Standard Operating Procedure for Maternity Transfers around the Time of Birth from Neath Port Talbot Birth Centre and Home Birth Settings During COVID-19.

Speciality: Maternity

Approved by: Quality and Safety

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Contents

Introduction

There is national steer to ensure that midwife-led services are maintained wherever possible during the Covid-19 pandemic to enable promotion of safe care for low-risk women and minimise exposure to Covid-19 (RCM/RCOG, 2020).

There is also national concern around the potential impact of Covid-19 on Welsh Ambulance resources, this could threaten the ability to transfer women and/or babies for appropriate medical review and care where required. In very rare cases this delay may increase morbidity/mortality linked with delayed treatment.

As a result of the Covid-19 pandemic there is a need to review services and work in different ways to manage care safely particularly the process for emergency transport to an obstetric unit if required. By reviewing criteria for transfer and arranging alternative methods the maternity services are relieving pressure on the ambulance service. The All-Wales Maternity and Neonatal Network have reviewed circumstances for transfer and when alternative means can be used. The transfer flowchart (Appendix A) has been approved through the Maternity and Neonatal Network for use across Wales. It is an interim document for use during the Covid-19 pandemic initially, however it is expected that following review of transfer cases and outcomes that the flowchart may be adopted for permanent use.

This standard Operating procedure aims to support staff in safely and effectively making these changes.

The following aspects of care may lead to transfer during the COVID-19 pandemic.

- Women presenting with a clinical need in the antenatal or postnatal period requiring transfer to the obstetric unit.
- Uncomplicated, well women OR women with additional risk factors who are well and opting to birth at home against obstetric /medical advice, who subsequently develop complications that require transfer to an obstetric unit with access to a greater level of clinical support for the mother and the baby.
- Women with suspected or confirmed Covid-19 (who will have been advised to birth in an obstetric unit) who are rapidly progressing in labour at home or have had a BBA (Born Before Arrival).

Background to transfers

The All-Wales Midwife-Led Care Guidelines (WG, 2017) outline the clinical reasons where transfer in labour or in the immediate postnatal period may be warranted, these are varied and the majority of these are not for life-threatening emergencies.

National data suggests that the chance of intrapartum transfer is 36-45% for first time mother in labour or immediately after birth from home or FMU. This rate falls to 9-12% for subsequent births (NPEU, 2011).

Traditionally transfers from NPBC have been the only transfers monitored, in 2019 the overall transfer rate for women and babies around the time of birth was 19%, 6.8% of transfers were acute red responses where paramedic assistance could have been required ie PPH or neonatal resuscitation. Most transfers are the result of delay in labour or for suturing.

For decision around place of birth, women should be informed of intrapartum transfer rates and informed that there could be delay in getting an ambulance at this time because of the pressure being generated by Covid-19 related ambulance activity. The Welsh Ambulance Service NHS Trust has confirmed that it will attend maternity calls during this period and they will be prioritised accordingly, but there may be a delay.

All transfers via C or D criteria should be arranged in accordance with relevant flowchart (Appendix 3 and 4) including escalation of any expected delay. The midwife in charge of the care is able to upgrade the transfer category at any time based on clinical assessment.

Transferring women asymptomatic of Covid-19 from Home or FMU to an obstetric Unit during Covid-19 pandemic

Where transfer is required the flow chart in Appendix A should be reviewed to ascertain the most appropriate transfer method.

Clinical judgement remains paramount in all situations and the list is not exhaustive. Where it is deemed appropriate to travel by own car in accordance with Appendix A, the woman should be provided with her notes and ensure the family know where they are going to. The midwife must contact the receiving obstetric unit to ensure the family have arrived.

Where it is deemed appropriate to transfer by taxi with a midwife, as in Appendix A. This will be arranged via Switch. The midwife will travel with the woman. The birth partner should travel separately. The midwife should take a kit bag for the transfer. Clinical judgement based on the circumstances for transfer is paramount.

Where urgent transfer is required the Urgent Care Service can be contacted as per flow chart (Appendix 4) – 03001239236 and a clear, concise summary provided. This service no longer routinely provides ‘blue light’ trained drivers. Midwives should request an arrival time within 1 hour. On transfer midwives should take a kit bag for transfer, where a delay is expected then the call should be upgraded to 999 pathway.

A risk assessment (Appendix 2) should be undertaken prior to using both A B and C mode of transfer and this should be filed in the woman’s records on completion.

Where required, a 999 ambulance will be summoned and the member of staff will clearly state the situation and that it is a life-threatening emergency and a paramedic crew is required. In certain situations the Emergency Medical Retrieval Transfer Service Cymru (EMRTS – Flying Doctors) may be dispatched.

At the earliest opportunity the receiving obstetric unit must be contacted and an SBAR handover provided including detail of the method of transport.

Care of women with suspected or confirmed Covid-19 in labour

All women will be risk assessed at onset of labour by phone, as per SBUHB risk assessment for potential symptoms of Covid-19 in the last 14-days, including

assessment of birth partner and other household members, this will minimise the chance of women presenting in the wrong clinical area for their needs.

RCOG (2020) recommends that where a women has been confirmed Covid-19 or is symptomatic it is recommended that she has her baby in an obstetric unit to enable close monitoring including continuous fetal monitoring and hourly oxygen saturations. The guidance currently suggests that suspected or confirmed cases should be encouraged to remain at home in early labour. Individual assessment should be made if women are asymptomatic but have had a positive COVID-19 test in the last 10 days, or who have had close contact and have been advised to self-isolate.

If a woman with suspected Covid-19 arrives at the birth centre or is seen at home and develops symptoms during labour it will be recommended that she transfers to the Obstetric Unit. If she is not in established labour and she is otherwise well she may be asked to attend Singleton hospital for a swab to be undertaken to aid care planning, transport in her own car is acceptable. The midwife will liaise with the OU to arrange transfer. Where women are uncompromised and not in established labour then they can be supported to return home with latent care advice.

If a woman who is symptomatic or confirmed to have Covid-19 is found to be in labour she will need to be transferred by ambulance when it is anticipated that there is time to do so. This will depend on the emerging clinical picture, rate of uterine activity, vaginal examination findings if completed as well as fetal well-being. Should the birth be imminent it will be safer for the woman to birth where she is and be transferred afterwards. Midwives have appropriate PPE should this circumstance arise.

When arranging transfer the midwife must notify the call handler that the woman is suspected or confirmed Covid-19.

The OU must be informed that a woman with suspected or confirmed Covid-19 is being transferred with detail of the stage of care. The OU can then arrange which clinical area the woman needs to be transferred to.

Postnatal support
All women should be offered the opportunity to talk about their birth experience during the postnatal period, but where there has been transfer the midwife should ensure this opportunity is actively offered and ensure any question relating to the episode of care are answered.

Documentation and Reporting
All intrapartum transfers should have the SBAR handover form in the All-Wales Normal Labour Pathway completed. Contemporaneous records should be completed during the transfer. Where women are transferred in their own car they will take their notes.
SBAR handover record (yellow acetate form) together with a transfer form (Appendix 5) should be completed and filed either in NPBC or Labour Ward in singleton hospital. Methods and timings for any transfers should be recorded so that there can be ongoing assessment of services.

Transfers will be reviewed on a monthly basis with full case reviews where required as a result of delayed transfer or sub-optimal outcome.

All transfers are recorded on a database within maternity with the reason and length of transfer so that themes and trends can be assessed and cases escalated to the Ambulance Service as required. A specific audit will be conducted during this period.

Where there is specific learning relating to Covid-19 that may require urgent sharing to avoid recurrence this will be shared with the central Quality and Safety group for wider sharing. There will also be mechanism to share relevant learning through the All-Wales Maternity and Neonatal Network.

Review and Change Control
This document will be reviewed in 6-months/the end of Covid-19 critical period or earlier should audit results or changes to legislation / practice within SBUHB indicate otherwise.

References

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Appendix 1 - All Wales Criteria for Selecting Mode of Transport for Women and/or Babies Requiring Transfer from FMU or Home During COVID-19 Pandemic. Amended for SBUHB November 2020.

After every transfer regardless of the mode of transport the SBAR in AWCPNL must be completed and returned to relevant area.
Please document clearly on the form the women's information, reason for transfer and mode of transport. All handovers should be given to the relevant clinician. Please DATIX any transfer where a delay was experienced. Midwives must use their own clinical judgement at all times. Risk assessments must be completed for A,B and C.

A. Own Car

Women will be passengers and midwives do not need to accompany.

Part two of All Wales Clinical Pathway for Normal Labour – Risk assessment

Maternal

- Raised blood pressure first diagnosed during the risk assessment, without significant symptoms of Pre eclampsia.
- Concerns regarding maternal pulse rate
- High presenting part or abnormal presentation and the woman is not in active labour.
- Any concerns requiring an obstetric opinion but there isn't a life threatening problem to either the woman or the baby.
- Prolonged latent phase/or requires additional analgesia.

Fetal

- Concerns about the fetal movements when a normal fetal heart has been heard during auscultation using a pinard or a sonic aid.
- Clinically small for gestational age where there are no concerns regarding fetal well being

Neonatal

- Second opinion from a paediatrician when the baby is well.
- Feeding problems
- Positive antibodies identified through cord blood sampling

Postnatal period

If the mother needs to be transferred and the baby is well, the immediate family should be asked if they are happy to take the baby in their car seat in their own car. If this is not possible then a member of staff can take the baby in a taxi secured in car seat.

B. Hospital taxi accompanied by a midwife escort

The woman will not be able to have nitrous oxide during the transfer.

Maternal

- Delay in the first stage of labour and the woman's cervix is no more than 5 cm centimeters dilated.
- Woman requesting further analgesia and her cervix is no more than 5 cm,(may need UCS if requiring nitrous oxide).
- Significant meconium stained liquor with a normal fetal heart and cervix no more than 5 cm.
- Requiring perineal review or suturing by a doctor without active bleeding.

Neonatal

- Well babies who required screening care via hypoglycaemic pathway.
- Baby showing signs of withdrawal from antidepressants or maternal misuse of substances
- Jaundice < 24 hours of age where there are no other concerns.

Note: Where transfer is required after a home assessment due to confirmation of active labour the midwife should consider the most appropriate form of transfer based on the clinical picture, this will sometimes be via own transport.

C. Urgent transfer where paramedic intervention is not required-HCP pathway.

Call -03001239236

Midwives will need to request a response time. In most cases the required response time in this group will be within 1 hour. Where there is likely to be a delay revert to 999 pathway.

Maternal

- Delay in first stage of labour when the woman's cervix is more than 5 cm dilated.
- Malpresentation in active labour
- Women requesting further analgesia and still in the first stage of labour more than 5cm.
- Significant meconium stained liquor, and cervix more than 5cm, with normal FH.
- Raised blood pressure (as categorised By NICE,2014) in active labour with no other signs of fulminating pre-eclampsia.
- Maternal observations outside of normal range in active labour (NICE 2014).

Contact receiving OU to confirm all transfers

Telephone Number of Obstetric Unit
01792530862

Contact numbers to arrange transport:
UCS: 03001239236
Taxi: Switch/ 01639862000

Cost Code for Taxi- H431

D. Emergency transfer for life threatening emergency where paramedic intervention may be required- 999

Emergency Medical Retrieval and Transfer Service (EMERTS) may also be asked to attend dependant on clinical scenario this is a 24 hour service.

Maternal

- Antenatal or postpartum haemorrhage, or symptomatic of hypovolemic shock.
- Placental abruption
- Maternal collapse
- Eclampsia or Raised blood pressure in active labour with other signs of fulminating pre eclampsia.
- Delay in the 2nd stage of labour
- Sepsis
- Inverted uterus.
- Retained placenta

Fetal/Neonatal

- Fetal distress- Changes in the FH and CTG is recommended.
- Imminent breech birth
- Cord Prolapse
- Shoulder Dystocia
- Baby born in poor condition (Apgar <7 at 5 mins)
- Need for active resuscitation

Supporting information

*UCS (Urgent Care Service) vehicles can be used where paramedic support is not required. These vehicles Support the transportation service users who require urgent care in a hospital. The UCS vehicles are standard ambulances but it is expected that they will not use a blue light response on transfer, they carry AED's and oxygen, staff manning UCS are trained in basic life support.

* Health Care Professional line to request UCS: 03001239236. Health Care Professionals are able to request a suitable response time. In most instances where a UCS is requested via the HCP line the required response time will be within 1 hour.

*Where midwives are not happy with the grade of WAST response assigned, they should ask the call handler to refer them to the clinical services desk for a clinician to clinician discussion.

* If at any time the clinical situation changes or the midwife identifies a delay in response time required the call will need to be upgraded via 999 this may require a clinician to clinician discussion.

* **To discuss with WAST duty Manager please call 01267229476.**

*** To discuss with dispatch ref ETA call 01267229461**

* Midwives should use their clinical judgement at all time.

Appendix 2 - Mode of transport Risk assessment.

Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Addressograph

Date and time of assessment ……..

Name……

Signature…….

*** To be filed in birth records**

To aid decision making when considering mode of transportation. In this instance the RA is around the result from birth occurring during transfer or a sudden change in maternal/fetal/neonatal condition during transfer.

Within 'likelihood' clinicians will need to consider all individual clinical information.

	Consequence			
Likelihood	Insignificant	Minor	Moderate	Major
A=Almost certain	High	High	Severe	Severe
B= Likely	Moderate	Moderate	High	Severe
C=possible*	Low	Moderate	High	High
D=Unlikely	Low	Low	Moderate	High
E=Rare	Low	Low	Low	Moderate

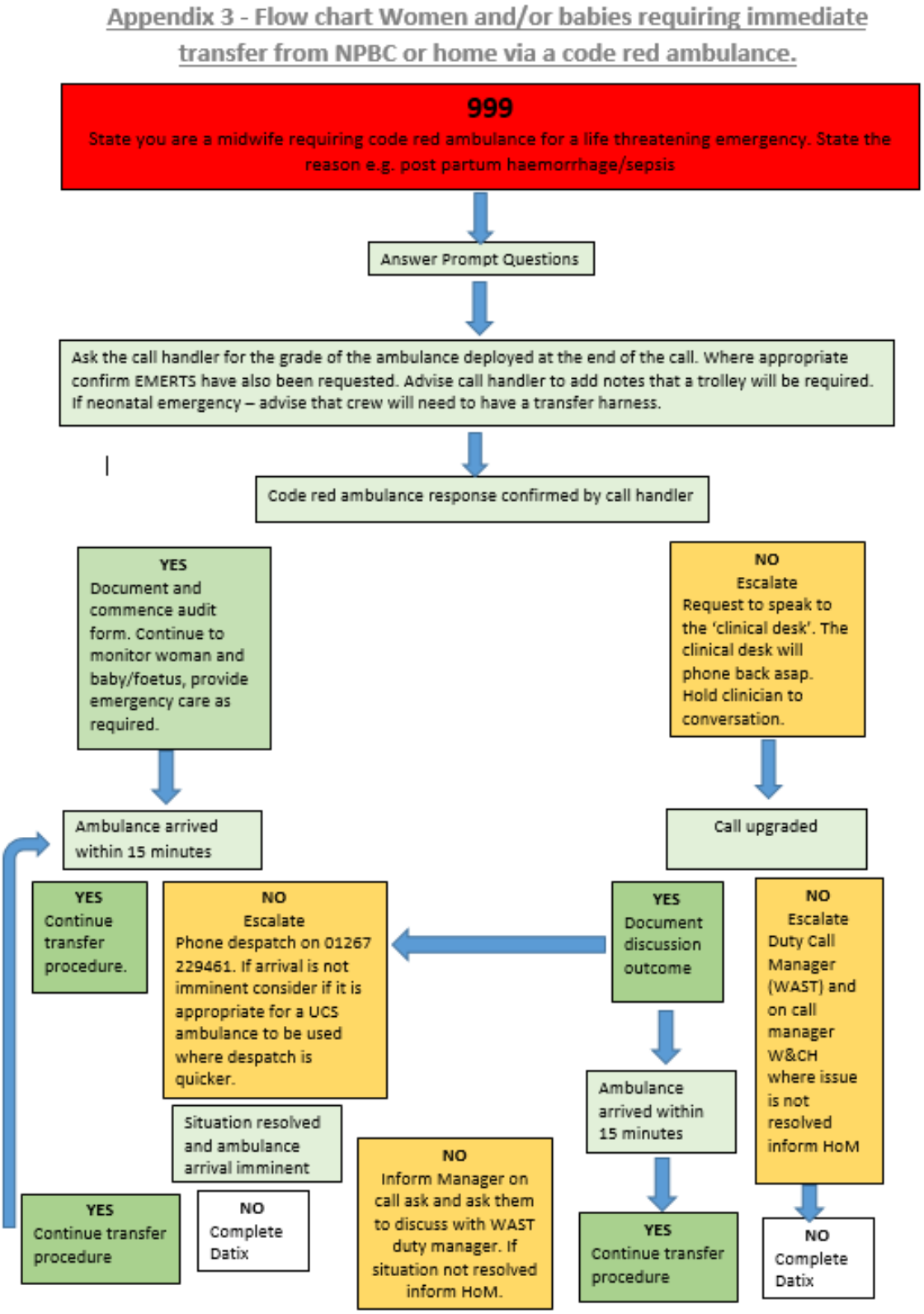
**For Category B and C where traffic is likely to be heavy, likelihood should always be possible.*

** For Category B and C Where the address of transfer is more than 20 miles or 30 minutes away from the OU then the likelihood should always be possible.*

Results of assessment- Risk category

Identified Risk Category of Transfer	Detail of risk	Tick
Severe	The likelihood of maternal/fetal/neonatal complication or birth during transfer is likely or almost certain the consequence of which will be Moderate or Major. Use 999 ambulance for transfer.	
High	The likelihood of maternal/fetal/neonatal complication or birth occurring during transfer is unlikely to almost certain the consequence may vary from Insignificant to Major. Use 999 ambulance for transfer.	
Moderate	It is likelihood of maternal/fetal/neonatal complications or birth occurring during transfer is rare to likely the outcome may vary between Insignificant to Major. Upgrade transport mode.	
Low	The likelihood of maternal/fetal/neonatal complications or birth occurring during transfer is rare to possible the consequence may be Insignificant to Moderate. Continue with recommended transfer mode.	

Appendix 3 – Flow chart Women and/or babies requiring immediate transfer from NPBC or home via a code red ambulance



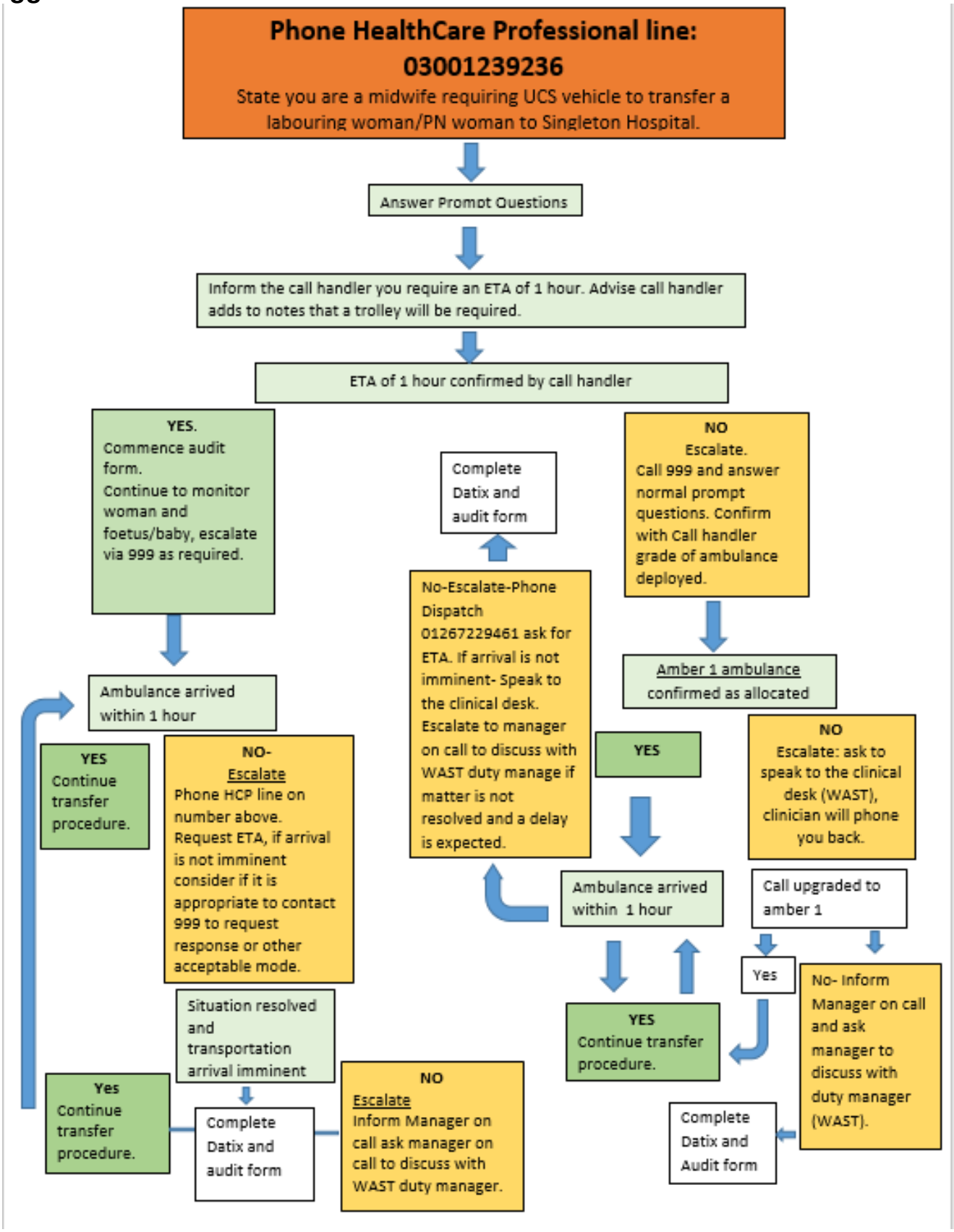
Trigger words for code red- 8 minute response

- **Sepsis maternal/neonatal**
- **Antepartum/postpartum Haemorrhage**
- **Pre eclampsia/Eclampsia**
- **Maternal collapse/arrest**
- **Fetal distress**
- **Delay in the 2nd stage of labour**
- **Cord prolapse**
- **Shoulder dystocia**
- **Inverted uterus**
- **Neonatal resuscitation.**
- **Neonatal compromise.**

***When the call handler asks if 'there are any high risk complications' the answer will always be 'yes' in this pathway.**

***Avoid terms such as raised temperature, increased respiration, if providing any resuscitative measures to a neonate then the answer to the question 'is the baby alert and breathing' will always be 'no'.**

Appendix 4 – Flow chart Women requiring transfer from NPBC or home - Amber trigger



***UCS (Urgent Care Service) vehicles can be used where paramedic support is not required. Some of these vehicles are trained for emergency blue light transportation but not all have this function. These ambulances carry defibs and oxygen, staff manning UCS are trained in basic life support.**

*** If at any time the clinical situation changes the call will need to be upgraded via 999**
***To request a call from the clinical desk, for a clinician to clinician discussion, please call 01267229476.**

Appendix 5 – Transfer Audit form

***Please attach to yellow AWNLP transfer form.**

Transfer Audit Form

Date: _____ Transfer from :

ADDRESSOGRAPH	Time of decision ……. Time transport called ……. Time transport arrived …… Time woman in transport ……

- Reason for Transfer: ……
- Name of midwife coordinating transfer ……..
- Category of transfer A B C D (Please Circle)
- Type of transport used: Own car Taxi with Midwife UCS 999
- If required Transfer flowchart used **RED / AMBER** (please circle)
- Grade of ambulance confirmed at end of call: YES / NO (please circle)
- Time of escalation ……
- Discussion with clinical desk: YES (please circle)

  Time …… Name ……..
- Maternity Manager on-call contacted: YES / NO

  Time …… Name ……..
- Upgraded due to changing clinical picture: YES
- Time of upgrade: …….
- Datix completed: YES / NO Incident Number ……...

Please record any further information here i.e. discussions with WAST; manager on-call.

To be filed in the woman's/baby notes after audit.