NHS

MATERNITY RESOURCE PACK

Safer Maternity Services

SECTION 1

Reports

- Safer Maternity Care, Progress Report 2021
- HSIB Maternity programme year in review 2020/21
- The NHS Patient Safety Strategy 2019
- Saving Babies Lives Care Bundle
- A review of sudden unexpected death in infancy
- Equity & Equality: Guidance for Local Maternity Systems
- Local Transformation Hub on NHS Futures
  (log in access to NHS Futures required)
- The Ockenden Report

Immediate & Essential Actions:

1) Enhanced safety

Essential action - Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

2) Listening to women and families

Essential action - Maternity services must ensure that women and their families are listened to with their voices heard.

3) **Staff training and working together**

Essential action - Staff who work together must train together.

4) Managing complex pregnancy

Essential action - There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

5) Risk assessment throughout pregnancy

Essential action - Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway,

6) Monitoring fetal wellbeing

Essential action - All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

7) Informed consent

Essential action - All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

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SECTION 2

Vaccine

Pregnant?

Have your COVID-19 vaccines!

- COVID-19 infection is currently circulating and can be serious for pregnant women
- thousands of pregnant women have been safely vaccinated in the UK and worldwide
- it is important to have both doses of your COVID-19 vaccine to protect you and your unborn baby

Find out more:

COVID-19 vaccinations are recommended for pregnant women by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists.

You can use this QR code to read more about the COVID-19 vaccine and pregnancy.

www.gov.uk/government/publications/covid-19-vaccination-women-of-childbearing-age-currently-pregnant-planning-a-pregnancy-or-breastfeeding

Use this QR code to see the RCM\RCOG decision aid and videos.

www.rcog.org.uk/globalassets/documents/guidelines/2021-02-24-combined-info-sheet-and-decision-aid.pdf

Call 119 or go online to www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/ to register for your vaccination appointment. You can also attend walk in, mobile or pop up vaccination clinics in your area.

COVID-19 immunisation
Protect yourself and your pregnancy

We know this is a challenging time, particularly for expectant and new mums who may be feeling more anxious. One the most pressing decisions is around whether it is safe for mums and their babies to have the Covid-19 vaccine. The information about vaccination against COVID-19 for pregnant and breastfeeding women and birthing people has evolved during the COVID-19 pandemic. Vaccines are now being recommended for all pregnant women, and there are some helpful resources to support discussions with women making choices about vaccination in pregnancy.

Royal College of Obstetricians & Gynaecologists

THE ROYAL COLLEGE OF MIDWIVES

uktis uk teratology information service

MOMS MacDonald Obstetric Medicine Society

Information sheet and decision aid: Updated 20 August 2021

All pregnant women in the UK over the age of 18 have now been offered COVID-19 vaccination. Pregnant women aged 16 and 17 will be offered a COVID-19 vaccine this summer.

Vaccination is recommended in pregnancy, but the decision whether to have the vaccine is your choice. The information below will help you make an informed choice about whether to get the COVID-19 vaccine if you are pregnant or trying to get pregnant.

Your options:

Get a COVID-19 vaccine **or**

Wait for more information about the vaccine in pregnancy

What are the benefits of the vaccination?

✓ **COVID-19 may be more dangerous in pregnancy**

Studies have shown that hospital admission and severe illness are more common in pregnant women (compared to those not pregnant), especially those in the third trimester of pregnancy, and that stillbirth and preterm birth is more likely (compared to pregnant women without COVID-19). Pregnant women with underlying medical conditions are at higher risk of severe illness.

✓ **Vaccination is effective in preventing COVID-19 infection**

✓ **You cannot get COVID-19 from vaccination**

- COVID-19 vaccines do NOT contain live coronavirus
- Vaccines do NOT contain any additional ingredients that are harmful to pregnant women or their babies
- Other non-live vaccines (whooping cough, influenza) are safe for pregnant women and their unborn babies.

The source for this graphic is available here.

The Royal College of Obstetricians and Gynaecologists decision aid shows the options to be vaccinated or to wait for more information. It explains that COVID-19 increases the likelihood of hospital admission and severe illness in pregnancy, particularly in people with underlying medical conditions, and explains the emerging data about the safety of vaccination during pregnancy, and the lack of evidence of harm to the mother or baby.

The resource above and those below can help when talking with parents about vaccination to reduce their risk of infection and severe illness.

- COVID-19 vaccination: a guide for all women of childbearingage, pregnant or breastfeeding
- Pregnancy, breastfeeding, fertility and coronavirus (COVID-19) vaccination
- Royal College of Obstetricians & Gynaecologists report on Coronavirus (COVID-19) vaccination in pregnancy
- A guide to COVID-19 vaccination for all women of childbearing age, those currently pregnant or breastfeeding
- Five reasons to get the COVID-19 vaccine if you're pregnant - Public health matters (blog.gov.uk)
- Pregnancy and Coronavirus NHSE Comms materials June 2020
  (log in access to NHS Futures required)
- COVID-19 Vaccination in Pregnancy: Masterclass for Midwives

SECTION 3

Projects

This is a space is to facilitate shared learning on projects and initiatives that improve safety in maternity services, some examples below.

If you would like to share any work you have done to improve safety in maternity services, please contact: **england.sematernity@nhs.net**

Intelligent Intermittent Auscultation, Oxford AHSN

Intelligent Intermittent Auscultation (IIA) is an award winning, innovative, education and training programme aiming to support midwives and student midwives in training to improve accuracy of intermittent auscultation.

The most important aspect of this programme is that improved midwifery knowledge and accuracy in intermittent auscultation (IA) means that low risk women and babies receive high quality safe care to ensure the best possible outcomes. This unique programme will standardise the teaching and assessment of competency of IA and Contact to improvements in the accuracy of this midwifery skill, patient safety and perinatal outcomes.

Video interviews with Wendy Randall and Christine Harding IIA programme authors are incorporated within this short promotional film.

The programme is accredited by the RCM, is free and available to all. You can find out more here.

International audiences can access the programme here.

To find out more contact: Eileen.dudley@oxfordahsn.org

Newborn Pulse Oximetry Screening, Thames Valley & Wessex Neonatal ODN

A project is underway in Thames Valley and Wessex to ensure that every newborn baby receives pulse oximetry screening (POS)

Research shows that when POS is added to the existing postnatal examination of the newborn, it increases the identification of critical congenital heart disease to over 90%.

Congenital heart disease accounts for up to 10% of all infant mortality.

This work supports the NHS Long Term Plan to reduce neonatal deaths and brain injury by 50% by 2025

For further information, see the Abstract Summary submission to British Association of Perinatal Medicine (BAPM). You can also contact: Lambri Yianni, vetlam_yian@hotmail.com

Improving the Safety of Intravenous (IV) Cefotaxime to Neonates

The Preceptee became aware when administrating IV Cefotaxime injection to neonates, after reconstitution, the required dose was **not** being diluted to a concentration of 50mg/ml. In addition, MEDUSA (Neonatal Formulary) states that the IV injection should be given slowly over at least 3 minutes. This was not being followed in the practice observed. There were two aims to this project correct dilution and correct time of administration.

QI methodology using the Plan, Do, Study, Act (PDSA) cycle were utilised to measure and analyse data. There were 3 cycles of change measured and changes implemented.

There has been a significant and recordable improvement in the safe administration of intravenous Cefotaxime injection to neonates:

1) In accordance with MEDUSA 500mg vials of Cefotaxime are being reconstituted with 4.8mL of water for injection to give 500mg in 5mL. After drawing up the required dose the solution is being further diluted as recommended. **This further dilution represents an 100% improvement with every dose (which was recorded) being further diluted appropriately.**

2) **The administration of the IV injection is being given more slowly than before**. Prior to this patient safety project 100% of the Cefotaxime injections observed were administered in less than three minutes, with 90% being administered in less than 60 seconds and the lowest being given in only 5 seconds. Alongside education to reiterate best practice and raise awareness of the negative effects of existing practice/behaviours, **currently 81% of the Cefotaxime injections measured and recorded were administered over three minutes or more. 16% were administered between 2 minutes 30 seconds and 2 minutes 58 seconds. The lowest time recorded was 2 minutes 10 seconds (compared to 5 seconds pre project).**

Neonatal Patient Safety QI Projects, Thames Valley & Wessex Neonatal ODN

Preceptorship Foundation Education Programme

As part of the Thames Valley and Wessex Neonatal Preceptorship Education Programme curriculum the Preceptees undertake a patient safety/ QI project. Most have been implemented into clinical practice within neonatal services. Four exemplars below.

To find out more contact Kim.Edwards@hee.nhs.uk

Neonatal Patient Safety QI Projects, Thames Valley & Wessex Neonatal ODN

Implementation of a Body Map to a Neonatal Unit

The aim of this project was to introduce a clear and concise body map document into the Preceptee's local neonatal unit to enable practitioners/parents to document and record any wound, mark, bruise, rash, cellulitis, extravasation, trauma, or surgical site. This is to reduce risk harm and promote early documentation, treatment, and monitoring.

QI methodology using the Plan, Do, Study, Act (PDSA) cycle were utilised to measure and analyse data. There were 3 cycles of change measured and changes implemented.

From the data that was collected, it was clear that the body map document was needed on the neonatal unit, and it was successfully implemented with 83.4% positive feedback. It is being used for all patients.

To find out more contact Kim.Edwards@hee.nhs.uk

Improving Nurses confidence in anaphylaxis and contrast transfers

The aim of this project is to increase the confidence of nurses new to specialty that take babies for contrast studies.

QI methodology using the Plan, Do, Study, Act (PDSA) cycle were utilised to measure and analyse data. There were two cycles of change the use of information cards were implemented, measured and changes implemented using qualitative data.

Nurses' confidence and knowledge was improved with the use of the information cards.

To find out more contact Kim.Edwards@hee.nhs.uk

Neonatal Patient Safety QI Projects, Thames Valley & Wessex Neonatal ODN

The use of a visual aid poster for signposting for parental mental health (neonatal)

The aim of this project was to design and introduce a poster and/or leaflet for our Neonatal Unit to promote and improve the mental health of parents with babies on our unit. These publications would be displayed throughout the unit and parent areas.

The focus for this project will be promoting the mental health of new parents on the neonatal unit, to do this we will implement posters using the acronym **MINDFUL, M=Mood, I= Isolation, N= No judgement, D= Daily Living, F=Fear, U= Under Pressure, L =Lethargy.**

QI methodology using the Plan, Do, Study, Act (PDSA) cycle were utilised to measure and analyse data. There were 3 cycles of change measured and changes implemented. The effectiveness of using colours was also studied in the 2nd cycle of change. After each cycle changes were made to the poster.

The Preceptees identified the project has been proactive in encouraging and raising a higher profile of mental health and wellbeing for parents within the unit. The visual reminder provided parents with an awareness to all elements of their mental wellbeing, and aspects they might have initially considered.

Additionally, to this, an outcome we didn't consider as a potential positive outcome of the project was the impact upon our colleagues. Although, due to the negative impact and restraints of COVID-19, we have been unable to gather written feedback about our MINDFUL poster project, we have received verbal praise and acknowledgement about the positive promotion of mental health that the poster has provided for both parents and staff.

To find out more contact Kim.Edwards@hee.nhs.uk

Enhanced Maternal Care Service, Buckinghamshire Healthcare NHS FT

A project being rolled out to support critically ill women in childbirth will see collaboration between maternity, ITU and critical care outreach, leading to fewer obstetric admissions to ICU, improved interface between maternity and critical care and avoid the separation of mother and baby.

For information on EMC and other work around supporting women to make informed choices, contact Heidi Beddall on h.beddall@nhs.net

Patient Safety Initiative at Queen Elizabeth The Queen Mother Hospital (QEQM) Neonatal Unit

What started as a project to clarify inconsistent SpO2 data during patient transfers, has triggered a workflow revolution for the Special Care Baby Unit (SCBU) at Queen Elizabeth The Queen Mother Hospital (QEQM). Working with the clinical applications team to create an oxygen therapy tool tailored to its neonatal requirements, QEQM has cut the average length of stay for patients, delivering babies back to parents in a more timely way. QEQM worked closely with the clinical applications team to create its own unique goal management tool for oxygen therapy on its new monitors.

The personalised neonatal dashboards now allow the consultants to make discharge decisions at the bedside, collecting all the saturation data they need into one screen. The ability to take in all their key data at a glance has dramatically improved workflows and helped to keep mothers and babies together. It has also given clinical time back to the consultants and improved bed capacity, as decision making is more efficient and backed by multiple targeting metrics.

With such vulnerable patients at varying levels of stabilisation, the unit also identified the need for more precise individualised targeting. SpO2 target tracking is now defined into precise high and low limits for each baby, through an easy-to-read sliding scale graphic. This level of personalisation and accuracy has improved patient safety at an individual level and allowed staff to track minute changes in saturation levels for a more precise and holistic view of patient performance.

QEQM has fundamentally improved patient safety for its patients. By reducing discharge times and improving patient safety, QEQM has increased its cot availability, reduced costs by £32k per annum and ultimately delivered a more efficient and positive experience for staff, patients and parents alike. The reproducibility and successful uptake of this new dashboard has helped wards across the UK reimagine their care pathways.

To find out more contact: jennifer.lomas@nhs.net

‘Making NICU safer in 5 minutes’ – an Introduction to Human Factors in Neonatology, from the Trevor Mann NICU, Brighton

Impact of Human Factors training:

- Culture change - flatter hierarchy especially nurses of all seniorities speaking up about safety concerns
- Safety improvement projects:
    - Re-design resus trolleys so the same in any area you may meet a baby
    - New airway boxes
    - New advanced airway kit
    - Redesign treatment area for better privacy and ergonomics
    - Re-hanging monitors for improved visibility
    - New neonatal bleep groups with more nursing involvement
    - Improved access and speed of access to o neg blood in an emergency
- Improved understanding of Human factors with team wide understanding of the importance of communication and raising concerns ie if a work around or snag is noted we now fix it rather than accepting it!
- Safety STEPPs (**S**ituation, **T**hink problems, **E**quipment, **P**repare (patient, people, plan) **P**roceed). These are checks performed before procedures streamline team approach and preparation.
- Prompt cards for rapid, early management of emergencies as an adjunct to our guidelines.
- Roll out STEPPS and SPS to transport service , other UHS depts and other trusts in London and network
- Staff surveys completed before and after introduction of SPs demonstrated improvement across the board in staff ratings of the safety, time efficiency, equipment effectiveness and teamworking in all processes on the unit.

To find out more contact: jennifer.lomas@nhs.net

‘Safety Huddle’, Ashford & St Peter’s Hospital NHS Foundation Trust

A patient safety initiative at ASPH is the Safety Huddle. It occurs daily (7/7); and is an invaluable opportunity to discuss our shared service, patients, and staffing. There are numerable examples of where this has led to an improvement in working on a day to day and longer-term basis:

- Acknowledgement of staffing pressures across the division so that we can try and share the burden and decision making. For example, moving staff around to different areas such as MEON’s (Midwives responsible for Examination of the Newborn) to do checks and facilitate discharges. Also, greater cross-working and understanding
- Proactive discussion about in utero transfer and the management of high-risk patients
- Rapid MDT review of safety incidents
- Shared safeguarding concerns and wellbeing concerns

To find out more contact: sam.edwards8@nhs.net