecological surgery including to pelvic floor, hysterotomy or perforation of the uterus Previous cervical suture Cone biopsy or large loop excision of the transformation zone Fibroids	20/40 12/40 12/40 20/40 after ultrasound scan
Cardiovascular	Confirmed cardiac disease Requiring or not requiring treatment or antibiotics in labour. Hypertensive disorders	12/40 or other dependent upon individual circumstances 12/40
Respiratory	Asthma requiring an increase in treatment or hospital treatment Cystic fibrosis	16/40 First trimester
Endocrine	Hyperthyroidism or Hypothyroidism Pre-existing Diabetes History of Gestational Diabetes	16/40 with TFT results 8/40 with advice from Diabetic Specialist Nurse 18/40 GTT
Renal	Abnormal renal function Renal disease requiring renal specialist Supervision	Upon diagnosis First trimester
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident Other neurological deficits	12/40 12/40 12/40 Dependent upon individual circumstances
Gastrointestinal	Liver disease associated with or without current abnormal liver function tests	First trimester or as appropriate depending upon

		individual circumstances
	Crohn's disease or Ulcerative colitis	Dependent on individual circumstances
Haematological	Haemoglobinopathies: sickle-cell disease, Beta-thalassaemia major	8-10/40 appt with Screening Co-ordinator
	History of thromboembolic disorders Increased VTE risk	8-10/40
	Persistent anaemia	Depending upon individual circumstances
	Immune Thrombocytopenia purpura or other platelet disorder or platelet count below 100,000	20/40
	Von Willebrand's disease or other clotting disorder	20/40
	Atypical antibodies which carry a risk of haemolytic disease of the newborn.	Following antibody titre levels from Tooting. Will be seen within 2 weeks
	Atypical antibodies which do not put newborn at risk of haemolytic disease	As appropriate dependent upon individual circumstances
	Identification of women who will decline blood and blood products	As appropriate dependent upon individual circumstances
Infective	Risk factors associated with Group B Streptococcus whereby antibiotics in labour would be recommended	As appropriate dependent upon individual circumstances
Infective (cont)	Hepatitis B or C carrier	12/40 appt with Screening Co-ordinators

	Carrier of/infected with HIV Toxoplasmosis – women receiving treatment Current active infection of chicken pox/rubella/first episode of genital herpes Tuberculosis under treatment	12/40 12/40 with Screening Co-ordinator or following diagnosis if infected during pregnancy 12/40 with Screening Co-ordinator or following diagnosis if infected during pregnancy First trimester
Cancer		Dependent upon individual circumstances
Skeletal	Spinal abnormalities Previous fractured pelvis	20/40 20/40
Psychiatric & Social issues increasing vulnerability in pregnancy	Psychiatric disorder requiring current inpatient care Personal history of psychosis/puerperal psychosis/bipolar disorder or schizophrenia Family history of bipolar disorder or puerperal psychosis Any identified factors that may make a woman more vulnerable in pregnancy including women on medication for depression or a personal history of self-harm Issues that have been raised in the pregnancy for example lack of social support, suspected domestic violence, issues raised on Concern & Vulnerability form when consultant input or opinion is felt appropriate	Emergency referral 12/40 12/40 Appt depending upon individual circumstances Appt depending upon individual circumstances
Previous anaesthetic problems		May require anaesthetist input during pregnancy. Dependent upon

		individual circumstances
Previous pregnancy complications		
Pregnancy loss	Women with significant pregnancy loss including: Recurrent miscarriage (3 or more) mid trimester loss, stillbirth, IUD, NND, previous death related to intrapartum difficulty or morbidity	Placed under Consultant care and management plan made according to individual circumstances
Neonatal concern	Previous term baby with jaundice requiring exchange transfusion	20/40
Hypertensive related disorders	Pre-eclampsia requiring preterm birth Eclampsia HELLP syndrome	20/40 20/40 20/40
Placental abruption		20/40
Uterine	Uterine rupture Caesarean section	20/40 20/40 (referral as appropriate to Birth Options Clinic prior to ANC appt)
Third stage related	Primary post partum haemorrhage (more than 1litre or any amount requiring additional treatment or transfusion) Retained placenta requiring manual removal in theatre.(*May be considered for home or birth centre birth if placenta removed from vagina or 3rd stage mismanagement a contributory factor*)	20/40 20/40
Previous delivery problems	Including shoulder dystocia, difficult or traumatic delivery	20/40
Previous baby more than 4.5 kg		28/40 GTT Consultant input as appropriate
Previous extensive vaginal,		20/40

cervical or third or fourth degree perineal trauma		

Factors relating to current pregnancy		**Gestation at which ANC appt is likely to be offered or alternative consultation undertaken**
Grand multiparity	4 or more previous births	20/40
Multiple birth		20/40 MCMA at 16/40 following ultrasound
Placenta praevia		34/40 after USS
Hypertensive disorders	Pre-eclampsia or pregnancy induced hypertension	Will be reviewed by on-call team at diagnosis and individual plan of care made
Preterm	Preterm labour Preterm pre-labour rupture of membranes	With Consultant input as inpatient ANC as appropriate following inpatient admission. Individual plan of care formulated
Mal-presentation	Breech or transverse lie after 36 weeks of pregnancy	Following diagnosis
Anaemia	Haemoglobin less than 10 g/dl at onset of labour	Consultant input as inpatient
Induction of Labour		Appt as appropriate in ANC to discuss depending on individual circumstances
Unbooked in		Placed under

this pregnancy		Consultant Care upon presentation. ANC follow up if prelabour
Onset of gestational diabetes		Following diagnosis. Initial appt will be with Diabetes Nurse Specialist
Lifestyle factors/ Substance misuse, drug or alcohol dependency requiring assessment or treatment		Placed under consultant care and plan of care formulated depending upon individual circumstances
Confirmed intrauterine death		Placed under Consultant care at diagnosis and individual management plan formulated
Fetal indications	Small for gestational age in this pregnancy or slowing in growth – refer for prompt USS assessment of growth, liquor and Doppler studies if SFH 3 cms or more **below** expected for gestation	Placed under Consultant care following diagnosis of restricted growth or oligohydramnios. Clinician reviewing ultrasound results will formulate appropriate plan of ongoing care.
	SFH 3cms or more **above** expected for gestation on 2 occasions. Refer for prompt USS of growth and liquor volume	Placed under Consultant care following diagnosis of polyhydramnios and/or fetal growth on 95th centile or above. Clinician reviewing ultrasound results will formulate appropriate plan of ongoing care
Fetal indications (cont)	Large or small fetus identified on scans undertaken privately	Following review of scan results by midwife in community-led clinics

Recurrent Antenatal Admissions **Recurrent non-attendance at CMW appts for low risk women**	Women self-referring for example to Triage or MDU for assessment three or more times, and then discharged as NAD. Refer to MTW Guideline Missed Antenatal Appts (2011).	Seen in ANC as appropriate Seen in ANC as appropriate
Abnormal fetal heart rate or Doppler studies		On diagnosis. Will require urgent same day review in Triage or Maternity Day Unit
Fetal Abnormality		At diagnosis. Individual plan of care formulated
Request from woman or midwife for consultant clinic review		As appropriate depending upon individual circumstances

ANTENATAL RISK ASSESSMENT FORM FOR LOW RISK CARE Appendix Five

Complete at booking and 34 weeks for all women planning Birth Centre or homebirth

Name: Address: Postcode: Hospital Number: NHS number Home phone number: Mobile phone number: Work phone number	GP Surgery Ethnic origin Interpreter required: Yes / No Gravida Para Date of birth Age Confirmed EDD
Midwifery Led Care	**Consultant led care** **Reason**

PLACE OF BIRTH – WOMAN'S CHOICE circle below as appropriate

34 weeks

Birth Centre

Home

Any Risk factors identified from Risk assessment indicators (see overleaf)

Request Main Hospital notes from Antenatal Clinic Tina Usher or Yvonne Ellender # 24293

(on receipt place in notes tray office shelf)

Place this assessment in 'Ladies for Risk Assessment file' as usual

IF BIRTH CENTRE OR HOMEBIRTH IS CHOSEN

Have risks of transfer been discussed?
(Nulliparous women 30%, Multiparous women 8-10%): Yes / No

Aware that no medical/obstetric/paediatric or epidural services are available at Birth Centre and that if any of these services are required, the woman must be transferred to Tunbridge Wells Hospital Yes or No

Additional information (e.g. directions to home if home birth etc) Yes / No

Woman's name (printed): Woman's signature:

FORM COMPLETED BY

Signature **Print name** **Designation**

Date

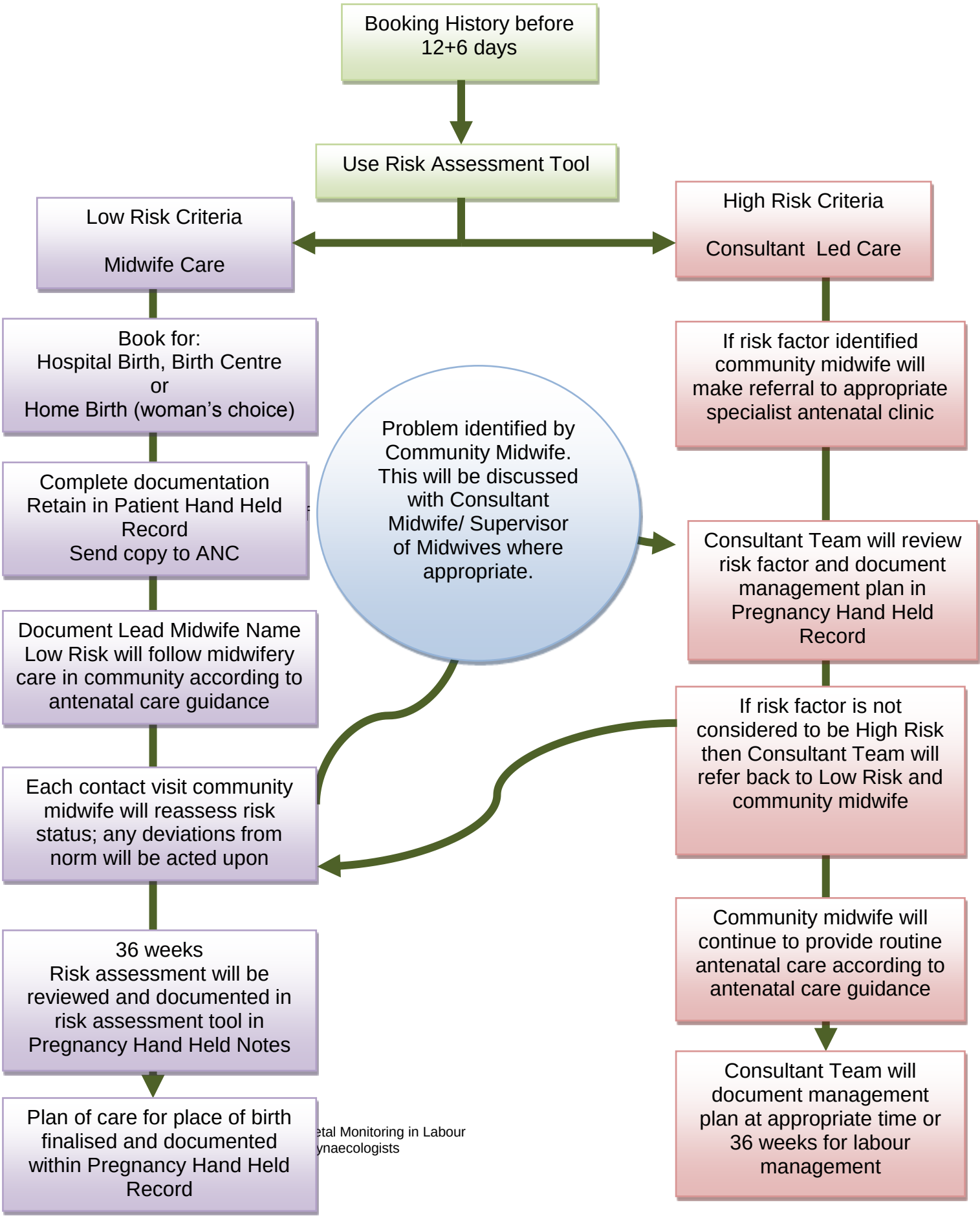
AGREED SUITABLE FOR BIRTH CENTRE: Name / Signature / Date

RISK FACTORS BELOW INDICATE REFERRAL TO CONSULTANT FOR PLAN OF CARE	
Maternal age < 16 & > 40 at term (nulliparous woman only) BMI <18 or >35 Parity of 4 or more	Drug / alcohol dependency Learning disability Physical disability Multiple pregnancy
PAST AND PRESENT MEDICAL HISTORY	
Hypertension Cardiac disease Renal or liver disease Epilepsy Anaemia Hb <10 gm / dl Diabetes Asthma (severe) Spinal, pelvic or back trauma	Clotting disorder / Thromboembolism Crohn's disease / Ulcerative Colitis MS or other active neurological problem Carcinoma Thyroid dysfunction Blood disorder (sickle cell / APS / Lupus / Autoimmune) Mental health problems
PAST GYNAECOLOGICAL HISTORY	
Fibroids Uterine Anomaly	Cervical cone biopsy and loop Sexually transmitted disease (last year)
FAMILY HISTORY First degree relative with :	
Diabetes (Does not require a referral but GTT should be arranged at 28 weeks) Cardiac abnormality	Haemoglobinopathies Genetic abnormality Ataxia
PREVIOUS OBSTETRIC HISTORY	
Previous spontaneous 2nd trimester abortion 3 consecutive miscarriages Previous birth weight < 10th centile Previous delivery < 36 weeks Stillbirth / neonatal death IUGR Shoulder dystocia Caesarean section Difficult instrumental delivery Pre eclampsia	Congenital abnormality Placental abruption / praevia Retained placenta Rhesus antibodies / incompatibility Cholestasis Gestational diabetes Previous abnormal GTT Previous 3 degree tear Pre-existing continence problems Anaemia <9.0g / dl
COMPLICATIONS ARISING DURING CURRENT PREGNANCY	
Blood group antibodies Positive VDRL / Hep B or C / HIV Distorted HCG / AFP / UE3 Hypertension Proteinurea without UTI Anaemia ,10gm Abnormal GTT Small for dates Reduced fetal movements	Low lying placenta (after 34 weeks) Oligo / Poly hydramnios Malpresentation after 36 weeks Confirmed chicken pox / rubella/ parvo infection Group B Strep Any mental health concerns Any other C and V concerns? Other
Risk assessment is a continuous process and should be undertaken at every contact **Completed form to be faxed to antenatal clinic, birth centre and then filed at front of antenatal notes**	
Date and Signature of person completing form	

Maidstone and Tunbridge Wells NHS
NHS Trust

APPENDIX SIX

Pathway for Risk Assessment in Pregnancy



Appendix Seven
APPENDIX SEVEN

Audit Tool for Antenatal Clinical Risk Assessment

Hospital Number ……

Criteria	Yes/No/Not applicable	Comments
Clinical risk assessment undertaken at booking and documented in maternity notes (completion of Euroking questionnaire)		
Evidence of documented ongoing antenatal clinical risk assessment within maternity notes (refer to 5.1 of guideline)		
Medical conditions considered and documented in risk assessment within maternity notes		
Anaesthetic history considered and documented in risk assessment within maternity notes		
Psychiatric history considered and documented in risk assessment within maternity notes		
Factors from previous pregnancies considered and documented in risk assessment within maternity notes		
Lifestyle history considered and documented in risk assessment within maternity notes		
Criteria	**Yes/No/Not Applicable**	**Comments**

Documented evidence of whether blood or blood products will be declined within maternity notes		
Evidence of documented risk assessment for appropriate place of birth within maternity notes		
Individual Management Plan developed and documented within maternity notes for women in whom risks are identified during clinical risk assessment		
Women, in whom risks are identified during clinical risk assessment, are appropriately referred. Evidence of referral is documented within maternity notes		
Women who may return to midwifery led care following obstetric review are appropriately referred. Evidence of referral is documented within maternity notes.		

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Auscultation & Continuous Electronic Fetal Monitoring in Labour

Requested/ Required by: Women's Directorate

Main author: Consultant Obstetrician & Gynaecologists (MPM, SA, LF)

Other contributors: Obstetric Registrar (HC)

	Midwife and Supervisor of Midwives (SP)
Document lead:	CNST Maternity Co-ordinator (AC) **Contact Details:** ext 33154
Division:	Women & Children's
Specialty:	Obstetrics & Gynaecology
Supersedes:	Auscultation & Continuous Electronic Fetal Monitoring in Labour (Version 4.0: October 2011)
Approved by:	Guideline Group **Date:** 21st September 2012
Ratified by:	Clinical Risk Management Group **Date:** 3rd October 2012
Review date:	October 2015

Document history

Requirement for document:	To comply with national recommendations for good practice • Clinical Negligence Scheme for Trusts Maternity Standards 2012/13, Criteria 1.2.2 and 1.2.3 • Annual audit required
Cross references:	○ Fitzpatrick T, Holt L. (2008). '*A 'buddy' approach to CTG'.* The Royal College of Midwives Journal. Oct/Nov: pp 40-41. ○ National Institute for Health and Clinical Excellence. (2004). *Caesarean Section.* London: NICE. Available at: www.nice.org ○ National Institute for Health and Clinical Excellence. (2007). *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE. Available at: www.nice.org.uk ○ Royal College of Anaesthetists, Royal College of Midwives, Royal

	College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press. Available at: www.rcog.org.uk ○ Royal College of Midwives. (2008) *Midwifery practice Guideline Fetal Heart Rate Monitoring.* London: RCM. Available at: www.rcm.org.uk ○ Royal College of Obstetricians & Gynaecologists. (2007) Birth After previous Caesarean section. London: RCOG. Available at: www.rcog.org.uk
Associated documents:	• Maidstone & Tunbridge Wells NHS Trust Maternity. *Training Strategy.* Trust Intranet, Policies & Guidelines • Maidstone & Tunbridge Wells NHS Trust Maternity. *Fetal Blood Sampling.* Trust Intranet, Policies & Guidelines

Version Control:		
Issue:	**Description of changes:**	**Date:**
2.0	Replaces two guidelines: Fetal Monitoring - in Labour (2005) Fetal Monitoring – Interpretation of CTG's (2005)	November 2009
3.0	Advice from MDA/2010/054	August 2010
4.0	Reviewed. Amendments to address service reconfiguration and update	October 2011
5.0	Reviewed. Minor amendments to include collating CTG stickers into one (Fresh eyes, Routine & Concerns). Agreement in Maternity Forum (Sept 2012)	October 2012

Policy Statement for

Auscultation & Continuous Electronic Fetal Monitoring in Labour

Maidstone & Tunbridge Wells NHS Trust Women's Services recognises the need for an approved system for improving care and learning lessons relating to continuous electronic fetal monitoring in labour that is implemented and monitored.

The monitoring of the fetal heart rate in labour aims to identify hypoxia before it is sufficient to lead to long-term poor neurological outcome for babies. When risk factors are identified or develop in labour, consideration should be given to the use of continuous electronic fetal monitoring.

Obstetric litigation is expensive not solely due to the number of obstetric litigation cases, which have actually decreased as a percentage of total clinical negligence claims, but due to the nature of the injury or disabilities caused by obstetric incidents. In particular, neurological damage to a fetus, which may result in the cost of the provision of a lifetime of care, makes this an area of high risk and high claims costs. Whilst the numbers of such cases are small, the potential in terms of cost is massive.

Auscultation & Continuous Electronic Fetal Monitoring in Labour

Contents

11.0 Introduction and scope

This guideline applies to all Trust midwives and obstetricians caring for women in labour.

The document outlines when electronic fetal monitoring should be undertaken rather than intermittent auscultation and the actions required to ensure fetal monitoring is appropriately carried out, documented and acted upon when necessary.

Appropriate monitoring of the fetal heart rate in labour aims to identify hypoxia before it is sufficient to lead to long-term poor neurological outcome for babies.

The Maternity Service provided to women by Maidstone & Tunbridge Wells NHS Trust was reconfigured in September 2011. Inpatient services for high risk women were transferred to the Tunbridge Wells Hospital at Pembury (TWH) with the Neonatal Unit also based at TWH.

Women are offered the following:

- Low risk women may choose to give birth at TWH, at home or the new midwife-led Birth Centre at Maidstone
- A range of outpatient maternity services including Antenatal Clinics, Obstetric Ultrasound and a Maternity Day Unit, continue to be offered at both TWH and Maidstone Hospital. These will be accessed, as appropriate by both high and low risk pregnant women in each geographical area.

12.0 Definitions

Intermittent Auscultation: where the fetal heart is listened to and the rate measured by means of a Pinard stethoscope or by hand held Doppler device (sonicaid).

Continuous Electronic Fetal Monitoring (Cardiotocograph): where the fetal heart rate and maternal uterine activity is continuously recorded and printed on graph paper.

13.0 Duties

Midwifery staff have a duty to monitor and document the fetal heart rate appropriately when a woman is in labour. In the presence of any abnormalities it is the midwife's responsibility to inform the obstetrician and ensure that further assessment is undertaken.

Obstetric staff are responsible for the assessment of and any action required following any abnormalities detected in the fetal heart rate.

14.0 Training / competency requirements

All midwifery and obstetric staff have access to regular updates regarding fetal monitoring and have mandatory training required every 6 months.

Refer to: MTW Guidelines, Training Strategy. (See page 2 for full reference)

15.0 Procedure for auscultation in all care settings & continuous electronic fetal monitoring in hospital / consultant led service in labour

5.1 Equipment required for fetal monitoring

The following options are available and should be employed as appropriate to the care setting and relevant risk factors:

1. **Pinard stethoscope:** a simple trumpet shaped device which when applied to the mother's abdomen amplifies the fetal heart sound to the ear of the professional

2. **"Sonicaid" / Doppler USS machine:** a hand held, battery operated device with "microphone" which transmits the fetal heart sound to the speaker attachment. The professional is thus able to listen to the heart sounds. Some of these devices will calculate and display the fetal heart rate and some are waterproof, enabling the fetal heart to be monitored when the mother is in water
3. **Cardiotocograph:** an electronic machine which transmits, displays and records the fetal heart sound and maternal abdominal pressure, via transducers applied to the maternal abdomen. This enables the continuous recording of the fetal heart rate as it corresponds to maternal uterine contractions and gives printed documentation. Staff should familiarise themselves with the manufacturer's instruction for the CTG machine.

5.2 Intermittent auscultation

For a woman who is healthy and has had an uncomplicated pregnancy, intermittent auscultation (I.A.) should be offered and recommended to monitor fetal wellbeing in labour.

I.A. can be performed using either a Sonicaid/Doppler USS or a Pinard and the method must be clearly documented within the records.

The maternal pulse should be palpated simultaneously with the fetal heart rate (FHR) every hour and documented, in order to differentiate between maternal and fetal heart rates.

In addition, **if an abnormality in the fetal heart rate is detected,** the maternal pulse must be palpated simultaneously and the rate recorded.

In active labour the FHR should be auscultated for a *minimum of 60 seconds* after a contraction and at least:

- Every 15 minutes in the first stage
- Every 5 minutes in the second stage

The FHR should be documented in the maternal notes following each auscultation, with maternal pulse recorded hourly.

When to transfer from intermittent auscultation to continuous electronic fetal monitoring:

If there are any FHR Abnormalities on I.A:

- Baseline <110 bpm or >160 bpm
- There is evidence of decelerations
- Refer to 5.4 for indications for electronic fetal monitoring
- If there is a transfer for I.A. to CEFM, the **indication for this should be clearly documented in the notes**

5.3 Continuous EFM

Prior to commencing CTG monitoring the following process should occur:

- Explain the reason for fetal monitoring to the woman
- Ensure an abdominal palpation is performed and findings recorded
- Maternal pulse should be palpated simultaneously with the fetal heart rate and recorded on the CTG in order to differentiate between maternal and fetal heart rate

- Confirm fetal heart rate using independent means prior to commencing by using Pinard's stethoscope or hand held doppler, and when there is any uncertainty over the fetal heart rate
- If CTG discontinued or interrupted, fetal heart and maternal pulse should be differentiated again at re-commencement and documented on CTG recording.

Staff should be aware that the ultrasound may pick up the maternal pulse from the aorta, iliac or uterine artery. The FHR displayed will then actually be the maternal heart rate (MHR). **Sometimes the maternal artery movement is double counted so MHR x 2 is displayed. This can be within the same range as the expected FHR and can be more difficult to interpret.** The resulting trace shows reactivity and variability due to MHR changes and muscle contractions and can be difficult to distinguish from FHR.

The date and time clocks on the monitor should be checked prior to each use to see that they are correctly set and the paper speed is running at 1cm/min.

Traces should be labelled with:

- Woman's name
- Date and time
- Hospital number
- Maternal pulse and blood pressure
- Reason for continuous electronic fetal monitoring
- The CTG sticker **i.e. CTG Check List (attach to start of CTG Trace) in Appendix 6** should be completed and attached at the start of any Intrapartum CTG.

Intrapartum events that may affect the FHR (e.g. VE, FBS, change in maternal position, epidural siting or top up, administration of pethidine, maternal pyrexia) should be noted contemporaneously (at the time) on the trace, signed and time noted.

Maternal pulse should be palpated simultaneously with the fetal heart rate and recorded on CTG trace if any abnormalities of the fetal heart rate are observed. Staff should also consider the use of continuous recording of maternal pulse rate to check that maternal heart rate is not being mistaken for fetal heart rate when rates are similar.

Any member of staff who is asked to provide an opinion on a trace should note his or her findings on both the trace and the maternal notes, including actions to be taken and/or plan of care. The small CTG sticker available in **Appendix 7** should be completed and stuck onto the CTG tracing if an opinion is requested and provided. The plan/actions should be written in the notes and a brief note can be made on the CTG sticker with regards to the plan due to the minimal space available on the sticker. It is important that the CTG tracing should not be obscured in any way by the sticker and the sticker is not pasted over the perforated area of the CTG. If there is concern that the sticker will cover any information, then the details should be handwritten on the CTG rather than using the sticker. If the CTG sticker is not available, the same details may be handwritten on the CTG.

Systematic assessment of the CTG should be documented hourly. This should be based on the guideline for the Interpretation of CTG (see **5.6**) and documented in the notes using pro forma stickers provided in antenatal and intrapartum care

settings. The baseline rate, baseline variability, accelerations and decelerations must be included.

The CTG should be reviewed by a second professional every hour and a "fresh eyes" sticker completed. The small CTG sticker must also be completed and pasted on the CTG at the same time. If the CTG sticker is not available, the same details may be handwritten on the CTG.

Following delivery (on completion of the CTG tracing), sign the trace and record date, time and mode of birth. The trace should be stored securely in the brown envelope and filed in the medical notes (not the maternity booklet). The CTG sticker in appendix 6 (**CTG Check List (attached to End of CTG Trace))** may be completed and attached to the end of the CTG trace following delivery, or the details may be written at the end of the tracing.

<u>If at any point the CTG tracing is discontinued or interrupted for any reason details must be recorded and signed at the end of the trace, and CTG stored as above.</u>

Please see next page as to when continuous EFM is required. The list is not exhaustive. If in doubt, discuss with the obstetric middle grade.

5.4 Indications for use of continuous electronic fetal monitoring (EFM)

Continuous EFM (i.e. CTG) should be offered and recommended where any of the following risk factors are present (list not exhaustive):

1) FHR Abnormalities on I.A.
- Baseline <110 bpm or >160 bpm
- There is evidence of decelerations (**5.5**, Interpretation of CTG)

2) Maternal
- Previous LSCS
- Hypertension (>140/90 on more than two readings)
- Prolonged rupture of membranes (>24 hours)
- Induced labour (unless initial CTG following ARM or prostaglandin normal and no other risk factors)
- Diabetic women on insulin
- Antepartum haemorrhage after 24 weeks gestation
- Other maternal medical disease - consideration
- Maternal request

3) Fetal
- Fetal growth restriction - suspected from SFH<3cm from dates or proven on USS measurement
- Prematurity – however gestation between 24-26 weeks should be discussed with obstetric middle grade or consultant prior to commencing trace
- Oligohydramnios
- Abnormal doppler studies
- Multiple pregnancy
- Meconium stained liquor
- Breech presentation
- Post-term pregnancy (>42 weeks)

4) Intrapartum
- Oxytocin augmentation

- Epidural analgesia
- Vaginal bleeding in labour
- Maternal pyrexia
    - 38.0 C on one occasion or 37.5 C on two occasions two hours apart

5.5 Definitions and Description of CTG

BASELINE FHR	The mean level of the FHR when this is stable, excluding accelerations and decelerations. It is determined over a time period of 5 or 10 minutes. Preterm fetuses tend to have values towards the upper end of this range. A trend to a progressive rise in the baseline is important as well as the absolute values.
NORMAL BASELINE FHR	110-160 bpm
MODERATE BRADYCARDIA	100-109 bpm
MODERATE TACHYCARDIA	161-180 bpm
ABNORMAL BRADYCARDIA	<100 bpm
ABNORMAL TACHYCARDIA	>180 bpm
BASELINE VARIABILITY	The minor fluctuations in baseline FHR occurring at three to five cycles per minute. It is measured by estimating the difference in beats per minute between the highest peak and lowest trough of fluctuation in a one-minute segment of the trace.
NORMAL BASELINE VARIABILITY	≥ 5 bpm between contractions
NON-REASSURING BASELINE VARIABILITY	< 5 bpm for 40 minutes or more but less than 90 minutes
ABNORMAL BASELINE VARIABILITY	< 5 bpm for 90 minutes or more
ACCELERATIONS	Transient increases in FHR of 15 bpm or more and lasting 15 seconds or more. The significance of no accelerations on an otherwise normal trace is unclear
DECELERATIONS	Transient episodes of slowing of FHR below the baseline of 15 bpm or more and lasting for 15 seconds or more
EARLY DECELERATIONS	Uniform, repetitive, periodic slowing of FHR with onset early in the contraction
LATE DECELERATIONS	Uniform, repetitive, periodic slowing of the FHR with onset mid to end of contraction and nadir more than 20 seconds after the peak of the contraction and ending after the contraction. In the presence of a non-accelerative trace with baseline variability < 5 bpm, the definition would include decelerations < 15 bpm

VARIABLE DECELERATIONS	Variable, intermittent periodic slowing of FHR with rapid onset and recovery. Time relationships with contraction cycles are variable and they may occur in isolation. Sometimes they resemble other types of deceleration in timing and shape.
ATYPICAL VARIABLE DECELERATIONS	Variable decelerations with any of the following additional components: 1) Slow return to baseline FHR after end of contraction 2) Prolonged secondary rise in baseline rate 3) Biphasic deceleration 4) Loss of variability during deceleration Continuation of baseline rate at lower level
PROLONGED DECELERATION	An abrupt decrease in FHR to levels below the baseline that last at least 60-90 seconds. These decelerations become pathological if they cross two contractions, i.e. greater than 3 minutes
SINUSOIDAL PATTERN	A regular oscillation of the baseline long-term variability resembling a sine wave. This smooth, undulating pattern, lasting at least 10 minutes, has a relatively fixed period of 3-5 cycles per minute and an amplitude of 5-15 bpm above and below the baseline. Baseline variability is absent.

5.6 Interpretation of CTG

The trace should be interpreted using the Dr C BRAVADO mnemonic.

DR	**Define Risk**	high or low risk, eg. Previous CS
C	**Contractions**	number in 10 minutes
BRA	**Baseline Rate**	as per NICE definitions
V	**baseline Variability**	as per NICE definitions
AD	**Accelerations or Decelerations**	as per NICE definitions
O	**Overall impression**	Normal, Suspicious, Pathological

5.7 Categorisation of the CTG

The interpretation of the FHR trace should be divided into two aspects. First by categorisation of the fetal heart rate ***features*** and then by categorisation of the overall fetal heart rate ***trace***.

5.8 Classification of FHR trace features

Feature	Baseline (bpm)	Variability (bpm)	Decelerations	Accelerations

Reassuring	110–160	≥ 5	None	Present
Non-reassuring	100–109 161–180	< 5 for 40– 90 minutes	Typical variable decelerations with over 50% of contractions, occurring for over 90 minutes Single prolonged deceleration for up to 3 minutes	The absence of accelerations with otherwise normal trace is of uncertain significance
Abnormal	< 100 > 180 Sinusoidal pattern ≥ 10 minutes	< 5 for 90 minutes	Either atypical variable decelerations with over 50% of contractions or late decelerations, both for over 30 minutes Single prolonged deceleration for more than 3 minutes	The absence of accelerations with otherwise normal trace is of uncertain significance

5.9 Definition of normal, suspicious and pathological FHR traces

Category	Definition
Normal	An FHR trace in which all four features are classified as reassuring
Suspicious	An FHR trace with one feature classified as non-reassuring and the remaining features classified as reassuring
Pathological	An FHR trace with two or more features classified as non-reassuring or one or more classified as abnormal

Refer to **5.5** for definitions and descriptions of specific FHR trace features.

True early uniform decelerations are rare and benign and therefore are not significant.

If repeated accelerations are present with reduced variability, the FHR trace should be regarded as reassuring.

A tachycardia in the baby of 160-180 bpm where accelerations are present and no other adverse features appear should not be regarded as suspicious.

5.10 Actions to be taken in the event that the tracing is assessed as suspicious or pathological / management of labour in presence of abnormal FHR patterns (NICE Guidance)

When completing the Intrapartum CTG sticker in the notes - complete the checklist of actions below as appropriate. The small CTG sticker for the tracing should be pasted on the tracing, but the actions need to be completed in the notes sticker / records.

1. The senior midwife and/or middle grade obstetrician on duty should always be made aware of any deviations from a normal trace.
2. Consider correctable causes depending on the clinical situation:
    - position – adopt left lateral position

- hypotension – i.v. fluids
- recent VE
- tachycardia – correct depending on cause
- pyrexia – paracetamol and i.v. fluids as appropriate
- recent siting or topping up of epidural
- recent SRM – check for cord prolapse
- vaginal bleeding

3. If a bradycardia occurs in the baby for more than 3 minutes, clinical assessment should be made and preparations should be made to expedite delivery, if appropriate. This could include moving the woman to theatre if the fetal heart has not recovered by 9 minutes. If the fetal heart recovers within 9 minutes the decision to deliver should be reconsidered in conjunction with the woman if reasonable.

4. If uterine hyper contractility in absence of syntocinon consider 0.25mg terbutaline subcutaneously.

5. If Oxytocin running:
    - suspicious trace – for obstetric review; but may continue to increase oxytocin until contractions 4:10
    - pathological trace – stop oxytocin; for obstetric review

6. If fetal death suspected with recordable trace, perform ultrasound scan.

7. Fetal blood sampling (FBS) is advised in the presence of a pathological FHR trace unless there is evidence of acute fetal compromise (i.e. prolonged deceleration > 3 min) in which case immediate delivery would be advised. The decision for fetal blood sampling should be made by the obstetrician if clinically appropriate.

Refer to: MTW Maternity Guidelines, Fetal Blood Sampling (see page 2 for full reference)

6.0 Monitoring and audit (of this policy/procedure)

An audit of the minimum requirements related to this guideline should be annual, the results should be reviewed in a multidisciplinary forum and the action plans monitored. A basic audit tool is attached in **Appendix 4**.

6.0: Monitoring and audit (continued)

Elements of this guideline will be audited by the Women's Directorate using the audit tool in Appendix 4

Monitoring - Auscultation and Electronic Fetal Monitoring in Labour

Key Elements to be monitored	Lead	Tool	Frequency	Reporting arrangements	Action Lead(s)	Change in practice and lessons to be shared
Whether women have been correctly assigned to the'Intermittent Auscultation' or 'Continuous Electronic Fetal Monitoring' group	Lead Midwife for Delivery Suite/other person designated by the audit team	Multidisciplinary audit of 1% of maternity notes using audit tool in Appendix 4	Annually	Findings from audit are reported to Delivery Suite Forum, presented at Clinical Governance Meeting, Junior Doctors Teaching and reported to Clinical Risk Management Group	Obstetric Lead for Clinical Risk Management or Lead Midwife Delivery Suite or as designated by the audit team	Required changes to practice will be identified and actioned by lead designated by the Clinical Risk Management Group Required changes to be taken to labour ward meetings, CTG training sessions, clinical governance meetings with time frame for changes identified
Whether the maternal pulse and fetal heart were appropriately monitored and documented (both IA and continuous CTG)	Lead Midwife for Delivery Suite/other person designated by the audit team	Multidisciplinary audit of 1% of maternity notes using audit tool in Appendix 4	Annually	Findings from audit are reported to Delivery Suite Forum, presented at Clinical Governance Meeting, Junior Doctors Teaching and reported to Clinical Risk Management Group	Obstetric Lead for Clinical Risk Management or Lead Midwife Delivery Suite or as designated by the audit team	Required changes to practice will be identified and actioned by lead designated by the Clinical Risk Management Group Required changes to be taken to labour ward meetings, CTG training sessions, clinical governance meetings with time frame for changes identified

Whether the indication for transfer from intermittent auscultation to continuous fetal heart monitoring was documented in the notes and on the CTG	Lead Midwife for Delivery Suite/other person designated by the audit team	Multidisciplinary audit of 1% of maternity notes using audit tool in Appendix 4	Annually	Findings from audit are reported to Delivery Suite Forum, presented at Clinical Governance Meeting, Junior Doctors Teaching and reported to Clinical Risk Management Group	Obstetric Lead for Clinical Risk Management or Lead Midwife Delivery Suite or as designated by the audit team	Required changes to practice will be identified and actioned by lead designated by the Clinical Risk Management Group Required changes to be taken to labour ward meetings, CTG training sessions, clinical governance meetings with time frame for changes identified
Whether documentation regarding fetal monitoring has met standards set out in guideline	Lead Midwife for Delivery Suite/other person designated by the audit team	Multidisciplinary audit of 1% of maternity notes using audit tool in Appendix 4	Annually	Findings from audit reported to Delivery Suite Forum, Clinical Risk Management Group, at Clinical Governance Meeting, Junior Doctors Teaching	Obstetric Lead for Clinical Risk Management or Lead Midwife Delivery Suite or as designated by the audit team	Required changes to practice will be identified and actioned by lead designated by the Clinical Risk Management Group Required changes to be taken to labour ward meetings, CTG training sessions, clinical governance meetings with time frame for changes identified

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Action Lead(s)	Change in practice and lessons to be shared
Whether guideline was followed in event of abnormal fetal heart rate pattern	Lead Midwife for Delivery Suite/other person designated by the audit team Lead Midwife for Delivery Suite	Multidisciplinary audit of 1% of maternity notes from each site using audit tool in Appendix 4	Annually	Findings from audit reported to Delivery Suite Forum, at Clinical Governance Meeting, Junior Doctors Teaching reporting to Clinical Risk Management Group	Obstetric Lead for Clinical Risk Management or Lead Midwife Delivery Suite or as designated by the audit team	Required changes to practice will be identified and actioned by lead designated by the Clinical Risk Management Group Required changes to be taken to labour ward meetings, CTG training sessions, clinical governance with time frame for changes identified meetings
Compliance with mandatory multidisciplinary update every 6 months on fetal monitoring and interpretation of CTG	Consultant Midwife	Review of training database	Monthly	Findings reported to Clinical Risk Management Group	Clinical Skills Facilitators	Action taken to follow up non attendance and dates rebooked to ensure completion of training

APPENDIX ONE

Process requirements

7.0 Implementation and awareness

7.1 Once approved this policy/procedural document will be published on the Trust intranet.
7.2 A monthly publications table will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust intranet) under "Trust Publications", and notification of the posting will be included on a bi-weekly notification email circulated Trust wide by the COMMS team.
7.3 On receipt of the Trust wide Bulletin board notification, all managers should ensure that their staff members are aware of the new publications.
7.4 On publication of any Maternity document, the CNST Maternity Co-ordinator will ensure that an email is sent to all Maternity staff and other stakeholders, as appropriate.
7.5 Women & Children's Clinical Governance Newsletter (Quarterly publication)
7.6 Dissemination from staff team meetings
7.7 Delivery Suite Notice Boards or Guideline Folders (as appropriate)

8.0 Review

8.1 It is essential that Trust Policy/procedural documents remain accurate and up to date; this policy/procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure. It is the responsibility of the Document Lead for this policy/procedure to ensure this review is undertaken in a timely manner.
8.2 The Document Lead should review the policy/procedure and, even when alterations have not been made, undertake the consultation process as detailed in **Section 5.5 Consultation** of MTW Policy and Procedure '*Production, Approval and Implementation of Policies and Procedures*'.

9.0 Archiving

3.1 The Trust Intranet retains all superseded files in an archive directory in order to maintain document history.
3.2 Old paper guideline copies pre-dating Datix Guidelines are stored at:
Chatham Archive & Storage document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634 826665

APPENDIX TWO

CONSULTATION ON: Auscultation & Continuous Electronic Fetal Monitoring in Labour

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: CNST Maternity Co-ordinator

By date: *16Th October 2011 (all documents must undergo a minimum of two weeks consultation). In August, September & October 2012 circulated to Consultant Obstetricians responsible for development of guideline.*

Name: Name: *List key staff appropriate for the document under consultation. Select from the following:*	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Consultant Paediatricians	3/10/11			
Consultant Obstetricians	03/10/11			
Consultant Anaesthetists	03/10/11			
Head of Midwifery / ADN	03/10/11	Oct 2011	Y	Y
Matrons – Inpatient & Community	03/10/11			
Clinical Manager for Governance & Risk	03/10/11			
Maternity Risk Manager	03/10/11			
Supervisor of Midwives	03/10/11			
Midwifery Staff via drafts for comments on Datix	03/10/11			
Team Leads	03/10/11			
Clinical Governance Assistant	03/10/11			
Counter Fraud Specialist	03/10/11			
Circulated to authors/contributors to guideline	20/08/12 onwards to Oct 2012	20/08/12 onwards	N (agreed changes to CTG sticker)	N
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Auscultation & Continuous Electronic Fetal Monitoring in Labour
What are the aims of the policy or practice?	The monitoring of the fetal heart rate in labour aims to identify hypoxia before it is sufficient to lead to long-term poor neurological outcome for babies.
Identify the data and research used to assist the analysis and assessment	See references page 2
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	No
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	**Yes**
When will you monitor and review your EqIA?	With review of the guideline, which as a minimum is every three years
Where do you plan to publish the results of your Equality Impact	With publication of this guideline on the Trust Q-Pulse Policy & Guideline system

Assessment?	

APPENDIX FOUR

Audit Tool for Fetal Monitoring Guideline

Hospital Number ……..

Indication for Continuous Electronic Monitoring Identified	Yes ☐	No ☐
Date and time checked on the CTG machine	Yes ☐	No ☐
Woman's name	Yes ☐	No ☐
Date and time	Yes ☐	No ☐
Hospital Number	Yes ☐	No ☐
Maternal Pulse	Yes ☐	No ☐
Blood Pressure	Yes ☐	No ☐
Intrapartum Events; Timed and signed	Yes ☐	No ☐
Documentation of any opinion required on CTG	Yes ☐	No ☐
Documentation of any opinion required on notes	Yes ☐	No ☐
Grade	Yes ☐	No ☐
Signature	Yes ☐	No ☐
Name	Yes ☐	No ☐
Time	Yes ☐	No ☐
Date	Yes ☐	No ☐
Impression	Yes ☐	No ☐
Plan	Yes ☐	No ☐
Hourly systematic assessment of the trace on stickers	Yes ☐	No ☐
Data added when CTG was completed	Yes ☐	No ☐
Signature	Yes ☐	No ☐
Date of Delivery	Yes ☐	No ☐
Time of Delivery	Yes ☐	No ☐
Mode of Delivery	Yes ☐	No ☐
Cord pHs	Yes ☐	No ☐
Actions to be taken if CTG is Suspicious or Pathological	Yes ☐	No ☐
When CTG is Abnormal		
Maternal Pulse documented	Yes ☐	No ☐
Senior midwife or Obstetrician informed	Yes ☐	No ☐
Correctable causes considered	Yes ☐	No ☐
Appropriate action taken	Yes ☐	No ☐

APPENDIX FIVE

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

CTG Sticker
Date: Time:
Normal / Suspicious / Pathological
Plan:
Name:
Designation:
Signature:

APPENDIX SIX

CTG Check List (attach to start of CTG Trace)

Indication for CTG:

Gestation:

Date: Time:

Date set correctly on CTG:

Time set correctly on CTG:

Paper speed set to 1cm/min:

Maternal Pulse: Maternal BP:

FH Auscultated prior to CTG:

Patient Name:

Hospital Number:

(or attach Mother's Label)

CTG Check List (attach to End of CTG Trace)

Date of Delivery:

Time of Delivery:

Mode of Delivery:

Cord Ph and Base Excess

Arterial:

Venous:

Name:

Signature:

Designation:

APPENDIX SEVEN

CTG REVIEW: Fresh Eyes / Routine / Concerns

Date: Time:
Maternal pulse: Contractions:
Baseline rate: Variability:
Accelerations: Decelerations:

Overall impression:
Normal / Suspicious / Pathological

Actions if Suspicious/Pathological:
Obstetric Review □ Senior Midwife Review □
Consider Correctable causes □ Terbutaline □
Reduce Oxytocin □ Stop Oxytocin □
Fetal Blood Sampling □ Check FH with USS □
Prepare for Delivery □ Transfer to theatre □

Partogram reviewed: Yes / No (circle)

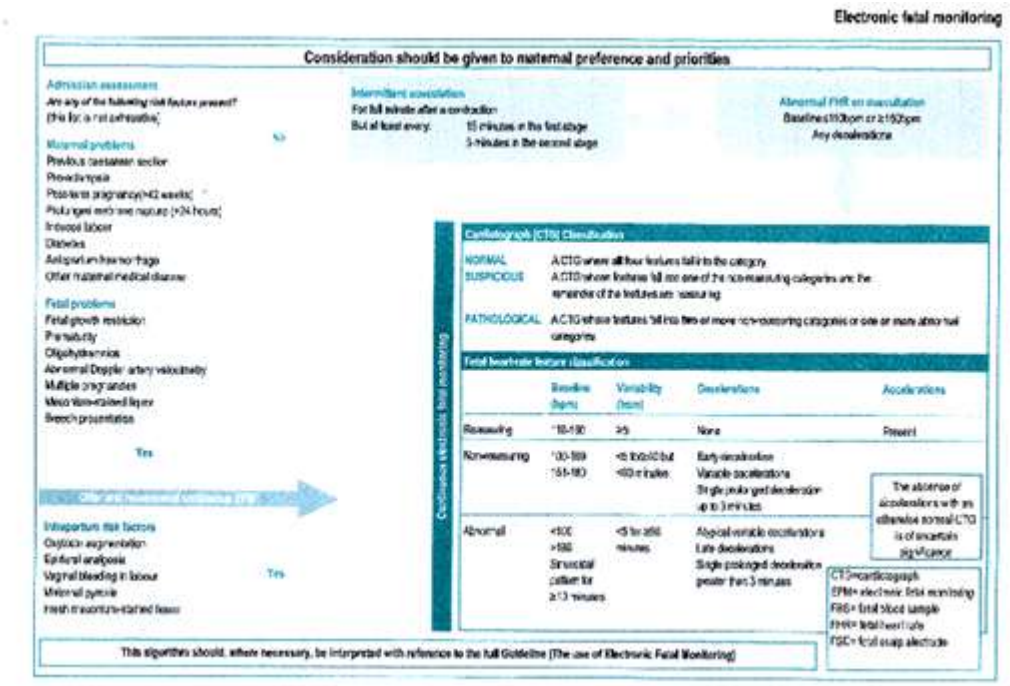
Signature: …….. Print name: ……
Designation: ……..

Classification of CTG

The intended use of this CTG classification system is to suggest clinical conditions in which adjunctive use of ST waveform changes may aid the interpretation of specific CTG patterns.

	Baseline heart frequency	Variability Reactivity	Decelerations
Normal CTG	• 110–150 bpm	• Accelerations • 5–25 bpm	• Early uniform decelerations • Uncomplicated variable decelerations with a duration of <60 sec and loss of <60 beats
Intermediary CTG	• 100–110 bpm • 150–170 bpm • Short bradycardia episode (<100 bpm for ≤3 min)	• >25 bpm (saltatory pattern) • <5 bpm >40 min with absence of accelerations	• Uncomplicated variable decelerations with a duration <60 sec and loss of >60 beats
	A combination of several intermediary observations will result in an abnormal CTG		
Abnormal CTG	• 150–170 bpm and reduced variability • >170 bpm • Persistent bradycardia (<100 bpm for >3 min)	• <5 bpm for >60 min • Sinusoidal pattern	• Complicated variable decelerations with a duration of >60 sec • Repeated late uniform decelerations
Preterminal CTG	• Total lack of variability (<2 bpm) and reactivity with or without decelerations or bradycardia		

APPENDIX NINE



MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Guideline for Operative Vaginal Delivery

Requested/ Required by:	Women's & Sexual Health Directorate
Main author:	Consultant Obstetrician (WO)
Other contributors:	Consultant Obstetrician & Gynaecologist (SA)
	Clinical Manager for Governance & Risk (PD)
Document lead:	Consultant Obstetrician (WO)
	Contact Details: wunmi.ogunnoiki@nhs.net
Supersedes:	Operative Vaginal Delivery (2011); Version 2.0
Approved by:	Guideline Group **Date:** 11 May 2015
Ratified by:	Clinical Risk Management Group **Date:** 13 May 2015

Review date: May 2018

Document History

Requirement for document:	To comply with national recommendations for good practice: • NICE guidance • RCOG guidance • CNST Maternity Clinical Risk Standards 2011/12, Standard 3, Criterion 3
Cross References / Associated Documents:	**Cross-references:** Trust Intranet, Q-Pulse Document Storage system, Women & Children's Procedures Database: 1. MTW. (2011). Guideline for neonatal admissions to Neonatal Unit 2. MTW. (2012). Auscultation & Continuous Electronic Fetal Monitoring in Labour 3. MTW. (2013). Venous Thromboembolism (VTE) in Pregnancy and Puerperium: Prophylaxis, Diagnosis and Management **Associated Documents:** Healthcare Commission. (2008). *Towards better births: A review of maternity services in England.* London: Commission for Healthcare Audit and Inspection. Available at: www.healthcarecommission.org.uk King's Fund. (2008). *Safe Births: Everybody's business - Independent Inquiry into the Safety of Maternity Services in England*.

London: King's Fund. Available at: www.kingsfund.org.uk

National Institute for Health and Clinical Excellence. (2006). *Routine postnatal care of women and their babies*. London: NICE. Available at: www.nice.org.uk

National Institute for Health and Clinical Excellence. (2007). *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE. Available at: www.nice.org.uk

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Paediatrics and Child Health. (2008). *Standards for Maternity Care: Report of a Working Party.* London: RCOG Press. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists. (2007). *Operative Vaginal Delivery*. London: RCOG. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists. (2011). *Operative Vaginal Delivery*. London: RCOG. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists. (2008). *Obtaining Valid Consent.* London: RCOG. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists. (2008). *Presenting Information on Risk.* London: RCOG. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists. (2010) Operative Vaginal Delivery (Consent Advice 11). London: RCOG Press. Available at: www.rcog.org.uk

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	First iteration of clinical guideline	November 2009
2.0	Amendments to address service reconfigurations and address recent recommended changes in practice	October 2011
3.0	Three year review and update.	October 2014 – May 2015

Policy Statement for

Operative Vaginal Delivery

Maidstone & Tunbridge Wells NHS Trust recognises that there is an increasing awareness of the potential for morbidity for both the woman and the newborn relating to Operative Vaginal Delivery. Caesarean section in the second stage of labour however, also carries significant risk of morbidity and implications for future births.

The aim is to offer women the option of a safe operative vaginal delivery, performed by an operator with the knowledge, experience and skills necessary to use the instruments and manage complications that may arise.

Operative Vaginal Delivery

Contents

16.0 Introduction and Scope of Procedural Document

The aim of this guideline is to provide up to date information on the use of the forceps and vacuum extractor for both rotational and non rotational operative vaginal deliveries. Obstetricians should be confident and competent in the use of both instruments. The RCOG recommends that obstetricians achieve experience in spontaneous vaginal delivery prior to commencing training in operative vaginal delivery. The goal of operative vaginal delivery is to mimic spontaneous vaginal birth, thereby expediting delivery with a minimum of maternal or neonatal morbidity.

2.0 Definitions

The following is the classification for operative vaginal delivery (from RCOG – adapted from ACOG 2000)

Outlet	Fetal scalp visible without separating the labia Fetal skull has reached the pelvis floor Sagittal suture is in the AP diameter or right or left occipito-anterior position. (rotation does not exceed 45 degrees)
Low	Leading point of the skull (not caput) is at station plus 2 cm or more below the ischial spines but not on the pelvic floor. Two subdivisions: a. rotation of 45 degrees or less b. rotation of more than 45 degrees
Mid	Fetal head is 1/5th palpable per abdomen Leading point of the skull is at station plus 2cm but not above ischial spines Two subdivisions: a. rotation of 45 degrees or less b. rotation of more than 45 degrees
High	Not included in classification

3.0 Duties

It is the registered professional's responsibility to ensure that they have the knowledge, experience and skills necessary to use the instruments and manage any complications that may arise.

The anatomy of the birth canal and the fetal head must be understood as a prerequisite to becoming skilled in the safe use of the forceps or vacuum extractor.

4.0 Training / Competency Requirements

All instrumental deliveries should be performed or supervised by Middle Grade staff or Consultant level. ST1/2 Doctors should rarely do a delivery unsupervised unless they have proven competency in the technique. Acting up Middle grade staff are not permitted to supervise operative vaginal deliveries.

Doctors new to the department complete a self assessment competency log with their Clinical Tutor at induction; their personal learning log will also be reviewed.

5.0 Operative Vaginal Delivery

5.1 Introduction

Assisted vaginal delivery is an important skill for managing the second stage of labour overall. Operative vaginal delivery rates vary between 10% and 15%.There is the potential for morbidity for both the mother and the baby.

5.2 Background

There has been increasing awareness of the potential for morbidity for both the mother and the baby. The risk of traumatic delivery in relation to forceps, particularly rotational procedures, has been long established, although with careful practice overall rates of morbidity are low. In 1998, the US Food and Drug Administration (FDA) issued a warning about the potential dangers of delivery with the vacuum extractor. This followed several reports of infant fatality secondary to intracranial haemorrhage. In addition, there has been a growing awareness of the short and the long term morbidity of pelvic floor injury following operative vaginal delivery. It is not surprising, therefore, that there has been an increase in litigation relating to obstetric delivery. Caesarean section in the second stage of labour, however, also carries significant morbidity and implications for future births.

5.3 Who can perform the procedure?

All instrumental deliveries should be performed or supervised by Middle grade staff or Consultants. Staff should clearly document their designation and grade within the woman's maternity notes. ST1 & ST2 Doctors should be supervised by either a Middle Grade or Consultant unless they have been deemed (by senior staff) to be competent in the procedure.

Acting-up Middle grade staff are not allowed to supervise operative vaginal deliveries. Rotational deliveries with Kiellands forceps should only be conducted by the Middle grade staff under the direct supervision of a Consultant or by a Consultant.

5.4 Indications for instrumental deliveries

Operative intervention is used to shorten the second stage of labour. It may be indicated for conditions of the fetus or of the mother. No indication is absolute and each case should be considered individually. **The indication for the procedure must be clearly documented in the section where the instrumental delivery notes are written, by the person who performs the instrumental delivery.**

Type	Indication
Fetal	Presumed fetal compromise
Maternal	Medical conditions to minimise pushing, (e.g. Cardiac disease or hypertensive crises, cerebral vascular disease, particularly uncorrected cerebral vascular malformations, myasthenia gravis, spinal cord injury)
Inadequate progress	**Nulliparous women**: lack of continuing progress for **total** of 4 hours ('passive phase' of up to 2 hours with an epidural or 1 hour without an epidural **plus** an 'active phase' of up to 2 hours). **Multiparous women:** lack of continuing progress for **total** of 2 hours ('passive phase' of up to 1hour with or without an epidural **plus** an 'active phase' of up to 1hour) Maternal fatigue / exhaustion

Decision to Delivery Interval: the time of decision to deliver should be recorded in the notes and on the CTG along with the indication. The decision to delivery interval should be documented in the instrumental delivery notes.

5.5 Preparation for operative vaginal delivery/Assessment prior to performing the procedure:

The need for an operative delivery can be reduced by the following:

- Continuous support during labour
- Use of upright or lateral positions in the second stage
- Avoiding epidural analgesia
- Delayed pushing in a primiparous woman with an epidural

Safe operative vaginal delivery requires a careful assessment of the clinical situation, clear communication with the mother and midwifery staff caring for the woman and the Doctor should be competent in the chosen procedure.

Prior to an operative vaginal delivery the following actions should be taken and criteria met

5.5.1 Full Abdominal and vaginal examination

- Head is ≤ 1/5 palpable per abdomen
- Cervix is fully dilated and the membranes have ruptured
- Vertex presentation (expect for forceps in the after coming head with a breech delivery
- Exact position of the head must be determined so proper placement of the instrument can be achieved
- Pelvis is deemed adequate

The findings of the abdominal and vaginal examination must be recorded in the woman's notes and the management plan for delivery recorded.

5.5.2 Maternal requirements

- Clear explanation must be given and **informed consent** obtained and documented. Women should be aware of the possibility of an Operative delivery from discussions in the antenatal period. The RCOG Patient Information: *An Assisted Birth (Operative Vaginal Delivery): Information for You* may be given to patients in pregnancy/antenatally. The benefits and risks of the procedure should be clearly explained to the couple. **A written consent form** must be signed if an instrumental delivery/trial is planned in theatre. If the delivery is carried out in the **delivery room, documenting consent in the maternity records** along with the explained maternal and fetal risks is satisfactory, though it is good practice to do a formal written consent form.

Intended Benefits:
- *Expedited delivery where fetal compromise is suspected*
- *Relief where the second stage of labour is delayed owing to maternal exhaustion or other reasons*
- *Safer delivery in cases where maternal pushing is not advisable – such as cerebral aneurysm, proliferative Retinopathy or cardiac problems*

Serious Risks*:*
Maternal:
- *Third- and fourth-degree perineal tear, 1–4 in 100 with vacuum-assisted delivery (common) and 8–12 in 100 with Forceps delivery (very common)*
- *Extensive or significant vaginal/vulval tear, 1 in 10 with vacuum 1 and in 5 with forceps.*

Fetal:
- *Subgaleal haematoma, 3–6 in 1000 (uncommon)*
- *Intracranial haemorrhage, 5–15 in 10 000 (uncommon)*
- *Facial nerve palsy (rare)*

Frequent risks include:

- *Maternal:*
  - *Postpartum haemorrhage, 1–4 in 10 (very common)*
  - *Vaginal tear/abrasion (very common)*
  - *Anal sphincter dysfunction/voiding dysfunction.*
- *Fetal:*
  - *forceps marks on face (very common)*
  - *chignon/cup marking on the scalp (practically all cases of vacuum-assisted delivery) (very common)*
  - *Cephalhaematoma 1–12 in 100 (common)*
  - *Facial or scalp lacerations, 1 in 10 (common)*
  - *Neonatal jaundice /hyperbilirubinaemia, 5–15 in 100 (common)*
  - *Retinal haemorrhage 17–38 in 100 (very common).*

Any extra procedures which may become necessary during the procedure

- *Episiotomy (5–6 in 10 for vacuum assisted delivery, 9 in 10 for forceps)*
- *Manoeuvres for shoulder dystocia*
- *Caesarean section*
- *Blood transfusion*
- *Repair of perineal tear*
- *Manual rotation prior to forceps or vacuum-assisted delivery.*

Appropriate analgesia should be in place, for mid-cavity rotational deliveries this will usually be a regional block, however a Pudendal block may be appropriate particularly in the context of urgent delivery. The clinician performing the delivery should ascertain that the analgesia is effective for the delivery.

- Maternal bladder has been emptied recently
- Indwelling catheter should be removed or balloon deflated
- Aseptic techniques should be used by operator

5.5.3 Staff requirements

- Operator must have the knowledge, experience and skills necessary to use the chosen instruments
- Adequate facilities and back up personnel are available
- Theatre facilities should be available in case of failure to deliver
- Staff to be aware of and able to manage complications that could arise (e.g. Shoulder dystocia, PPH)

Appropriate personnel present who are trained in neonatal resuscitation

5.6 Where should an operative delivery take place?

5.6.1 Delivery Suite

Only low cavity operative vaginal deliveries should be undertaken in a delivery room.

5.6.2 Theatre

Operative vaginal deliveries classified as a “trial of delivery” should be conducted in theatre as there is immediate recourse to proceeding to a caesarean section. All attempts at rotational or mid-cavity operative deliveries should take place in theatre.

Trial of instrumental delivery in theatre

A "trial" should be considered when there is **ANY** doubt that an instrumental delivery can be achieved without difficulty.

Higher rates of failure are also associated with:

- Maternal body mass index greater than 30
- Estimated fetal weight greater than 4000g or clinically big baby
- Occipito-posterior position
- Mid-cavity delivery or when 1/5 head palpable per abdomen

Warning signs are:

- Clinically large baby especially in a woman of small stature
- Slow progress in the late first and second stages
- Significant caput and moulding
- Previous difficult instrumental delivery or shoulder dystocia

5.7 Preparations prior to operative vaginal delivery in theatre

- Blood should be taken for FBC, G & S
- IV Ranitidine if oral Ranitidine not previously given
- Consent obtained for caesarean section if instrumental delivery not successful.

5.8 Special considerations

- A bimanual VE is very helpful to assess (i) moulding, (ii) the true amount of head abdominally, (iii) liquor/meconium behind the head.
- Ventouse or forceps deliveries should not be done prior to full dilatation.
- Ventouse and rotational forceps will not usually be used <34 weeks.
- When patients are taken to theatre, there must be continuous FHR monitoring during provision of anaesthesia and setting up for delivery and during the interval between trial and CS.
- Where pH is <7.20 or trace is seriously abnormal, it is important not to do a difficult rotational delivery if the fetus is hypoxic because of increased risk of intracerebral bleeding.
- If delivery after augmentation with Syntocinon, manage the 3rd stage with IV Syntocinon infusion
- After delivery take a cord paired sample for pH and base excess.
- A paediatrician should be present at delivery. (see Guidelines for admission to neonatal unit)

5.9 Choice of instruments

The operator should choose the instrument most appropriate to the clinical circumstances and their level of skill. Forceps and vacuum extraction are associated with different benefits and risks.

5.9.1 Benefits and Risks

The relative merits of vacuum extraction and forceps have been evaluated in a Cochrane systematic review of nine RCT involving 2849 primiparous and multiparous women.

5.9.2 Ventouse Delivery

Vacuum extraction compared to forceps is:

More likely to fail at achieving vaginal delivery(OR 1.7; 95% CI 1.3–2.2)	less likely to be associated with significant maternal perineal and vaginal trauma (OR 0.4; 95% CI 0.3–0.5
More likely to be associated with cephalohaematoma OR 2.4; 95% CI 1.7–3.4	no more likely to be associated with delivery by caesarean section (OR 0.6; 95% CI 0.3-1.0)
More likely to be associated with retinal haemorrhage (OR 2.0; 95% CI 1.3–3.0)	no more likely to be associated with low 5-minute Apgar scores (OR 1.7; 95% CI 1.0–2.8)
More likely to be associated with maternal worries about baby (OR 2.2; 95% CI 1.2–3.9)	no more likely to be associated with the need for phototherapy (OR 1.1; 95% CI 0.7–1.8)

5.9.3 Forceps Delivery

The following are situations where the use of forceps is usually superior to vacuum extraction:

- Delivery of the head at assisted breech delivery (singleton or twin)
- Assisted delivery of preterm infant. Avoid rotational forceps delivery (< 34 weeks' gestation).
- Controlled delivery of head at caesarean section
- Assisted delivery with suspected coagulopathy or thrombocytopenia in fetus
- Instrumental delivery for maternal medical conditions that preclude pushing
- Instrumental delivery under general anaesthesia
- Cord prolapse in the second stage of labour
- Direct Occipito-anterior position at spines (mid-cavity)

5.9.4 Rotational delivery

The options available for rotational delivery include Kiellands forceps, manual rotation followed by direct traction forceps or rotational vacuum extraction.

Rotational deliveries with Kiellands forceps should only be conducted by the Middle grade staff under the direct supervision of a Consultant or by a Consultant.

5.9.5 Reasons for abandoning the procedure

Operative vaginal delivery should be abandoned where there is no evidence of progressive descent with each pull or where delivery is not imminent following THREE PULLS of a correctly applied instrument by the operator.

- **If there is difficulty applying the Ventouse or blades, achieving descent or rotation, or if great force required then STOP and proceed to CS.**

- Remember to disimpact the head by elevating vaginally to ease delivery at CS. This is usually accomplished by another member of staff (midwife or medical staff) “scrubbed” at operation and available to elevate the head vaginally.

5.9.6 Use of a second instrument to achieve delivery / Sequential Instruments

The use of sequential instruments is associated with an increased risk of trauma to the infant. However, the operator must balance the risks of a caesarean section following failed vacuum extraction with the risks of forceps delivery following failed vacuum extraction.

Sometimes the instrumental delivery is commenced using a ventouse, and then converted to a forceps if the cup slips or maternal effort is inadequate. This is acceptable as long as the couple are kept informed at all times and the person carrying out the delivery is completely comfortable with the fetal position and vaginal delivery is anticipated. A ventouse may also be converted to a forceps delivery if the ventouse is initially used to bring about rotation and descent of the fetal head and then slips off, and the subsequent delivery is by forceps application and traction.

Do not try repeatedly to deliver using instruments. There is a higher morbidity rate for babies following a failed ventouse and failed forceps delivery.

5.10 Care following operative delivery

5.10.1 Bladder care

A fluid balance chart should be maintained for at least 24 hours, to detect postpartum urinary retention. A post-void residual should be measured if retention is suspected.

Women who have had a spinal anaesthetic or epidural anaesthesia that has been topped up for a trial of instrumental delivery may be at increased risk of retention and should be recommended to have an indwelling catheter. This should be kept in place for at least 12 hours following delivery to prevent asymptomatic bladder overfilling.

5.10.2 Analgesia

Regular Paracetamol and Diclofenac have been shown to be beneficial for perineal pain and should be considered in the absence of contraindications.

5.10.3 Thromboprophylaxis

Mid cavity delivery, prolonged labour and immobility are risk factors for thromboembolism. Women should be reassessed after delivery for risk factors for VTE and considered for thromboprophylaxis if necessary. (Refer to Maternity guideline for VTE)

5.11 Documentation

Good record keeping is essential and should include as a minimum the following:

- Name and grade of person undertaking the procedure
- Abdominal and vaginal examination findings prior to delivery
- Analgesia used
- Instrument used
- Pressure of vacuum (ventouse deliveries)
- Amount of traction used to expedite delivery
- Amount of pulls used to expedite delivery
- Whether episiotomy performed or perineal damage sustained
- Method of perineal repair
- Rectal examination post procedure
- Swab needle and instrument count
- Post procedure analgesia
- Need for catheter/antibiotics/stool softeners
- If postnatal referral made

Records should be completed as soon as possible after the delivery

6.0 Monitoring and Audit

Monitoring and Audit of this guideline will be identified with issues raised via Clinical Risk / Clinical Governance.

APPENDIX ONE

Process Requirements

1.0 Implementation and Awareness

1.1 Once approved this policy/procedural document will be published on the Trust intranet by the Maternity Compliance & Safety Co-ordinator.

1.2 On publication of any Maternity document, the Maternity Compliance & Safety Co-ordinator or Maternity Secretary will ensure that an email is sent to all Maternity staff and other stakeholders, as appropriate.

1.3 On receipt of notification, all managers should ensure that their staff members are aware of the new publications.

1.4 Women & Children's Clinical Governance Newsletter (Quarterly publication)

2.0 Review

2.1 It is essential that Trust Policy/procedural documents remain accurate and up to date; this policy/procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure. It is the responsibility of the Document Lead for this policy/procedure to ensure this review is undertaken in a timely manner.

2.2 The Document Lead should review the policy/procedure and, even when alterations have not been made, undertake the consultation process as detailed in **Section 5.5 Consultation** of MTW Policy and Procedure '*Production, Approval and Implementation of Policies and Procedures*'.

3.0 Archiving

3.1 The Trust Intranet retains all superseded files in an archive directory in order to maintain document history.

3.2 Old paper guideline copies pre-dating Datix are stored at:

Chatham Archive & Storage document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634 826665

APPENDIX TWO

CONSULTATION ON: Guideline for Operative Vaginal Delivery

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Miss Wunmi Ogunnoiki, Consultant Obstetrician (email: wunmi.ogunnoiki@nhs.net)

By date: 12 February 2015 *(all documents must undergo a minimum of two weeks consultation)*

Name: *List key staff appropriate for the document under consultation. Select from the following:*	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Consultant Obstetricians	29/01/15	28/04/15	Y	Y
Consultant Paediatricians	29/01/15			
Consultant Anaesthetists (Obstetric Leads)	29/01/15			
Head of Midwifery / Co-Clinical Director	29/01/15			
Manager for Governance & Risk	29/01/15			
Maternity Clinical Risk Manager	29/01/15	11/05/15	Query re timings	N
Consultant Midwife	29/01/15			
Supervisor of Midwives	29/01/15			
Midwifery Staff	29/01/15			
Maternity Team Leads	29/01/15	11/05/15	Query re timings	N
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Operative Vaginal Delivery guideline
What are the aims of the policy or practice?	To ensure best practice for women receiving maternity care
Identify the data and research used to assist the analysis and assessment	See page 2 & 3 for references
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	No
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	When this document is reviewed, which as a minimum is every three years
Where do you plan to publish the results of your Equality Impact Assessment?	With publication of this document on the Trust Intranet, Q-Pulse Document Storage system

Maidstone and Tunbridge Wells NHS
NHS Trust

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Antenatal Fetal Monitoring

Requested/ Required by:	Women's Directorate
Main author:	Clinical Manager for Governance & Risk
Other contributors:	
Document lead:	CNST Support Midwife **Contact Details:** ext 33154
Supersedes:	Guideline for Antenatal Fetal Monitoring (Version 1.0)
Approved by:	Amended version (Clinical Risk Management Group, 2nd June 2010)
Ratified by:	Clinical Risk Management Group **Date:** 2nd June 2010
Review date:	August 2013

Document History

Requirement for	To comply with national recommendations for good practice

document:	• MDA/2010/054 • Annual audit required
Cross References / Associated Documents:	References: Maidstone & Tunbridge Wells NHS Trust Maternity. (2009). *Training Strategy.* Trust Intranet, Datix Guidelines system: A - Clinical Policies & Guidelines Associated Documents: National Institute for Health and Clinical Excellence. (2007). *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE. .

Version Control:		
Issue:	**Description of changes:**	**Date:**
1.0	First iteration	
2.0	Confirmation of fetal heart using independent means prior to commencing CTG Seek assistance from colleagues if difficulties obtained in obtaining CTG	June 2010 June 2010

Policy Statement for

Antenatal Fetal Monitoring

Maidstone & Tunbridge Wells NHS Trust Women's Services recognises the need for an approved system for improving care and learning lessons relating to antenatal fetal monitoring.

Antenatal Fetal Monitoring

Contents

17.0 Introduction and Scope of Procedural Document

This guideline applies to all Trust midwives and obstetricians caring for women in the antenatal period

The document outlines when electronic fetal monitoring should be undertaken rather than intermittent auscultation and the actions required to ensure fetal monitoring is appropriately carried out, documented and acted upon when necessary.

Appropriate monitoring of the fetal heart rate aims to identify hypoxia before it is sufficient to lead to long-term poor neurological outcome for babies.

18.0 Definitions

Intermittent Auscultation: where the fetal heart is listened to and the rate measured by means of a Pinard stethoscope or by hand held doppler device ("sonicaid").

Continuous Electronic Fetal Monitoring (Cardiotocograph): where the fetal heart rate and maternal uterine activity is continuously recorded and printed on graph paper.

19.0 Duties

Midwifery staff have a duty to monitor and document the fetal heart rate appropriately when it is required during the antenatal period. In the presence of any abnormalities it is the midwife's responsibility to inform the obstetrician and ensure that further assessment is undertaken.

Obstetric staff are responsible for the assessment of and any action required following any abnormalities detected in the fetal heart rate.

20.0 Training / Competency Requirements

All midwifery and obstetric staff have access to regular updates regarding fetal monitoring and have mandatory training required every 6 months.

Refer to: MTW Guidelines 2009, Training Strategy. (See page 2 for full reference)

21.0 **Procedure**

Auscultation & Continuous Electronic Fetal Monitoring in Labour

5.1 Equipment Required for Fetal Monitoring

The following options are available and should be employed as appropriate to the care setting and relevant risk factors

4. **Pinard stethoscope:** a simple trumpet shaped device which when applied to the mother's abdomen amplifies the fetal heart sound to the ear of the professional
5. **Doppler machine/"Sonicaid":** a hand held, battery operated device with "microphone" which transmits the fetal heart sound to the speaker attachment. The professional is thus able to listen to the heart sounds. Some of these devices will calculate and display the fetal heart rate and some are waterproof, enabling the fetal heart to be monitored when the mother is in water
6. **Cardiotocograph:** an electronic machine which transmits, displays and records the fetal heart sound and maternal abdominal pressure, via transducers applied to the maternal abdomen. This enables the continuous recording of the fetal heart rate as it corresponds to maternal uterine contractions and gives printed documentation

5.2 Antenatal fetal monitoring

This guideline should be used in conjunction with the guideline for the use of fetal monitoring in labour. General principles regarding good practice for electronic fetal monitoring apply to both intrapartum and antenatal monitoring.

Women requiring antenatal admission should be assessed on an individual basis as regards the need for CTG monitoring to be performed. If there are any risk factors involved on admission, then a CTG should be performed. (List not exhaustive)

If staff experience difficulties in performing a CTG, assistance should be sought from another colleague. It may be necessary to involve medical staff in order establish the presence/location of the fetal heart by ultrasound scan.

5.3 Indications for performing a CTG

5.3.1 MATERNAL

Antepartum haemorrhage
Raised BP/Pre eclampsia
Abdominal pain
Prolonged rupture of membranes (Not SROM in normal labour)
Induction of labour
Diabetes
Pyrexia or suspected infection
Suspected pre term labour
Abnormal fetal heart rate on auscultation
Other maternal disease

5.3.2 FETAL

Reduced fetal movements
Growth retardation
Abnormal doppler studies
Post term pregnancy (>42 weeks)
Oligohydramnios

Prior to commencing CTG monitoring:

- Explain the reason for fetal monitoring to the woman
- Ensure an abdominal palpation is performed and finding recorded
- Maternal pulse should be palpated simultaneously with the fetal heart rate and recorded in order to differentiate between maternal and fetal heart rate
- Confirm fetal heart rate using independent means prior to commencing CTG (Pinard or hand held doppler)
- Consider gestation of pregnancy. CTG should not be performed before 24 weeks gestation. Gestation between 24-26 weeks should be discussed with Obstetric Registrar prior to commencing trace.

5.4 CONDUCT OF EFM

Ensure trace is of sufficient quality to enable adequate interpretation. The date and time clocks on the monitor must be correct and paper speed running at 1 cm/min. Traces should be labelled with the date and time of recording, and the woman's name and hospital number (addressograph label). Maternal pulse should also be recorded on the tracing and reason for undertaking a CTG.

5.5 INTERPRETATION OF CTG

The trace should be interpreted using the Dr C BRAVADO pneumonic

DR	**Define Risk**	high or low risk, e.g. Previous CS
C	**Contractions**	number in 10 minutes
BRA	**Baseline Rate**	as per NICE definitions
V	**baseline Variability**	as per NICE definitions
AD	**Accelerations or Decelerations**	as per NICE definitions
O	**Overall impression**	Normal, Suspicious, Pathological

5.6 CLASSIFICATION OF FHR TRACE FEATURES

Any member of staff involved in reviewing a CTG tracing should note their findings on the tracing and the notes (using the interpretation labels: **see Appendix Four**). All traces should be reviewed regularly and discontinued whenever either Dawes Redman criteria are met if performing a computerised trace, or when a 'normal' reassuring trace is obtained. If the midwife performing the CTG is concerned regarding any aspect of the trace, she should seek medical advice as soon as

possible. Any professional discontinuing the trace should sign the CTG and ensure that the reason for discontinuing is appropriate.

Staff should not rely solely on the CTG trace for fetal wellbeing and should be aware of limitations and artefacts, such as double maternal heart rate being displayed

5.7 FOLLOW UP

Follow up should be arranged on an individual basis dependent on the original reason for performing the CTG. If necessary, medical advice should be sought regarding repeat CTG's. Follow up may be arranged through Fetal / Day Assessment Units, Women's Health Centre or the Antenatal Ward.

Please see Guideline for the management of women reporting decreased fetal movements.

22.0 **Monitoring and Audit**

Elements of this guideline will be audited by the Women's Directorate using the audit tool in Appendix 4

Monitoring – Antenatal Fetal Monitoring

Key Elements to be monitored	Lead	Tool	Frequency	Reporting arrangements	Action Lead(s)	Change in practice and lessons to be shared
Whether documentation regarding fetal monitoring has met standards set out in guideline	Lead Midwife for Delivery Suite	Multidisciplinary audit of 1% of maternity notes from each site using audit tool in Appendix 4	Annually	Findings from audit reported to Delivery Suite Forum, reporting to Clinical Risk Management Group	Obstetric Lead for Clinical Risk Management Lead Midwife Delivery Suite	Required changes to practice will be identified and actioned by lead designated by the Clinical Risk Management Group Required changes to be taken to labour ward meetings, CTG training sessions, clinical governance meetings with time frame for changes identified
Whether guideline was followed in event of abnormal fetal heart rate pattern	Lead Obstetrician For Delivery Suite	Multidisciplinary audit of 1% of maternity notes from each site using audit tool in Appendix 4	Annually	Findings from audit reported to Delivery Suite Forum, reporting to Clinical Risk Management Group	Obstetric Lead for Clinical Risk Management Lead Midwife Delivery Suite	Required changes to practice will be identified and actioned by lead designated by the Clinical Risk Management Group Required changes to be taken to labour ward meetings, CTG training sessions, clinical governance with time frame for changes identified meetings

APPENDIX ONE

Process Requirements

4.0 Implementation and Awareness

Awareness of this guideline is via the following:

- Once approved the lead/author will send the guideline to the CNST Support Midwife for ensuring publication on the Trust Intranet (Datix Guidelines)
- W & C Clinical governance Newsletter
- Dissemination from Community Team
- Dissemination at unit meetings and Clinical governance sessions
- Following publication on Datix, email to all Maternity staff
- Monthly Trust wide circulation re documents published on the Datix system

5.0 Review

This guideline will be subject to review after 3 years or sooner if new evidence published

6.0 Archiving

3.1 The Trust intranet retains all superseded files in an archive directory in order to maintain document history

3.2 Old paper guideline copies pre-dating Datix are stored at:

Chatham Archive & Storage Document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634826665

APPENDIX TWO

CONSULTATION ON: Antenatal Fetal Monitoring

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Drafts for Comment or CNST Maternity Co-ordinator

By date: 2 November 2009 (all documents must undergo a minimum of two weeks consultation)

Name: Name: *List key staff appropriate for the document under consultation. Select from the following:*	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Consultant Paediatricians				
Consultant Obstetricians				
Consultant Anaesthetists				
Head of Midwifery / ADN				
Matrons – Inpatient & Community				
Clinical Manager for Governance & Risk				
Maternity Risk Manager				
Supervisor of Midwives				
Midwifery Staff via drafts for comments on Datix				
Team Leads				
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Antenatal Fetal Monitoring
What are the aims of the policy or practice?	To monitor fetal wellbeing in the antenatal period
Identify the data and research used to assist the analysis and assessment	See references page 2
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	No
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review	With review of the guideline

your EqIA?	
Where do you plan to publish the results of your Equality Impact Assessment?	With publication of this guideline

APPENDIX FOUR

CTG Stickers – To Be Used For Formal Review

CTG Review **Date: Time:** **Reason:** **Contractions;** **Baseline Rate:** **Variability:** **Accelerations:** **Decelerations:** **Overall impression: Normal** ☐ **Suspicious** ☐ **Pathological** ☐ **Signature Print Name**	**CTG Review** **Date: Time:** **Reason:** **Contractions;** **Baseline Rate:** **Variability:** **Accelerations:** **Decelerations:** **Overall impression: Normal** ☐ **Suspicious** ☐ **Pathological** ☐ **Signature Print Name**
CTG Review **Date: Time:** **Reason:** **Contractions;** **Baseline Rate:** **Variability:** **Accelerations:** **Decelerations:** **Overall impression: Normal** ☐ **Suspicious** ☐ **Pathological** ☐ **Signature Print Name**	**CTG Review** **Date: Time:** **Reason:** **Contractions;** **Baseline Rate:** **Variability:** **Accelerations:** **Decelerations:** **Overall impression: Normal** ☐ **Suspicious** ☐ **Pathological** ☐ **Signature Print Name**

Maidstone and Tunbridge Wells NHS
NHS Trust

Care of Women in Labour, including Clinical Risk Assessment in Labour

Requested/ Required by:	Women's and Children's Directorate
Main authors:	Consultant Midwife (SG) Acting Matron Maternity Inpatient Services (HB) Midwife (TC)
Other contributors:	Locum Consultant Obstetrician & Gynaecologist (SP)
Document lead:	CNST Maternity Coordinator (AC) **Contact Details:** Ext 33514
Supersedes:	Care of Women in Labour (Version 3.0: November 2013) following small revision (see pg 4 for further details)
Approved by:	Clinical Risk Management Group **Date:** 6th October 2011
Ratified by:	Clinical Risk Management Group **Date:** 6th October 2011
Review date:	October 2014

Document History

Requirement for	To comply with national recommendations for good practice:

document:	• 2011/12 Clinical Negligence Scheme for Trusts Maternity Clinical Risk Standards, Standards 1.2.1 and 1.4.7 • Annual audit
Cross References / Associated Documents:	**Associated Documents** Maidstone & Tunbridge Wells NHS Trust. (2011). *Admission to the Neonatal Unit.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Antenatal Clinical Risk Assessment.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Auscultation and Electronic Fetal Monitoring.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Examination of the Newborn.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Guideline for Peri Partum Bladder Care.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2005).*Guideline for Management of Epidural Anaesthesia in Labour.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2009). *Guideline for the Management of Perineal Trauma.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Immediate Care of the Newborn.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Maternal and Neonatal Transfer from the Maidstone Birth Centre, a Homebirth and Maidstone Antenatal Clinic or Day Assessment Unit.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Maternity Training Strategy & Training Needs Analysis Matrix.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Management of Hypertensive Disorders of Pregnancy, including Pre-eclampsia and Eclampsia.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2005). *Management of Women who Decline Blood Products.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity.

	Maidstone & Tunbridge Wells NHS Trust. (2011). *Neonatal Resuscitation.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Operational Policy for Birth Centre.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Obstetric Haemorrhage.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2011). *Postnatal Information and Care Planning Guideline.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2008). *Prelabour Rupture of Membranes at Term.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2010) *Preterm Labour and Delayed Cord Clamping in Preterm Infants.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines. Maternity. Maidstone & Tunbridge Wells NHS Trust. (2010) *Record Keeping and management of health records.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines. Maternity. Maidstone & Tunbridge Wells NHS Trust. (2010). *The requirement to document an individual management plan in the health records of women who decline blood products.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines, Maternity. Maidstone & Tunbridge Wells NHS Trust. (2006). *Waterbirth; Guideline for.* Trust Intranet, Datix Guideline System. A – Clinical Policies & Guidelines. Maternity. Maidstone & Tunbridge Wells NHS Trust. (2013). *Management of a Retained Placenta.* Trust Intranet, Q-Pulse Policy and Guideline system; Women & Children's Database; Maternity. **Cross References:** National Institute for Health and Clinical Excellence. (2007). *Intrapartum care: Care of Healthy women and their babies during childbirth.* London: NICE. Available at: www.nice.org.uk Confidential Enquiry into Maternal and Child Health (2004) *Why Mothers Die 2000-2002.* London: RCOG Press. Available at: www.cmace.org.uk National Institute for Health and Clinical Excellence. (2008). *Antenatal Care: Routine care for the healthy pregnant woman.* London: NICE. Available at: www.nice.org.uk

	Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynecologists', Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.* London: RCOG Press. Available at: www.rcog.org.uk Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland. (2006). *Best Practice Guidelines*. London: OAA/AGBI. Available at: www.aagbi.org.uk and www.oaa-aneas.ac.uk Royal College of Obstetricians and Gynaecologists. (2007). *Royal College of Obstetricians and Gynaecologists/Royal College of Midwives Joint statement No. 2: Home Births.* London: RCOG. Available at: www.rcog.org.uk Holdsworth, J. (1978). *Relationship between stomach contents and analgesia in labour*. British Journal of Anaesthesia 50:1145-8 Linderkamp, O. (1982). *Placental transfusion: determinants and effects*. Clinics in Perinatology. 9:559-592 Prendeville W, Elbourne, D. McDonald, S. (2004). *Active versus expectant management of third stage of labour (Cochrane Review).* In: The Cochrane Library, Issue 1. Chichester, UK: John Wiley and Sons McDonald S.J. Middleton P. (2009). *Effect of timing of umbilical cord clamping at birth of term infants on mother and baby outcomes*. Cochrane Library Database of Systematic Reviews. John Wiley & Sons, Ltd. Hutton EK, Hassan ES. (2007). Late *vs early clamping of the umbilical cord in full-term neonates: systematic review and meta-analysis of controlled trials*. JAMA. Journal of the American Medical Association, Vol: 297/11 (1242- 252)

Version Control:		
Issue:	**Description of changes:**	**Date:**
2.0	Guideline previously published as Intrapartum guideline. Content reduced by cross-referencing to appropriate guidelines/documents e.g. VTE guideline	November 2009
3.0	Updated to reflect service reconfiguration changes and incorporate Clinical Risk Assessment in Labour	October 2011
3.1	Clarification around management of physiological 3rd stage of labour made on 6/11/2013 (see pages 34 & 35). This followed uncertainty regarding management raised via skills drills teaching	November 2013

Care of Women in Labour, including Clinical Risk Assessment in Labour

Birth is a life changing event and the care given to women during this time has the potential to affect them both physically and emotionally in the short and long term.

Maidstone and Tunbridge Wells NHS Trust acknowledge that care in labour must be aimed towards achieving the best possible outcome for the mother and baby and, where labour is progressing normally, clinical intervention should not be offered or advised providing the mother and baby are well. Establishing each woman's individual clinical risk on admission and throughout labour is fundamental to planning the most appropriate care pathway towards meeting these outcomes.

Women should be made to feel in control and involved in their care planning in the intrapartum period and, respect and dignity should be paramount at all times.

Observations carried out and changes to care during the intrapartum period should be made in consultation with the woman and clearly documented in the notes.

Care of Women in Labour, including Risk Assessment in Labour

CONTENT

	of labour
Appendix Five	**Flow Chart for Women with Problems in their Pregnancy**
Appendix Six	**Intrapartum Risk Assessment Tool**
Appendix Seven	**Maternity Questionnaire**

Flow Diagram of Procedure to be followed

Flow diagrams showing expected progress, diagnosis of delay and appropriate action for both nulliparous and multiparous women in the first and second stage of labour can be found in appendix 4.

23.0 Introduction and Scope of Procedural Document

The Maternity Service provided to women by Maidstone & Tunbridge Wells NHS Trust was reconfigured in September 2011. Inpatient services for high risk women were transferred to the Tunbridge Wells Hospital at Pembury (TWH) with the Neonatal Unit also based at TWH.

Women are offered the following:

- Low risk women may choose to give birth at TWH, at home or the new midwife-led Birth Centre at Maidstone
- A range of outpatient maternity services including Antenatal Clinics, Obstetric Ultrasound and a Maternity Day Unit, continue to be offered at both TWH and Maidstone Hospital. These will be accessed, as appropriate, by both high and low risk pregnant women in each geographical area.

All pregnant women are risk assessed in consideration of their medical history (including anaesthetic history), current health, lifestyle factors and factors from previous pregnancies and the current pregnancy at antenatal booking and throughout this pregnancy. These factors will be taken into consideration in discussion with individual women in planning an appropriate place of birth.

Refer to MTW Guideline: (referenced on page 2)
- Antenatal Clinical Risk Assessment

This guideline applies to all midwifery and obstetric staff caring for women in labour.

All care given during the Intrapartum period, whether in the hospital at TWH, the Birth Centre or in the home setting, must be appropriately documented in the woman's health records.

Refer to: MTW Guideline (referenced on page 3)
- Record Keeping and management of health records

This document is intended to ensure:

- All women in labour are treated with respect and are in control of and involved in what is happening to them. Professionals should be aware that the environment in which a woman labours can have a significant effect on fear and anxiety and also progress in labour
- Good communication with woman and the multidisciplinary team, supported by evidence-based information, to allow women to reach informed decisions about their care
- A woman in established labour receives supportive one to one care
- Clinical intervention only to be advised if labour is not progressing normally or there are concerns regarding the mother and/or baby
- Significant deviations from normal are reported to the medical staff

24.0 Definitions

CTG	Cardiotocograph
EFM	Electronic Fetal Monitoring
SROM	Spontaneous Rupture of Membranes
PROM	Prolonged Rupture of Membranes
LVS	Low Vaginal Swab
HVS	High Vaginal Swab
IUGR	In Utero Growth Retardation
ARM	Artificial Rupture of Membranes
FSE	Fetal Scalp Electrode
SpR	Specialist Registrar
VE	Vaginal Examination
APH	Antepartum Haemorrhage
IV	Intravenous
LSCS	Lower Segment Caesarean Section
NNU	Neonatal Unit
TWH	Tunbridge Wells Hospital at Pembury
MTW	Maidstone & Tunbridge Wells NHS Trust

3.0 Duties

It is the registered professional's responsibility to deliver care that is based on current evidence, always acting in the patient's best interests.

4.0 Training / Competency Requirements

This procedure should be performed by registered midwives, student midwives (under supervision) and/or medical staff.

Multidisciplinary mandatory training is provided as outlined in the maternity training strategy.

A multidisciplinary normal birth session is included on day one of the mandatory skills drills training

Refer to MTW Guideline (referenced on page 2)
● Maternity Training Strategy & Training Needs Analysis Matrix

5.0 Procedure

5.1 Home Births

5.1.1 Contacting Triage at TWH or Maidstone Birth Centre re home birth

Women who have chosen to have their babies at home will have been advised in the antenatal period to contact Triage at TWH or Maidstone Birth Centre when they think they are in labour. Their point of contact will depend on their geographical area and they will have been advised accordingly.

The following information should be taken

- Name and date of birth
- Address, Telephone number/contact number
- GP/Community Midwife
- Hospital number
- Parity
- EDD/Gestation
- Reason for phoning
- Presence of symptoms
- Fetal movements (present/not present)
- Medical or Obstetric problems

This information should then be passed by Triage or the Birth Centre to the Midwifery Team to whom the woman is allocated. If this is during normal office hours this request should be passed by Triage or the Birth Centre to the Community Liaison Office who will contact the appropriate midwife.

The woman should be informed that she will be contacted shortly by a community midwife. She should be asked to contact Triage or the Birth Centre again in 30 minutes if a midwife has not been in contact or she requires assistance before the midwife has arrived at her home.

5.1.2 Risk Assessments for Home births

During the antenatal period, a risk assessment will have been undertaken on the suitability of a home birth both at booking and again at 36 weeks. Although the majority of women will be guided by a professional's opinion as to suitability, there may be occasions when women will choose to have a home birth who are not suitable. In these cases an individual management plan will have been formulated in the antenatal period which will include controls to support staff and to lessen the risk to the woman and her baby i.e. informing a Supervisor of Midwives, experienced midwives present etc.

Further risk assessments will be ongoing and should be undertaken when the midwife first arrives at the home and during the course of labour (see 5.2.3 and 5.2.4). If risks are identified, they should be documented, discussed with the woman and her partner and a management plan formulated. This may involve transfer into hospital.

Refer to MTW Guidelines: (referenced on page 2)

- Antenatal Clinical Risk Assessment
- Maternal and Neonatal Transfer from the Maidstone Birth Centre, a Homebirth and Maidstone Antenatal Clinic or Day Assessment Unit

5.1.3 Care during labour and delivery

Midwifery staff should follow the same pathways of care for women who choose to give birth at home as set out in this document, which includes:

- Observations to be undertaken during initial assessment at home and during all stages of labour
- Duration of all stages of labour.

5.1.4 Analgesia for women who choose to give birth at home

A discussion will have taken place in the antenatal period regarding analgesia which is available for women choosing to have a home birth. If Pethidine is requested this should have been obtained by the woman from her GP before labour. It should be documented in her notes that she has been advised on the associated risks to the baby.

A request may be made during labour for further analgesia which is not available in the home, such as an epidural, and if so the woman should be transferred into hospital for further pain relief.

5.1.5 Updating Triage at TWH/Maidstone Birth Centre and Contacting a 2nd Midwife for Delivery

During the labour the midwife caring for the women should give regular updates to Triage at TWH/the Birth Centre (as geographically appropriate). When she anticipates that she will require a second midwife to attend for the birth of the baby Triage/the Birth Centre should contact the appropriate midwife.

5.1.6 Following delivery at a home birth

Following the birth of the baby the midwife should update Triage/the Birth Centre. Before she leaves the home she should inform the family when they will be visited again and how to make contact if they need assistance before that time. Information leaflets should be given as appropriate.

A message should be left with Community Liaison Office that the baby will require a "First Physical Examination" by a suitably trained midwife.

Refer to MTW Guidelines: (see pages 2 and 3 for full reference)

- Examination of the Newborn
- Postnatal Information and Care Planning

If outside normal working hours the midwives should inform Triage at TWH/the Birth Centre when they have arrived home.

5.2 Admission to Maidstone Birth Centre

5.2.1 Telephone Advice and contacting Maidstone Birth Centre

Women who have chosen to give birth at Maidstone Birth Centre will have been advised in the antenatal period to contact the Birth Centre when they think they are in labour.

The following information should be taken:

- Name and date of birth
- Address, Telephone number/contact number
- GP/Community Midwife
- Hospital number
- Parity
- EDD/Gestation
- Reason for phoning
- Presence of symptoms
- Fetal movements (present/not present)
- Medical or Obstetric problems

This form will be filed in the woman's maternity notes on admission.

If any concerns with maternal or fetal wellbeing are detected by the midwife during this telephone contact the woman will be advised to attend TWH for further assessment, transported by whichever means the midwife feels is appropriate to her clinical condition. The Birth Centre midwife will contact Triage at TWH to advise of the woman's expected attendance at TWH.

5.2.2 Antenatal Risk Assessments for Births at Maidstone Birth Centre

During the antenatal period, a woman's suitability for giving birth at the Birth Centre will have been risk assessed at booking and again at 36 weeks. A woman with pregnancy complications/risk factors **will not** be able to give birth at the Birth Centre.

5.2.3 Admission to Maidstone Birth Centre in labour (includes intrapartum risk assessment)

On arrival in labour the woman's details will be entered on the admissions board, a history will be taken, and a further risk assessment undertaken to confirm the woman's suitability for birthing at the Birth Centre utilizing the intrapartum risk assessment tool at Appendix Six. The woman will be offered a vaginal examination as appropriate. If risks are identified at any time, either during initial assessment or as the labour progresses, they should be documented, discussed with the woman and her partner and a management plan formulated. This may involve transfer into the obstetric unit.

Refer to MTW Guideline: (referenced on page 3)

- Maternal and Neonatal Transfer from the Maidstone Birth Centre, a Homebirth and Maidstone Antenatal Clinic or Day Assessment Unit

5.2.4 Care during labour and delivery at Maidstone Birth Centre

Midwifery staff should follow the same pathways of care for women who choose to give birth at the Birth Centre as set out in this document, which includes

- Observations to be undertaken on admission and during all stages of labour
- Duration of all stages of labour

5.2.5 Analgesia and aids to promote progress and reduce pain for women who choose to give birth at the Birth Centre

A discussion will have taken place in the antenatal period regarding analgesia which is available for women choosing to give birth at the Birth Centre.

There is a selection of equipment to promote progress in labour and reduce pain such as birth balls and stools, bean bags and slings and deep warm water. Pethidine, TENs and Entonox will also be available to women labouring at the Birth Centre.

A request may be made during labour for further analgesia which is not available at the Birth Centre, such as an epidural, and if so the woman should be transferred into hospital for further pain relief.

5.3 Admission to Triage at TWH

5.3.1 Telephone Advice

Women may telephone Triage for advice. Record the following information on the advice sheet with the date, time of call and the name, designation and signature of the person taking the call. (These advice sheets will be stored in the main hospital notes when no longer required).

- Name and date of birth
- Address, Telephone number/contact number
- GP/Community Midwife
- Hospital number
- Parity
- EDD/Gestation
- Reason for phoning
- Presence of symptoms
- Fetal movements (present/not present)
- Medical or Obstetric problems
- Advice given

Low risk women in early labour should be encouraged to stay at home as long as they wish with the support and the reassurance that they can phone at any time for advice. This may help reduce unnecessary obstetric intervention.

5.3.2 Admission Criteria to Triage at TWH

The woman should particularly be asked to come in if she has:

- Been advised to present early in labour
- Symptoms suggestive of labour
- Antepartum haemorrhage
- Rupture of membranes
- Reduced fetal movements
- Previous poor obstetric or perinatal outcome
- Abdominal pain

If there is any doubt about her condition she should be advised to come to Triage for assessment. The majority of women in suspected labour will receive an initial Triage assessment. However, women in the following categories will be admitted directly to Delivery Suite (refer to Flow Chart for Women with Problems in their Pregnancy, attached at Appendix 5)

Women to be referred to Delivery Suite at TWH

- Transfer by ambulance with serious obstetric complication
- Significant obstetric haemorrhage
- Acute or severe abdominal pain
- Advanced stage of labour or imminent delivery
- Serious medical disorder of pregnancy
- Severe pre-eclampsia/eclampsia or altered state of consciousness
- In utero transfer

5.3.3 Admission process for TWH

Details should be entered on to the ward area board, hospital bed state and computer system.

5.4 Initial Assessment on admission of all women presenting in labour at TWH/the Birth Centre or attended by a Midwife at home

Initial Assessment on admission of all women presenting in labour/being attended in labour by Midwife at home
(including maternal observations to be carried out on admission)

Assess if urgent medical assistance is required.

- Listen to the woman's story/events prompting her admission, and take into account her emotional and psychological needs.
- A wristband must be given to all TWH/Birth Centre inpatients and if allergies are noted **a red wristband** must be given and details documented in the notes and on the prescription card. Identification details should be checked with the woman prior to applying wristband.
- Record baseline observations of temperature, pulse, blood pressure and urinalysis.
- Record vaginal loss, colour of liquor or if offensive liquor or discharge present. Other signs of sepsis/ chorioamnionitis should be sought, confirmed by investigations and managed appropriately.
- Record time of rupture of membranes if appropriate also time and onset of regular, painful contractions.
- Abdominal palpation to include symphysis fundal height (recorded in centimeters), fetal lie, presentation, position and degree of engagement. Discuss fetal movement pattern.
- In a low risk pregnancy, the fetal heart should be auscultated for a minimum of one minute after a contraction. Maternal pulse should be palpated to differentiate between maternal and fetal heart rate.
- A CTG should be performed ONLY if there is a clear indication. **Current evidence does not support the use of the admission CTG in low risk pregnancy.** CTG monitoring is not available for home births or birth at the Birth Centre.
- An assessment of pain, together with discussion of birth plan, pain relief options and woman's wishes for coping with labour should take place at the earliest opportunity.
- If the woman appears to be in established labour a vaginal examination should be offered (see 5.5.1)

5.4.1 Clinical Risk Assessment When Labour Commences

During the antenatal period, all pregnant women will have received an initial risk assessment at booking and this will have been reviewed at each subsequent contact with maternity services. If any risks have been identified, then an Individual Management Plan should be formulated and documented within the woman's hand held maternity notes.

To assist in safe and effective care planning for all women the midwife undertaking the initial labour consultation (including those observations of current maternal and fetal wellbeing outlined at 5.4) should make a further assessment of risk **within one hour** of when the woman presents in labour or is attended at home. The tool at Appendix 6 is intended to assist practitioners in undertaking and documenting this risk assessment.

Risk assessment to include consideration of:

- General health and medical conditions, including anaesthetic history
- Factors from current and previous pregnancy/ies
- Lifestyle history (for example smoking, recreational drug use past/current, alcohol etc)
- Identification of women who will decline blood and blood products
- Appropriate place of birth taking account of history given and risks assessed (low risk area (including the Birth Centre or at home), main delivery suite)
- Reason for this admission/midwife attendance

All women must have an individualised management plan for their care. High risk women must have obstetric involvement in the development of this plan. **The midwife undertaking the above assessment should discuss identified risk factors initially with the Delivery Suite Co-ordinator before referral to the obstetric team on call.**

The above assessment and actions planned must be documented in the client's hand held notes. The date and timing of the assessment needs to be clearly identified.

If new or previously unrecognized risks have now been identified at a home birth setting or at the Birth Centre, they should be documented, discussed with the woman and her partner and a management plan formulated. This may involve transfer into the obstetric unit.

Refer to MTW Guidelines: (referenced on pages 2 and 3)

- Maternal and Neonatal Transfer from the Maidstone Birth Centre, a Homebirth and Maidstone Antenatal Clinic or Day Assessment Unit
- Antenatal Clinical Risk Assessment
- Management of Women who decline blood products

5.4.2 Ongoing Clinical Risk Assessment throughout Labour and Delivery

Risk assessment is necessarily an ongoing process during labour and delivery whereby the midwife providing care is vigilant to developing deviations from normal in relation to labour progress and all observations of maternal and fetal wellbeing. Should any concerns arise the midwife providing care (at TWH) should liaise with the Delivery Suite Co-Ordinator and Obstetric Registrar.

Should significant deviations from normal arise at the Birth Centre or at home the Birth Centre Co-Ordinator or midwife in attendance will contact the Delivery Suite Co-Ordinator at TWH to discuss appropriate transfer to TWH.

Refer to MTW Guideline (referenced at page 2)

- Maternal and Neonatal Transfer from the Maidstone Birth Centre, a Homebirth and Maidstone Antenatal Clinic or Day Assessment Unit

5.4.3 Unbooked women

- Unbooked women should be allocated to the Consultant on-call.
- Unbooked women constitute a high-risk group and the Registrar should assess.
- On admission booking bloods should be taken if possible.

Refer to MTW Guideline: (referenced on page 2)

- Antenatal Clinical Risk Assessment

5.5 Diagnosis of Labour

Definition of established first stage of labour

- Regular, painful contractions accompanied by effacement and dilatation of the cervix

and

- A cervical dilatation of 4cm or more

Diagnosis should be by vaginal assessment unless labour is clearly advanced. Once labour is established a partogram must be commenced which then allows progress to be checked swiftly.

For women who have pain without cervical change, there is some evidence to suggest that admission to hospital will increase unnecessary intervention. Women who are not in established labour should be offered support and encouraged to return home. Some women may find coping strategies such as complementary therapies useful in this situation.

If the diagnosis of labour is uncertain, observation and reassessment should occur within a period of 2 – 6 hours.

5.5.1 Vaginal Examination

If, after a period of assessment, (within 2 hours of admission), birth is not imminent, it may be helpful to carry out a vaginal assessment to determine whether the woman is in established labour. This will be performed by the midwife unless gestation is < 34 weeks.

- Verbal consent must always be obtained. Privacy and dignity of the woman should be maintained at all times.
- **Caution should be exercised before carrying out a vaginal examination if SROM is suspected to minimize the risk of infection. A** speculum examination is more appropriate (see 5.5.2) unless the woman feels the pain is so severe that she requires pain relief, the CTG is abnormal or the labour is well established.

- The Registrar should be informed of any woman admitted with a history of fresh vaginal bleeding, the midwife having taken a detailed history of events, observed a sanitary pad for fresh loss (if available), and identified the placental location on ultrasound. Pelvic examination is not contraindicated in the absence of a low-lying placenta. Ideally, all women admitted with significant bleeding should be assessed and examined by the Registrar. If the Registrar is unable to attend immediately, if clinically appropriate, examination may be undertaken with caution by the midwife on the advice of the Registrar, having ensured the placenta is not low-lying.

- Vaginal examination must always be preceded by abdominal examination to assess engagement of the presenting part, bladder fullness, etc. This allows proper interpretation of findings on vaginal examination.
- Ideally the same person should perform repeat vaginal examinations to minimise subjective error.

Record in notes

- Dilatation of cervix, its application to presenting part and station.
- Effacement should be recorded as cervical length (in cms).
- Colour of liquor, if present.
- Position and station of presenting part.
- Presence of moulding and / or caput.

Refer to MTW Guidelines: (referenced on pages 2 and 3)

- Obstetric Haemorrhage
- Pre-Labour Rupture of Membranes at Term

5.5.2 Speculum Examination

Indications

- To confirm SROM
- Examine vaginal discharge
- Take vaginal swabs and LVS /HVS as appropriate
- Assess the cervix carefully if vaginal bleeding (exclude placenta praevia first by reviewing ultrasound report).

Examination may be carried out by

- Midwife if SROM >37/40.
- Registrar if <34/40 / bleeding / abnormal symptoms / placenta low on last scan / Midwife unable to visualise cervix.
- If between 34 and 37 weeks, discuss.

Examination

- Presence and colour of liquor, mucus and discharge.
- Ask woman to cough if no liquor is seen. If PROM is suspected, being supine for 30mins may encourage pooling of liquor
- Visually assess length, dilatation and position of cervix.

Refer to MTW Guidelines: (referenced on pages 2 and 3)

- Obstetric Haemorrhage
- Pre-Labour Rupture of Membranes at Term

5.6 Management Plan

Following initial assessment and after discussion with the woman a plan of care should be formulated. This may include the following options:

- Return home to await events
- Admission to antenatal ward if any concerns or analgesia required (a woman in early labour should be encouraged to return home).
- Transfer from Triage to Delivery Suite if labour diagnosed
- Women with 'increased risks' (e.g. induction of labour, raised blood pressure, IUGR etc) should have a CTG performed and follow flow chart in Appendix 4 (b) for expected progress during first stage of labour (1cm hour). This flow chart will also be used for any woman who has epidural anaesthesia
- 'Low risk' multiparous women will also use the same pathway of care (Flow chart [b] Appendix 4) (expected progress 1 cm hour)
  See also section 5.6.2 Midwifery led care
- **For 'low risk' nulliparous women ONLY** refer to Flow chart A, Appendix 4. Expected progress for this group of women ONLY will be ½ cm hour during the first stage of labour.
  See also section 5.6.2 Midwifery led care

5.6.1 If labour is diagnosed

- Commence partogram if labour is diagnosed and document management plan in notes.

- Handover to be given to Delivery Suite Co-ordinator and information recorded on Delivery Suite board. (at Birth Centre, Birth Centre Co-Ordinator to be advised woman is in established labour and board updated as appropriate)
- High risk women will be cared for at TWH. Inform Obstetricians and Neonatologists if there are any antenatal risk factors.

5.6.2 Midwifery Led Care

- Inform **Delivery Suite Co-Ordinator/Birth Centre Co-Ordinator** of all findings and keep board updated.

- Treat as low risk if no risk factors or complications during pregnancy / labour.

- Referral to the Obstetric team should follow consultation with the midwifery Co-Ordinator and should be documented (date, time, by whom, to whom and reason).

- The woman may be referred back to Midwifery care by the Obstetric Team.

- Safety of the woman depends on teamwork.

- **Room numbers 1-6 at TWH should be utilized, where possible, for all 'low risk' women in normal labour.**

- Women should be encouraged to be mobile and maintain upright positions during the first and second stage of labour.

- Use of water in labour should be encouraged – research has shown that it reduces women's perception of pain and reduces use of epidurals

High-risk clients must have medical involvement in planning and managing their care.

5.7 Care During the established First Stage of Labour (applies to care in all birth settings)

5.7.1 Observations

Once labour is established all observations should be recorded on the partogram. The frequencies listed below for these observations should be increased if abnormalities are detected.

Maternal

- 4 hourly temperature and blood pressure
- Hourly pulse
- Record frequency, length and strength of contractions half-hourly.
- Ongoing observation of vaginal loss. If membranes have ruptured, the colour of the liquor should be observed for the presence of meconium, abnormal blood staining or signs of sepsis.
- A vaginal examination should be offered 4 hourly or in response to a woman's wishes or when either opioid or conduction analgesia are being considered. Abdominal palpation and assessment of vaginal loss should always precede a vaginal examination.
- The woman should be encouraged to empty her bladder every 2-3 hours.
- Record the administration of all drugs and fluids, including oxytocin infusion. These must also be documented on the drug chart.

Fetal

- For low risk women the fetal heart should be auscultated every 15 minutes for the duration of one minute, after the contraction has finished.
- Women who have risk factors, including those who are having labour induced or augmented and those with epidurals should have continuous fetal heart monitoring. (See fetal monitoring guideline referenced below)
- For low risk women, any deviation from the normal, such as fetal heart rate abnormalities detected on external auscultation, meconium stained liquor, abnormal maternal observations and poor progress will require the instigation of continuous electronic fetal monitoring and transfer to the 'high risk' pathway of care (See flow chart B, Appendix 4).
- Should significant deviations from normal arise at the Birth Centre or at home the Birth Centre Co-Ordinator or midwife in attendance will contact the Delivery Suite Co-Ordinator at TWH to discuss appropriate transfer to TWH.

Refer to MTW Guideline: (see page 2 for full reference)

- Auscultation and Electronic Fetal Monitoring

5.7.2 Assessing Progress in Labour (see also flow charts A & B in Appendix 4)

- Most women in their first labour will reach the second stage within 18 hours without intervention, 12 hours in a multiparous woman.

  Clinical intervention should not be offered or advised where labour is progressing normally and the woman and baby are well.

- A diagnosis of delay in labour needs to take in all aspects of progress and should include

  - Descent and rotation of the head
  - Changes in duration, strength and frequency of contractions

AND

  - Cervical dilatation of less than 2cm in 4 hours for first labours **in low risk women ONLY**
  - Cervical dilatation of less than 4cm in 4 hours for second and subsequent labours

As outlined in flow charts A & B in Appendix 4 a confirmed diagnosis of delay requires a referral to the Obstetric Registrar. The Delivery Suite Co-Ordinator should also be informed.

- Findings of the abdominal palpation and vaginal examination must be clearly documented in the case notes.

5.7.3 Artificial Rupture of the Membranes (ARM)

- Routine amniotomy is NOT recommended. This procedure should be reserved for women where labour is deemed to be delayed (see flow charts) or for women having labour induced and should always be discussed with the woman first.

Indications

- For induction of labour
- Prior to oxytocin infusion with slow progress.
- To observe the amount and colour of liquor if fetal heart rate abnormal.
- To attach a fetal scalp electrode (FSE).

The indication for ARM must be documented in notes.

ARM in labour by a Midwife should only be performed if the fetal head is engaged and the cervix is 3cm or more dilated, after explanation and with consent of the woman.

If the presenting part is not engaged, the SpR only should perform an ARM. If there is doubt about the presenting part, the SpR should examine the woman before ARM or FSE application and carry out an ultrasound scan

5.7.4 Analgesia

Non-pharmacological pain-relieving strategies

- Pain is a normal part of the natural process of labour and midwives/birth partners should support the woman to utilize her own coping mechanisms. If possible continuity of carer should be maintained and non-pharmacological methods of pain relief, including immersion in water, massage, breathing techniques, changing positions and remaining mobile, coping strategies, TENS and alternative therapies suggested. Creating a birth environment conducive to the woman's individual needs may help reduce stress (subtle lighting, music etc) and enhance the birth experience.

- Women should be encouraged to move and helped to adopt whatever positions they find comfortable in labour.

- Labouring in water is recommended for pain relief unless there are contraindications.

  Refer to: MTW Guideline (referenced on page 3)
  - Waterbirth

Inhalation analgesia

- The woman should be informed that Entonox may provide limited pain relief. It may also make her feel nauseous and light headed.

- The midwife should give a full explanation of how it should be administered and document usage on the prescription chart.

Pethidine

- 200 mg in divided doses with a maximum single dose of 150mg IM can be given by the midwife, without consultation with the medical staff, providing the woman is in established labour.

- An appropriate antiemetic is recommended at the same time.

- The woman should be informed that Pethidine may cause drowsiness, nausea and vomiting and may also cause short-term respiratory depression and drowsiness in the baby that may last for several days and may interfere with breastfeeding.

- Further doses of Pethidine must be discussed with the on call obstetric registrar and prescribed by either the obstetric senior house officer or obstetric registrar.

Epidural

- An epidural is usually available on demand (at TWH) and can be arranged with the anaesthetist on call. It provides more effective pain relief than opioids. Women should be recommended to read the information card regarding epidural anaesthesia prior to the anaesthetist being called.

- A vaginal examination should be performed prior to insertion of epidural

- Continuous CTG monitoring is required for all women with epidural analgesia – monitoring is also required during insertion of the epidural. Prior to the epidural being sited a reassuring CTG must be obtained (minimum 20 minutes). If there is any doubt as to fetal wellbeing referral to obstetrician should be sought prior to proceeding with the epidural.

- It is appreciated that continuous monitoring may be difficult during the siting of the epidural. Nonetheless there must be evidence of fetal monitoring. In low risk women the fetal heart should be monitored every 15 minutes after a contraction (as a minimum). In situations where there is any concern as to fetal wellbeing the application of an FSE should be considered if continuous monitoring abdominally is not achievable.

- Consideration may also need to be given to the suspension of any Syntocinon infusion whilst the epidural is being sited

- Women should be informed that an epidural is associated with a longer second stage of labour and an increased chance of vaginal instrumental birth

- Women with medical or pregnancy complications should be discussed with the Obstetric Registrar and/or Anaesthetist (as appropriate) prior to the insertion of an epidural.

  Refer to MTW Guideline: (see page 2 for full reference)
  - Guideline for Management of Epidural Anaesthesia in Labour.

5.7.5 Positions in Labour

Encourage ambulation and upright positioning

Avoid supine position and aortocaval compression (especially when epidural in-situ).

5.7.6 Eating and Drinking in Labour

- Women may drink when in established labour and should be informed that isotonic drinks may be more beneficial than water.

- Women may eat a light diet in labour unless they have received opioids or have an epidural or develop risk factors (e.g. augmentation with Syntocinon) that make a general anaesthetic more likely. These women should be restricted to water based/clear fluids only.

- **Measure and record accurately all fluid intake and output for women receiving intravenous fluids**, particularly when Oxytocin is being used. No woman should receive more than 2 litres of Hartmann's sol^{n} in 12 hours or 3 litres in 24 hours without discussion with the Obstetric Registrar and Anaesthetist. All fluid intake and output must be recorded on the Partogram.

H2 antagonists / antacids

- Are not routinely indicated for low risk women.

- Women with risk factors for general anaesthesia or who have an epidural should be given oral Ranitidine 150mg 6 hourly.

- Women who are given narcotics (Pethidine, Morphine etc) should also be given oral Ranitidine 150mg 6 hourly as these agents are associated with delayed stomach emptying.

5.7.7 Peri-partum Bladder Management

It is essential that the woman is encouraged to void urine at least 3 hourly whilst in labour.

About 10 – 15% of women have voiding dysfunction to some degree and for sometime following delivery. It is often of a relatively minor degree.

Refer to MTW Guideline: (referenced on page 3)

- Guideline for Peri Partum Bladder Care

5.7.8 Complications or Concerns

Indications for electronic fetal monitoring in low risk women are included in the fetal monitoring guideline.

Refer to MTW Guideline: (Referenced on page 2)

- Auscultation and Electronic Fetal Monitoring

5.8 Care During the Second Stage of Labour (See also flow charts C & D in Appendix 4)

5.8.1 Diagnosis of Second Stage of Labour

The second stage of labour is usually diagnosed when full cervical dilatation has occurred and / or the woman has an overwhelming urge to push and the presenting part is visible.

Full dilatation is suspected when

- Anal dilatation is present.
- The presenting part is visible.
- A 'show' is noted.
- The onset of early decelerations of the fetal heart rate.
- It may be confirmed by VE.

5.8.2 Management of the Second Stage of Labour

Birth is expected to take place within 3 hours of start of the **active second stage** for nulliparous women and within 2 hours for multiparous women.
There is some evidence to suggest that if the 2nd stage of labour lasts for more than 3 hrs in a nulliparous woman there is a higher rate of morbidity. Also prolonged second stage has been shown to increase the risk of uterine prolapse and urinary and faecal incontinence.

Management of 2nd stage should be divided into two parts, passive (descent) and active (pushing)**.**

5.8.3 'Passive Phase'

The cervix is found to be fully dilated in the absence of expulsive contractions

- The 'passive phase' may last for up to 2 hours in a nulliparous woman with an epidural (1 hour for a multiparous), but progress should be kept under close review and, if poor, discussed with the co-ordinating midwife and the Obstetric Registrar in case treatment is indicated.

- If contractions are inadequate, the use of Oxytocin should be considered at onset of, or during the second stage

- It is not routine practice to allow the epidural top-up to wear off for the 2nd stage, although it can be advantageous for the woman to have some sensation to bear down. 'Not to top-up' should therefore be the decision of the woman and not the midwife.

- If a woman with an epidural does experience the desire to bear down and the fetal head is found to be in a position unfavourable for delivery, one epidural top up may be considered in order to allow spontaneous descent and rotation.

5.8.4 'Active stage'

- Pushing should start when the urge is uncontrollable and / or the head is visible or when the time limit for the passive stage (2 hours for nulliparous and 1 hour for multiparous women) has expired. Women should be discouraged from lying supine or semi-supine in the second stage of labour and should be encouraged to adopt upright positions.

- Women should be informed that in the second stage they should follow their own urge to push. The Valsalva Manoeuvre (deep breath and push against a closed glottis) should be avoided. If pushing is ineffective, or requested by the woman, strategies to assist birth can be used, such as support, change of position, emptying of bladder or encouragement.

- Active pushing can last for up to 2 hours in a nulliparous woman and 1 hour for a multiparous woman.
  It is essential that adequate progress is being made and good contractions are present. If progress is poor (after 1 hour for a nullip, 30 mins for a multip), the midwife should perform an abdominal palpation followed by a vaginal examination to ascertain progress and descent of the head. It may be appropriate to refer to the Obstetric Registrar at this point if progress is inadequate. The Delivery Suite Co-Ordinator should also be informed.

- The Co-ordinating midwife and Obstetric Registrar must be informed if the pushing phase becomes prolonged (2hours for a nullip, 1 hour for a multip). An instrumental delivery may be performed at this point. (See flow chart re delay in second stage)

- Any decision to prolong the second stage further should include assessment by the registrar every 15 minutes. Oxytocin should not be started at this point.

5.8.5 Delay in the Second Stage (See flow charts C & D in Appendix4)

Delay in the second stage is defined as either

- Poor descent of the vertex
- Active pushing >1 hour nulliparous woman and > 30 minutes in multiparous women.

If delay is suspected

- Midwife to discuss progress with Midwife-in-Charge and SpR.
- Abdominal palpation (fetal size, position and number of 5^{ths} of head palpable, bladder fullness).

- VE (position, station, dilatation, caput, moulding).
- Contraction strength, frequency and duration.
- Pushing techniques.
- Maternal position.

If obstructed labour or true disproportion is excluded then the SpR may allow augmentation with oxytocin in nulliparous women.

5.8.6 Monitoring in Second Stage

Maternal

- Hourly blood pressure and pulse (or more frequent if abnormal)
- Temperature should be continued 4 hourly
- Vaginal examination should be offered every hour (following abdominal palpation), depending on progress
- Significant deviations from normal must be reported to the Delivery Suite Co-Ordinator and the Obstetric Registrar at TWH. Should significant deviations arise at the Birth Centre or at home the Birth Centre Co-Ordinator or midwife in attendance will contact the Delivery Suite Co-Ordinator at TWH to discuss appropriate transfer to TWH.

Fetal

- If a CTG is not used, the fetal heart should be auscultated at 5 minute intervals for 1 minute following a contraction using a Pinnard or Sonicaid.

- If abnormalities are detected these must be reported to the co-ordinating midwife and / or the Obstetric registrar and continuous EFM commenced. It is common for there to be early decelerations of the fetal heart rate due to head compression. If there are no other abnormalities, these can be classed as physiological.

- Should significant deviations from normal arise at the Birth Centre or at home the Birth Centre Co-ordinator or midwife in attendance will contact the Delivery Suite Co-ordinator at TWH to discuss appropriate transfer to TWH.

- Maternal and fetal observations must be recorded on the partogram or in the case notes.

5.8.7 Documentation of Maternal Observations during labour

- Maternal observations required on admission in labour are specified at 5.4. These must be recorded in the woman's labour record within her maternity notes.

- Maternal observations (type and frequency) required in the established first stage of labour are specified at 5.7.1. These must be recorded on the partogram in the woman's maternity notes.

- Maternal observations (type and frequency) required in the second stage of labour are specified at 5.8.6. These must be recorded on the partogram in the woman's maternity notes.

- Maternal observations (type and frequency) required in the third stage of labour are specified at 5.9.1. These must be recorded in the woman's labour record within her maternity notes.

Refer also to MTW Guideline: (referenced on page 3)

- Record Keeping and the management of health records

5.8.8 Care of the Perineum

Episiotomy
Its indication should be clearly documented in the notes:

- Episiotomy is NOT a routine procedure and should only be carried out when there is clinical need (such as instrumental birth) or suspected fetal compromise to expedite the delivery.

- It should NOT be offered routinely following previous third or fourth degree trauma

- Tested effective analgesia should be provided prior to carrying out an episiotomy, except in an emergency

- If episiotomy is indicated it should be performed in the right mediolateral which will reduce the risk of it extending into the anal sphincter.

.

- Either the 'hands on' or the 'hands poised' technique can be used to facilitate spontaneous birth.

5.8.9 Delayed Cord Clamping and Clamping and Cutting the Cord

Delayed cord clamping for term infants > 37 weeks gestation

The evidence surrounding delayed cord clamping for term babies is not as clear cut as with premature babies. Parents who request delayed cord clamping should be informed that there is a small increased risk of neonatal jaundice requiring phototherapy. (This risk is only small and equates to 1 extra baby requiring phototherapy in 18 months across the whole Trust).

If parents still wish to opt for delayed cord clamping, this procedure can be offered and documented in the clinical notes.

Guideline

- There is no change to the timing of administration of Syntometrine
- If the baby is born in good condition and immediate resuscitation is not required, the baby may be placed on the mother's abdomen and the cord not cut until 3 minutes have passed, or the cord pulsation cease (whichever is earlier). The baby should be closely observed during this period to ensure that it's condition remains stable
- Blood samples can be taken from the umbilical cord in the normal way once the cord has been clamped and cut.
- Length of time before the cord is clamped and cut should be documented in the notes
- If immediate resuscitation is indicated, the cord can be 'milked' from the placental end of the cord towards the baby before the cord is clamped and cut.

  (For premature infants and delayed cord clamping
  Refer to MTW Guideline: (referenced on page 3)
  - Preterm Labour and Delayed Cord Clamping in Preterm Infants)

Clamping and cutting the cord

In active management of labour the cord should normally be clamped and cut within 3 minutes, but more rapidly if the baby is above the placenta (e.g. on mother's abdomen). It must also be clamped as rapidly as possible in diabetes / APH / asphyxia.

5.9 Third Stage of Labour

The third stage of labour is potentially the most hazardous for the mother and she must never be left unattended at this time

5.9.1 Observations in the Third Stage of Labour

Women should be closely observed in the third stage of labour. Observations should include:

- **The woman's general physical condition, as shown by her colour, respirations, and her own report of how she feels**
- **Vaginal blood loss**

These observations must be recorded in the woman's labour record.

5.9.2 Active vs Physiologicial Management of Third Stage of Labour

- The method chosen to deliver the placenta and membranes must be based on the mother's wishes and the midwife's clinical assessment of risk (see below)

- Active management of labour reduces blood loss, the incidence of postpartum haemorrhage, duration of 3rd stage of labour and postnatal anaemia. There are associated side effects of headache, nausea and vomiting for some women.
  Active management is therefore recommended for women who are at increased risk of postpartum haemorrhage.

- Physiological management is **only appropriate** for women with low risk of postpartum haemorrhage and those who have had a normal physiological labour.

  If the mother chooses this method it should be clearly documented in the notes and also that she has been told there may be an increased blood loss with this method.

5.9.3 Principles of Active Management of Third Stage of Labour

- Intramuscular injection of Syntometrine is given with the birth of the anterior shoulder as long as there are no contraindications to it's use (see below)

- The umbilical cord is clamped and cut. Double clamping of cord is indicated if cord blood is required for pH estimation (if obstetric intervention, suspected fetal distress or baby requiring active resuscitation)

- The uterine fundus is palpated to ensure that it is well contracted

- When signs of placental separation are present, one hand is placed above the level of the symphisis pubis, applying pressure in an upright direction, thus 'guarding' the uterus from inversion, whilst the other hand exerts controlled cord traction in a downward, backwards direction (modified Brandt-Andrews method)until the placenta appears at the vulva. The direction of traction then changes to upwards and outwards.

- Downward traction on the cord must be released before uterine counter traction is relaxed.

- Once the placenta is visible it may be taken in two hands and twisted, or an up and down movement made to ease the membranes out slowly.

- If there is delay in delivering the placenta, consider emptying the bladder

- The placenta and membranes must be checked for completeness. If incomplete the Co-ordinating midwife and Obstetric Registrar must be informed.

- Throughout the 3rd stage of labour the woman's condition and blood loss must be closely observed and documented in her maternal notes.

5.9.4 Relative Contraindications to the Use of Syntometrine and Ergometrine

- Hypertensive diseases of pregnancy – pre eclampsia, eclampsia, HELLP syndrome, Fatty liver disease of pregnancy

- Hypertension BP > 140/90

- Cardiac disease

  In the above cases Syntocinon 5 iu IV should be and administered, slowly, with the delivery of the anterior shoulder. (Syntocinon IV can cause profound hypotension)

Refer to MTW Guideline: (referenced on page 3)

- Management of Hypertensive Disorders of Pregnancy, including Pre-eclampsia and Eclampsia

5.9.5 Principles of Physiological Management of the Third Stage

- Midwives should be clear about the components of physiological management in order to ensure safe practice

- The atmosphere should be calm and unhurried

- It is important to explain to the woman that the normal process for management of physiological 3rd stage of labour may take up to one hour

- If a woman requests conversion to active management of 3rd stage, Syntometrine can be given up to 30 minutes following delivery of the baby.

- The placenta is delivered by maternal effort only. Encouraging the woman to adopt an upright position will facilitate expulsion of the placenta by gravity.

- The umbilical cord is not clamped or cut until pulsation has ceased. If cutting the cord is necessary (eg baby requires resuscitation), the maternal end of the cord should remain unclamped)

- Putting the baby to the breast (if the woman wishes to breast feed) will increase maternal oxytocin thus facilitating uterine contractions and placental separation.

- If the placenta is not delivered by one hour – follow the guideline for the Management of a Retained Placenta (see page 2 for full reference)

5.9.6 Concerns and Complications of the Third Stage

Failure to deliver the placenta within 30 minutes of active management or 60 minutes of physiological management, or if significant bleeding occurs this must be reported to the Co-ordinating midwife and the Obstetric Registrar

In the presence of haemorrhage, retained placenta or maternal collapse, frequent observations to assess the need for resuscitation are required and should be clearly documented.

Haemorrhage at home or the Birth Centre will necessitate the emergency transfer of the woman to TWH.

Refer to MTW Guidelines: (referenced on page 2 and 3)
- Obstetric Haemorrhage
- Maternal and Neonatal Transfer from the Maidstone Birth Centre, a Homebirth and Maidstone Antenatal Clinic or Day Assessment Unit

5.9.7 Cord pH Measurement (Paired Samples)

Cord blood pH measurements must **always** be obtained following:
- Delivery for ‘fetal distress’
- Low Apgar (<7) @ 5 minutes
- All emergency LSCS and instrumental deliveries.
- Shoulder dystocia.

Separate samples must be taken from the umbilical artery and vein (paired samples). The results must be recorded in the mother's and the baby's notes. The actual pH measurements can be taken at any time in the following 15-20 minutes, allowing birth attendants the opportunity to deal with the immediate needs of mother and baby.

5.10 Care After Birth

5.10.1 Care of Woman

Observations

- General physical condition, colour, respirations
- Temperature, pulse, Blood pressure, uterine contraction, lochia, bladder voiding
- Emotional / psychological condition

These observations should be taken and recorded within 15 – 30 minutes of birth unless the mother's condition prompts an earlier need.

5.10.2 Check placenta and membranes are complete

If baby is admitted to NNU or pregnancy complicated (e.g., preterm / stillborn / abruption / chorioamnionitis), send placenta for histology.

5.10.3 Care of Baby

Refer to MTW Guidelines: (referenced on pages 2 and 3)

- Neonatal Resuscitation
- Immediate Care of the Newborn
- Admission to Neonatal Unit

5.10.4 Perineal Care

- Carry out systematic assessment of any trauma, including a rectal examination sensitively if appropriate.

- Explain assessment to the woman and confirm adequate analgesia. It is important to remember that current recommendation is that 2nd degree tears should be sutured.

Refer to MTW Guideline (referenced on page 2)

- Guideline for the Management of Perineal Trauma

5.11 Unanticipated birth within the Accident & Emergency Department at TWH or the Emergency Care Centre at Maidstone Hospital

In the event of a self-referred imminent birth with the Accident & Emergency department at TWH the Delivery Suite at TWH will be contacted by A&E and a midwife asked to attend. A&E staff will request the paediatric on-call team to

attend to undertake any necessary resuscitation of the newborn and any appropriate transfer to the Neonatal Unit.

In the event of a self-referred imminent birth within the Emergency Care Centre (ECC) at Maidstone Hospital the Birth Centre will be contacted and a midwife asked to attend. ECC staff will undertake any necessary resuscitation of the newborn.

Refer to MTW Guidelines: (referenced at pages 2 and 3)

- Operational Policy for Birth Centre
- Neonatal Resuscitation
- Admission to Neonatal Unit

6.0 Monitoring and Audit

Monitoring Table for Care of Women in Labour and Clinical Risk Assessment in Labour

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Action Lead(s)	Change in practice and lessons to be shared
Telephone advice and admission to Delivery Suite/Triage/Birth Centre as appropriate	Lead Midwife Del. Suite	Review of 1% of all maternity record using telephone advice sheets and record keeping audit tool at Appendix 4 of MTW guideline *Record Keeping and management of health records*	Annually	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Lead Midwife. Delivery Suite	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.
Women's choices in labour	Matron In patient maternity services(IPS)	Review of 1% of all maternity records using Maternity Questionnaire at Appendix 7	Monthly	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Matron. IPS	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.
Record keeping. Maternal Obs. Carried out and documented according to guideline	Matron IPS	Review of 1% of all maternity record using telephone advice sheets and record keeping audit tool at Appendix 4 of	Annually	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Lead Midwives SOM's	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite

		MTW guideline *Record Keeping and management of health records*				meetings and multidisciplinary teaching sessions etc.
Appropriate risk assessment and documentation on admission in labour as outlined in the guideline	Lead Midwife for Delivery Suite	Review of 1% of all maternity record using telephone advice sheets and record keeping audit tool at Appendix 4 of MTW guideline *Record Keeping and management of health records*	Annually	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Lead Midwife for Delivery Suite	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.
Documented individual management plan made for women in whom risks are identified following risk assessment on admission or at any stage during labour	Lead Obstetrician for Delivery Suite	Review of 1% of all maternity record using telephone advice sheets and record keeping audit tool at Appendix 4 of MTW guideline *Record Keeping and management of health records*	Annually	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Lead Obstetrician for Delivery Suite	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.

Appropriate documented referral to obstetric care of women in whom risks are identified following risk assessment on admission or at any stage during labour	Lead Midwife for Delivery Suite	Review of 1% of all maternity record using telephone advice sheets and record keeping audit tool at Appendix 4 of MTW guideline *Record Keeping and management of health records*	Annually	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Lead Midwife for Delivery Suite	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.
Guidance followed and documented in relation to duration of stages of labour (as outlined in Guideline and flowchart appendices)	Lead Midwife for Delivery Suite	Review of 1% of all maternity record using telephone advice sheets and record keeping audit tool at Appendix 4 of MTW guideline *Record Keeping and management of health records*	Annually	Findings taken to Delivery Suite Forum (DSF) and reported to Clinical Risk Management Group (CRMG)	Lead Midwife for Delivery Suite	A lead member of the maternity team will be identified by CRMG to lead on any changes to practice. CRMG will monitor the action plan and ensure that changes are implemented within 3 months. Lessons to be learned will be shared via Risk Newsletter, Clinical Governance Meetings, Delivery Suite meetings and multidisciplinary teaching sessions etc.

APPENDIX ONE

Process Requirements

10.0 Implementation and Awareness

10.1 Once approved this policy/procedural document will be published on the Trust intranet by the CNST Maternity Co-ordinator or Maternity Secretary (as appropriate).

10.2 A monthly publications table will be produced by the Clinical Governance Assistant; this will be published on the Bulletin Board (Trust intranet) under "Trust Publications", and notification of the posting will be included on a bi-weekly notification email circulated Trust wide by the COMMS team.

10.3 On receipt of the Trust wide Bulletin board notification, all managers should ensure that their staff members are aware of the new publications.

10.4 On publication of any Maternity document, the CNST Maternity Co-ordinator will ensure that an email is sent to all Maternity staff and other stakeholders, as appropriate.

10.5 Women & Children's Clinical Governance Newsletter (Quarterly publication)

10.6 Dissemination from staff team meetings

10.7 Delivery Suite Notice Boards or Guideline Folders (as appropriate)

11.0 Review

11.1 It is essential that Trust Policy/procedural documents remain accurate and up to date; this policy/procedural document will be reviewed three years after approval, or sooner if there are changes in practice, new equipment, law, national and local standards that would require an urgent review of the policy/procedure. It is the responsibility of the Document Lead for this policy/procedure to ensure this review is undertaken in a timely manner.

11.2 The Document Lead should review the policy/procedure and, even when alterations have not been made, undertake the consultation process as detailed in **Section 5.5 Consultation** of MTW Policy and Procedure '*Production, Approval and Implementation of Policies and Procedures*'.

12.0 Archiving

3.1The Trust Intranet retains all superseded files in an archive directory in order to maintain document history.

3.2 Old paper guideline copies pre-dating Datix are stored at:

Chatham Archive & Storage document Co.
Anchor Wharf
Chatham
ME4 4TZ
Telephone: 01634 826665

APPENDIX TWO

CONSULTATION ON: Care of Women in Labour Incorporating Clinical Risk Assessment in Labour

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please reply on 'Drafts for Comments' on the Datix System.

By date: 11th October 2011

Name:	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Consultant Obstetricians	28/09/11	Oct 2011 (SA)	Y	Y
Consultant Paediatricians	28/09/11			
Consultant Anaesthetists (obstetric leads)	28/09/11			
Head of Midwifery/ADN	28/09/11	Oct 2011 (GD)	Y	Y
Maternity Matrons – Inpatient & Community	28/09/11	Oct 2011 (HB/HT)	Y	Y
Supervisors of Midwives	28/09/11			
Team Leads including Maternity Day Unit and Antenatal Clinic Leads	28/09/11			
Clinical Manager for Governance & Risk	28/09/11			
Maternity Clinical Risk Manager	28/09/11			
Midwifery Staff via Drafts for comments on Datix	28/09/11			
Clinical Governance Assistant	28/09/11			
Local Counter Fraud Specialist	28/09/11			
Neonatal Unit Managers	28/09/11			
Accident & Emergency Consultants and Managers at TWH & Maidstone Hospital	28/09/11			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

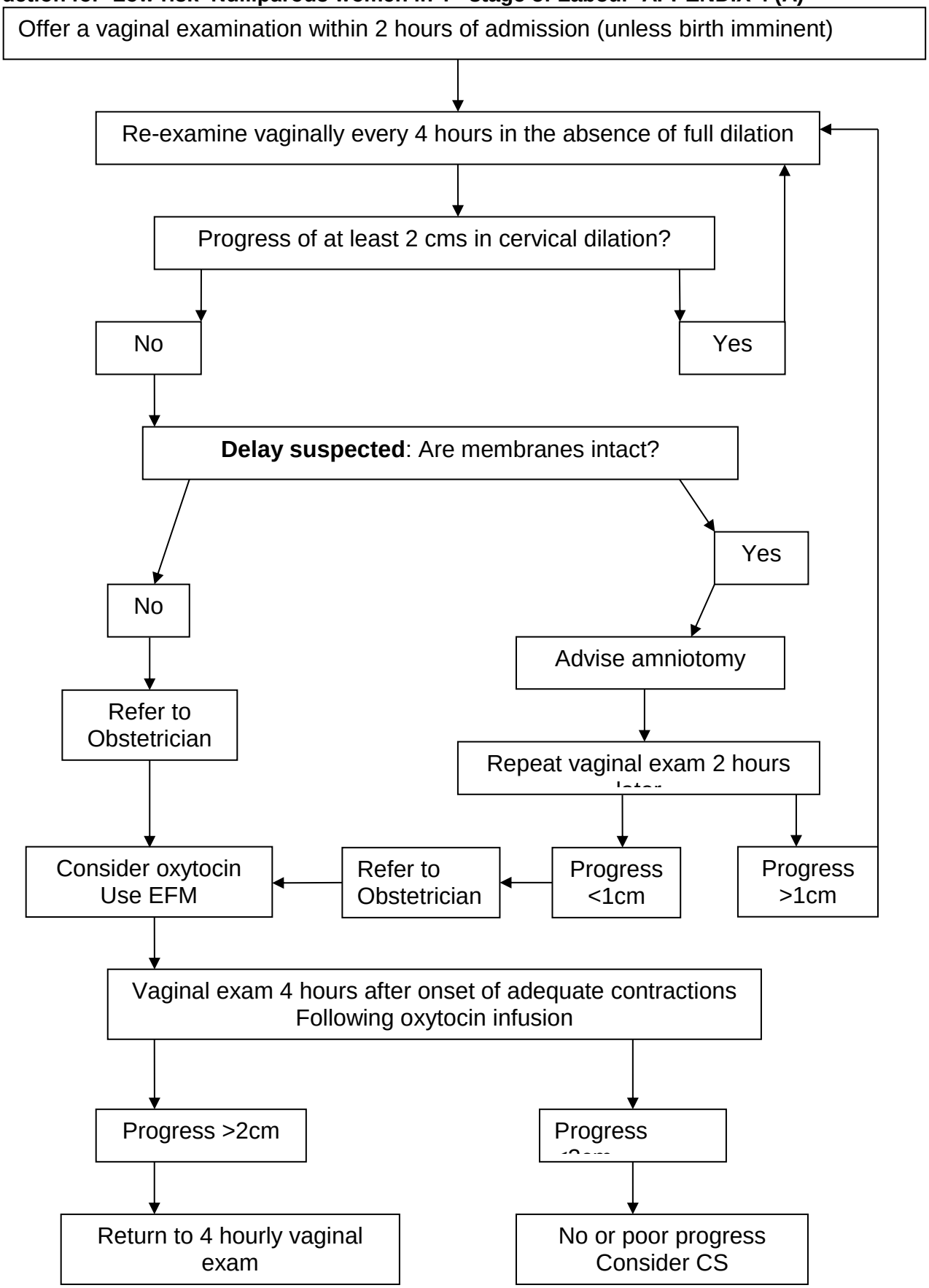
In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Care of women in Labour Incorporating Clinical Risk Assessment in Labour
What are the aims of the policy or practice?	To ensure optimum care for women in labour
Identify the data and research used to assist the analysis and assessment	See cross references on page 2
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	Is there an adverse impact or potential discrimination (yes/no). No.
Males or Females	Applies to females
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	No
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	When the document is reviewed which as a minimum is every three years
Where do you plan to publish the results of your Equality Impact Assessment?	As an appendix of this guideline on Trust Intranet, Datix Policies & Guidelines

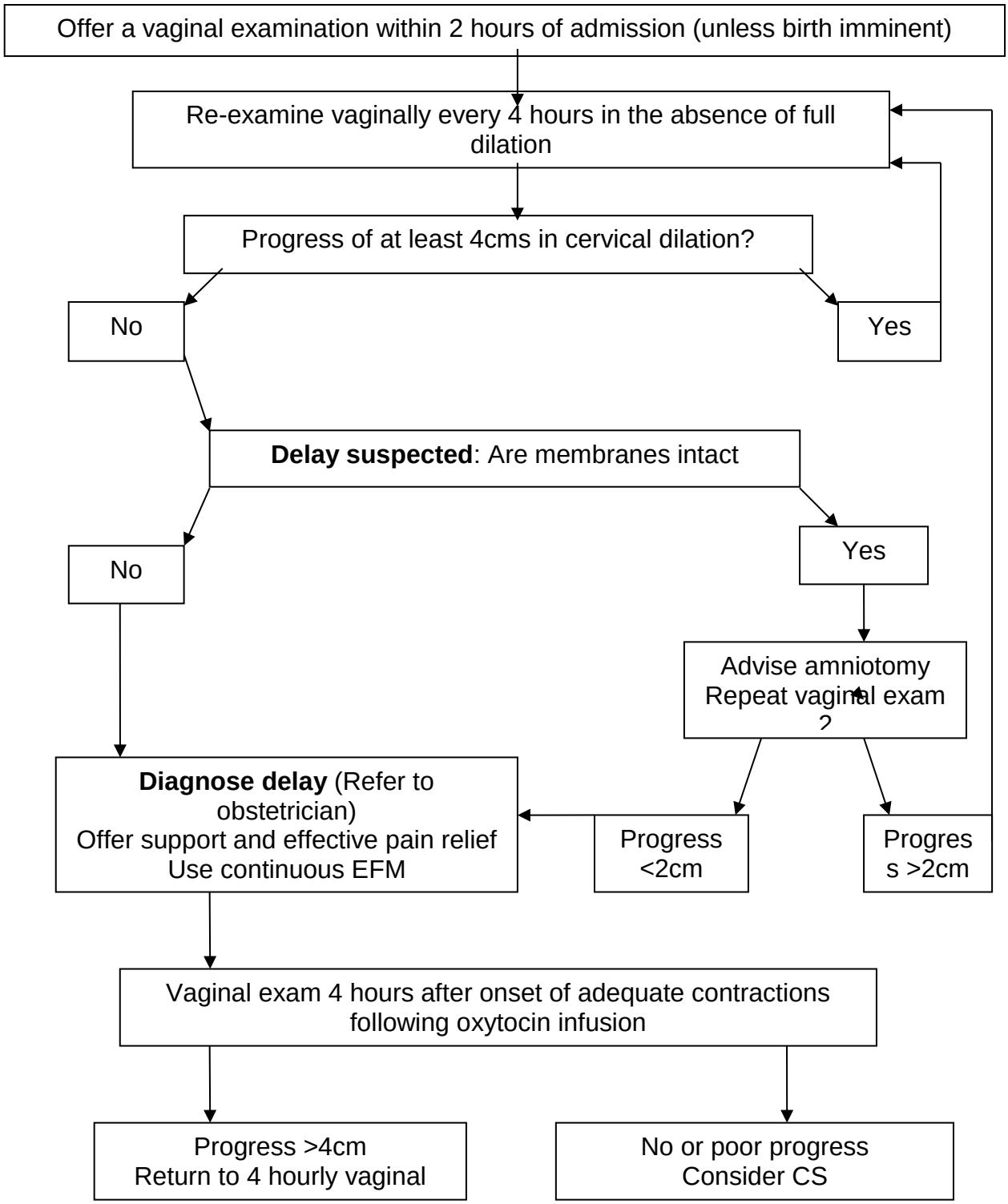
Flow chart showing expected progress, diagnosis of delay and Appropriate action for 'Low risk' Nulliparous women in 1st stage of Labour APPENDIX 4 (A)



APPENDIX 4 (B)

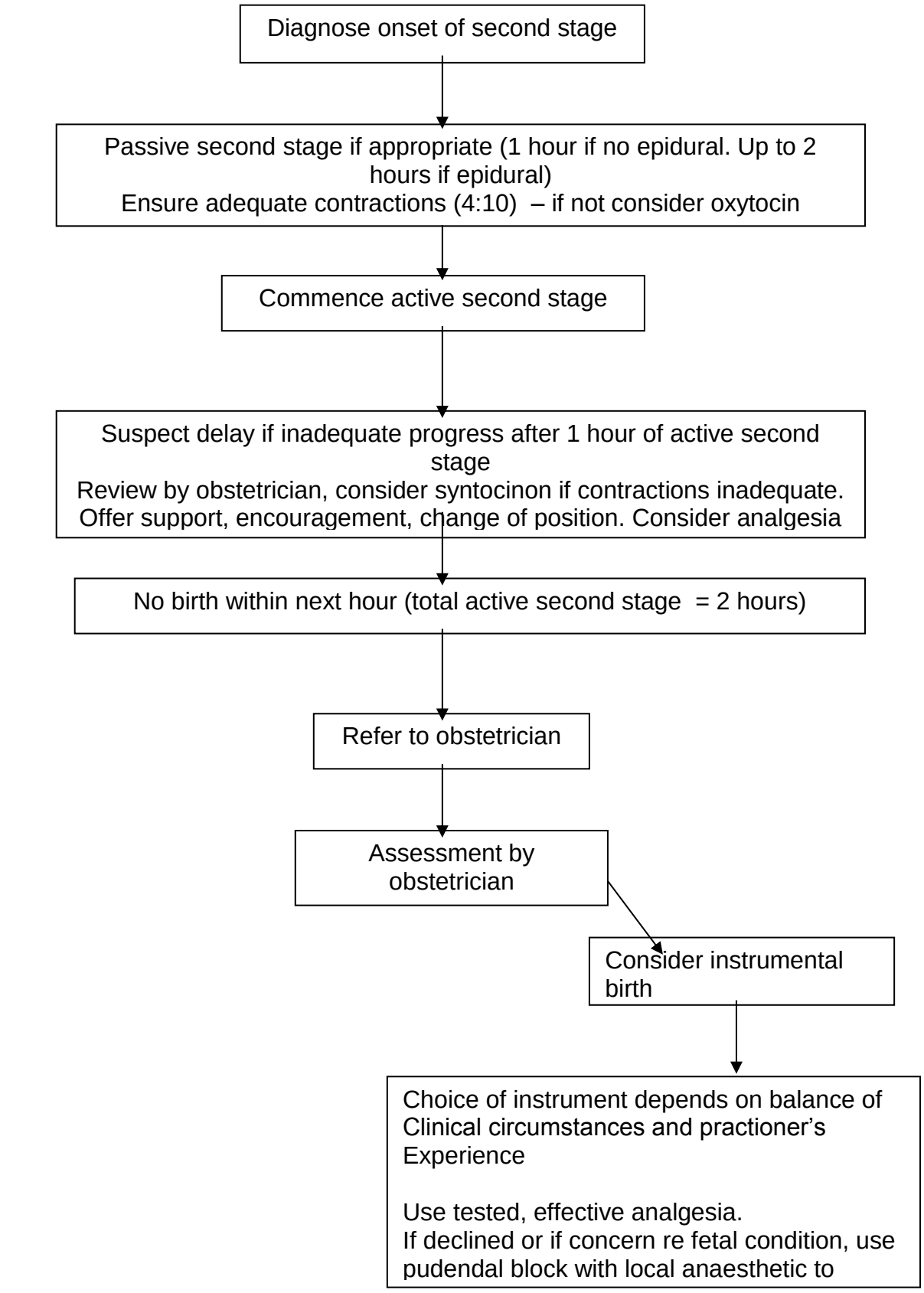
Flow chart showing expected progress, diagnosis of delay and appropriate action for First Stage of Labour

(This includes ALL multiparous women and 'increased risk' nulliparous)



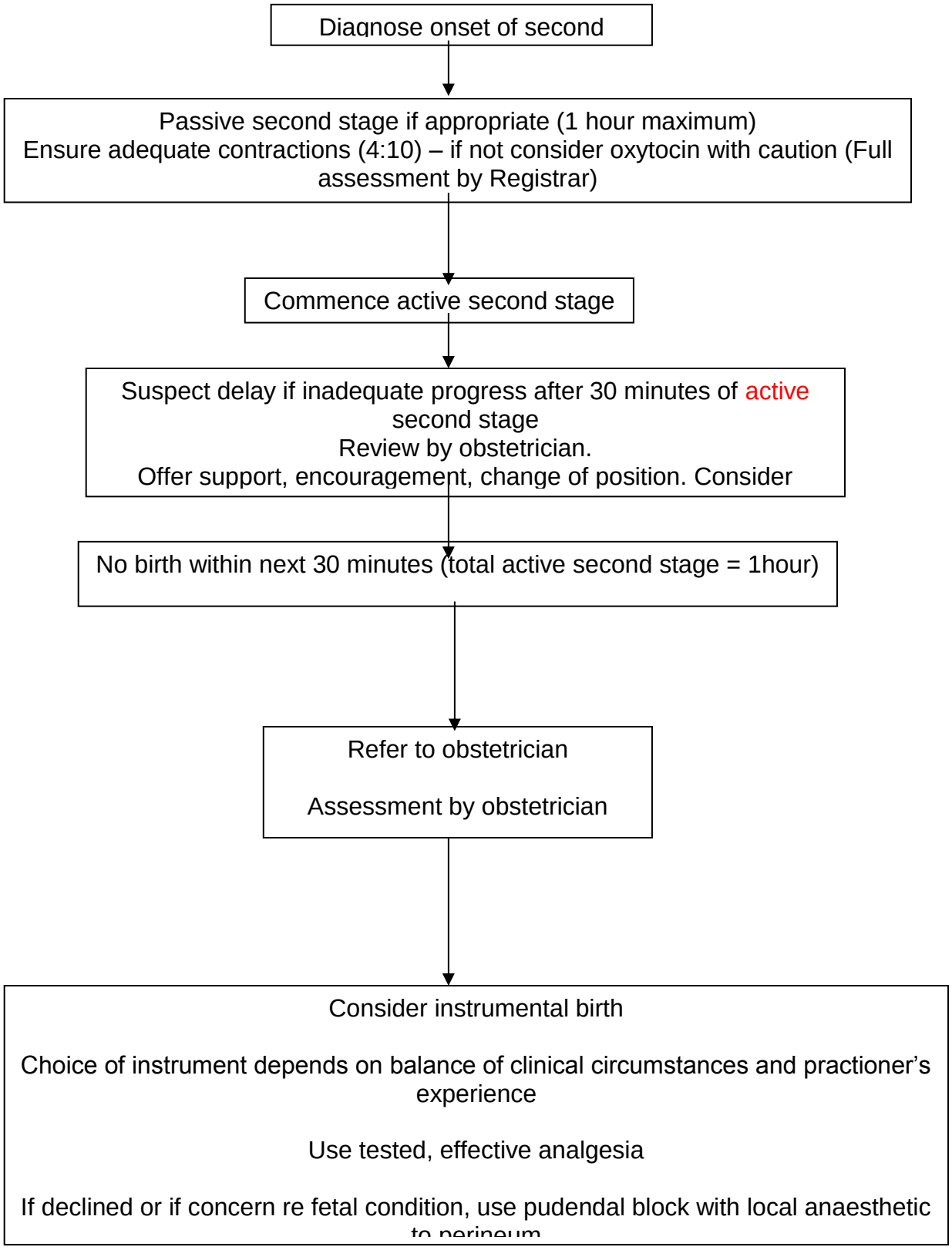
APPENDIX 4 (C)

Flow chart showing expected progress, diagnosis of delay and appropriate action for All Nulliparous woman in Second Stage of labour



APPENDIX 4 (D)

Flow chart showing expected progress, diagnosis of delay and appropriate action for Multiparous woman in Second Stage of labour



APPENDIX FIVE

Flow Chart for Women with Problems in their Pregnancy

Pregnant Clients ≤ 16 weeks

- **Pain and or bleeding refer to EGAU**
- **If Emergency refer to A&E at TWH Pembury**
- **Hyperemesis with ketones refer Maternity Triage at TWH Pembury**

→ **Refer EGAU at TWH Pembury**

TWH Pembury - Open: 08.00 –17.00hrs
Monday to Friday
Telephone: 01892 633448

Out of hours-refer A&E at TWH Pembury

≥ 16 weeks Gestation

Referral criteria for MDU Maidstone

- **SROM ≥ 37 weeks with no contractions**
- **Reduced fetal movement.**
- **GTT**
- **Anti D**
- **Uncertain presentation ≥ 36 weeks**
- **Pre-CS Assessment**

Referral criteria for MDU TWH Pembury: Above +

- **Raised B.P.+/- Proteinuria**
- **SROM ≥ 35 weeks with no contractions**
- **Itching in pregnancy**
- **Obstetric Cholestasis**

→ **Refer Maternity Day assessment units**:

Maidstone- Open 08.30-16.30hrs
Monday to Friday
Telephone: 01622 227121

TWH Pembury - Open: 08.00 – 16.00
Monday to Friday
Telephone: 01892 633041

≥16 weeks and immediate post-natal period

- **Fresh bleeding (NOT show)**
- **Pain (sudden onset, increasing and NOT responding to oral analgesia).**
- **Possible SROM with contractions at term or preterm.**
- **Suspected early labour including VBACs Anti D**
- **Reduced fetal movement (when MDU closed)**
- **Assessment for medical problems in pregnancy, following trauma / RTA & poor obstetric history (provided patient stable)**

→ **Refer Maternity Triage at TWH Pembury**

Open 24 hours, 7 days in a week
Telephone: 01892 633500

≥16 weeks and immediate post-natal period

- **Transfer by ambulance with serious obstetric complication**
- **Significant Obstetric haemorrhage**
- **Acute or severe abdominal pain**
- **Advanced stage of labour or imminent delivery**
- **Serious medical disorder of pregnancy**
- **Severe pre-eclampsia/ eclampsia or altered state of consciousness**
- **In utero transfer**

→ **Refer Delivery Suite at TWH Pembury**

Open 24 hours, 7 days in a week
Telephone: 01892 633502 or 01892 633923

MDU-Maternity Day Assessment Unit
EGAU-Emergency Gynaecology Assessment unit
TWH-Tunbridge Wells Hospital

Name:…… Hosp No: …….. **APPENDIX SIX**

Intrapartum Risk Assessment Tool
Please complete within one hour of labour admission/arrival of midwife
Please sign & print name in initials box once then initials may be used

Background Risks	Yes/No	Comments/Action	Initials
Factors from previous pregnancy	Yes/No		
Social Factors/Special Needs	Yes/No		
Declines blood products	Yes/No		

Red Risks High Risk pregnant women requiring obstetric involvement in planning and management of care during labour			
Diabetes (on treatment or sliding scale)	Yes/No		
Severe pre-eclampsia	Yes/No		
Medical conditions (significant)	Yes/No		
APH + actively bleeding/suspected placental abruption	Yes/No		
Haematological conditions eg von Willebrand's disease	Yes/No		
BMI 40 or above (current)	Yes/No		
Placenta Praevia	Yes/No		
Multiple pregnancy	Yes/No		
Prematurity (<34 completed weeks)	Yes/No		
Intrauterine death	Yes/No		
Induction of Labour for medical reasons	Yes/No		
A/N management plan requiring consultant involvement/awareness	Yes/No		
Suspected Sepsis	Yes/No		
Previous Uterine Surgery: - Where there is no consultant management plan for labour - Prior to considering augmentation	Yes/No		
Pathological CTG	Yes/No		
Abnormal presentation eg breech or transverse lie	Yes/No		
Pre-eclampsia/PIH	Yes/No		
Asthma requiring change in medication/hospital treatment	Yes/No		
Epilepsy	Yes/No		
Anaemia, Hb <9.0gdl	Yes/No		
IUGR – abnormal Doppler	Yes/No		
Oligohydramnios/Polyhydramnios	Yes/No		
Meconium-stained liquor	Yes/No		
APH – not actively bleeding	Yes/No		
VBAC	Yes/No		
Induction of Labour	Yes/No		
Post Term >42 weeks	Yes/No		

Name:…… Hosp No: ……

Intrapartum Risk Assessment Tool (continued)

Prematurity (34-36 completed weeks)	Yes/No		
PROM > 24 hours	Yes/No		
Pyrexia >38 degrees celcius	Yes/No		
Suspicious CTG	Yes/No		
Known infectious condition eg HIV, Group B Strep, Hepatitis B	Yes/No		

Low Risk Midwifery Care

Low risk women at term	Yes/No		
Latent phase of labour	Yes/No		
None of the above risks	Yes/No		

Anaesthetic Risks requiring Anaesthetist awareness and involvement

Severe latex or other allergy	Yes/No		
Previous anaesthetic problems	Yes/No		
Needle phobia	Yes/No		
BMI 40 or above	Yes/No		
Spinal abnormality	Yes/No		
Declines blood products	Yes/No		

Further comments/actions in relation to risks identified above:

Initial Labour Management Plan:

Name, signature & Designation: ……
Date & Time: …… Notes continue on page ……

Maidstone and Tunbridge Wells NHS
NHS Trust

APPENDIX SEVEN

Maidstone & Tunbridge Wells NHS Trust

Maternity Questionnaire.

Congratulations on the birth of your baby!

We are passionate about giving you a high quality service that is caring, professional and meets your needs. In order to help us do this we really want to hear your views about what we do.

We are giving this questionnaire to all Mum's once a week, so that we can get a regular snapshot to tell us how we are doing. We will be very grateful if you can take the time to answer the following questions and either leave this on the ward or give it to your community midwife when she visits you at home.

Thanking you in anticipation – we value your thoughts.

Ratings: Please circle the number you feel best applies to our performance – 1 = poor, 2= fair, 3= good, 4= excellent
write N/A if not applicable

No	Question	Delivery Suite	Wards	Comments (continue on back page if necessary)
1	You felt that you mattered all of the time.	1 2 3 4	1 2 3 4	
2	Staff's attitudes were kind, courteous and professional.	1 2 3 4	1 2 3 4	
3	You felt your privacy and dignity were respected.	1 2 3 4	1 2 3 4	
4	You felt able to ask staff questions and received helpful responses.	1 2 3 4	1 2 3 4	
5a	You felt involved in the planning of your care.	1 2 3 4	1 2 3 4	

5b	You felt you were given opportunities for choice in how your labour was managed	1 2 3 4	N/A	
6	You felt well informed about your care.	1 2 3 4	1 2 3 4	
7	If English is not your first language, did we communicate effectively with you.	1 2 3 4	1 2 3 4	
8	You received help with caring for your baby when needed.	1 2 3 4	1 2 3 4	
9	You received help with feeding your baby when needed.	1 2 3 4	1 2 3 4	
10	You had adequate opportunity to have 'skin to skin' contact with your baby.	1 2 3 4	1 2 3 4	
11	You were with your baby for his/her medical check and it was explained to you.	1 2 3 4	1 2 3 4	
12	You were orientated to the ward and told of the facilities.	1 2 3 4	1 2 3 4	
13	Your buzzer was easily accessible and was answered within 5 minutes.	1 2 3 4	1 2 3 4	
14	You were told of arrangements for food & drink.	1 2 3 4	1 2 3 4	
15	You had access to an adequate supply of drinking water.	1 2 3 4	1 2 3 4	
16	Your food was served hot or cold, as appropriate.	1 2 3 4	1 2 3 4	

17	You were satisfied with the presentation of your food.	1 2 3 4	1 2 3 4	
18	You were able to access adequate food if you missed a meal time.	1 2 3 4	1 2 3 4	
19	The food portion sizes were adequate.	1 2 3 4	1 2 3 4	
20	Please rate the overall standard of your food.	1 2 3 4	1 2 3 4	
21	If you received medication, the type and reason were explained to you.	1 2 3 4	1 2 3 4	
22	If you needed pain killers, you received them promptly.	1 2 3 4	1 2 3 4	
23	The environment was clean and tidy.	1 2 3 4	1 2 3 4	
24	Staff washed their hands or used hand gel before attending to you or your baby.	1 2 3 4	1 2 3 4	
25	The bathrooms and toilet facilities were clean and tidy.	1 2 3 4	1 2 3 4	
26	You felt able to report any problems in relation to cleanliness.	1 2 3 4	1 2 3 4	
27	You received adequate advice on health matters prior to leaving hospital.	1 2 3 4	1 2 3 4	
28	Your partner was made to feel welcome during your hospital stay.	1 2 3 4	1 2 3 4	

29	You were given adequate advice how to contact health professionals if you were worried.	1 2 3 4	1 2 3 4	
30	Overall, how do you rate the care you received.	1 2 3 4	1 2 3 4	
31	Did you see the Matron during your stay?	Y/N	Y/N	

Thank you for taking the time to complete this questionnaire. We look at the results on a monthly basis and use the information given to see how we are doing and where we need to improve. We are happy if you wish to remain anonymous, but if you would like to give your name please write in the space below.
We also welcome any other comments you wish to make below.

If you have any concerns about your care please ask to speak to the midwife in-charge.

Name ……

Additional Comments – Thank you