Imminent Unplanned Birth at a Non-Birthing Site Policy

1. Background

Each year in the WA Country Health Service (WACHS) there are on average nine imminent unplanned births in emergency departments of non-birthing hospitals.

These hospitals often do not have consistent on-site access to midwifery expertise or medical practitioners with obstetric experience.

While ideally the pregnant woman should be transferred with the Royal Flying Doctor Service (RFDS) or road ambulance, some situations will require the woman give birth at the presenting site.

While imminent normal birth itself is not an emergency, it is acknowledged this can be a very stressful situation for nurses and non-obstetric doctors.

This policy aims to provide registered nurses and non-obstetric medical practitioners with a level of confidence and support to immediately manage an unplanned, imminent birth with appropriate transfer pathways for both mother and newborn.

2. Policy Statement

2.1 Planned Birthing

There are to be no planned births at designated non-birthing sites.

All pregnant women who live communities with non-birthing hospitals are to be referred to an appropriate level maternity service to book for labour and birth care.

Antenatal care can be provided by local primary health services (public or private) as part of shared maternity care arrangements with either the WACHS or metropolitan birthing hospital clinicians.

Each pregnant woman is to have a pregnancy management plan, with information provided about their most appropriate birthing service, when to relocate for birth and accommodation/Patient Assisted Travel Scheme (PATS) arrangements.

Women assessed to be at low risk of pregnancy complications should be referred to the nearest WACHS birthing service or to the birthing service of patient choice.

Women assessed at moderate or high risk of pregnancy complications are to be referred to a WACHS Regional Resource Centre or metropolitan birthing service.

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Women at moderate or high risk with limited ability to access antenatal care (i.e. known drug and alcohol use, Aboriginality) should receive community midwifery care with the aim of encouraging antenatal engagement. This may also be via telephone or videoconference (see Telehealth information). Anecdotal evidence suggested this reduces the likelihood of presentation in late stages of pregnancy or labour at non-birthing hospitals.

Each WACHS region is to develop maternity care referral pathways for women according to the presence or absence of risk factors and with reference to the WACHS Maternal and Newborn Care Capability Framework Policy.

2.2 Local emergency escalation processes

Early contact with RFDS and/or local ambulance service should be made to enable timely transfer to a birthing service.

Imminent birth escalation processes should be followed to ensure the most senior available local medical, midwifery and / or nursing staff should be present to assist with care of mother and baby during the birth.

The Director of Nursing or a midwife or a senior clinical nurse is to assume the role of team leader for the birth.

Local senior staff required:

- The health service emergency on-call District Medical Officer (DMO) / General Practitioner (GP) is to be called to attend if not physically on site.
- Local community midwife or Child Health nurse with a midwifery qualification (CHNM) or registered nurse with a midwifery qualification (if known to be available).
- Additional nursing /midwifery / medical support as per local Medical Emergency Response (MER) escalation pathway.

2.3 Midwifery and obstetric support

Assistance may include clinical assessment as directed by the Emergency Telehealth Service (ETS) clinicians or via the regional hospital maternity service as per local escalation processes.

Use of ETS facilities or teleconference phone calls can facilitate efficient coordination of patient transfer and clinical care (i.e. involving multiple parties such as receiving site doctor, RFDS and transferring site doctor).

2.4 Transfer to the most appropriate maternity site

It is a requirement that as soon as is safe to do so, the mother / baby are to be transferred to the nearest maternity unit as soon as is practicable.

Where air transport is required, all antenatal patients who present to a non-birthing site hospital in labour should be discussed with RFDS in the first instance to facilitate RFDS transfer logistics.

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Decision for road transfer is to be made in consultation with the regional on-call obstetric and/or paediatric doctor and prioritised with St John Ambulance.

Where a metropolitan public maternity service is the closest available birthing unit, the on-call obstetric medical officer for that service will be the most appropriate point of consultation.

The King Edward Memorial Hospital (KEMH) may direct calls regarding low risk women in labour at term to another metropolitan maternity hospital as the most appropriate receiving site for transfer.

See further WACHS Assessment and Management of Inter-hospital Patient Transfers Policy.

2.5 Requirement to suppress labour

At term

For women in labour at term the decision to suppress, or await progression of labour is to be made in consultation with either the metropolitan hospital or regional obstetric doctor on call in consideration of individual circumstances including:

- gestation
- antenatal history
- current clinical assessment including stage of labour and co-morbidities
- the onsite availability of obstetric / midwifery and neonatal expertise
- distance.

Preterm

For most women in preterm labour (less than 37 weeks), immediate initiation of labour suppression therapy by following the RFDS or KEMH guidelines is appropriate:

- RFDS Clinical Manuals
- KEMH Clinical Guideline - Preterm Labour

While awaiting patient transfer, the advising obstetrician(s) providing clinical advice and support are to determine if medical or midwifery assistance can be provided from the nearest birthing hospital via telephone or videoconference communication.

2.6 Clinical management of the unplanned imminent birth

- Obtain your Emergency Birth Equipment Box (see Appendix 1) and
- follow the Imminent Birth Quick Reference Guide within (see Appendix 2).

For guidance on the management of normal labour / birth and immediate post birth care, refer to the KEMH clinical guidelines for Intrapartum care.

These guidelines are intended for use by midwives and obstetric doctors but can be used to provide general guidance for nurses or doctors when there is no access to support from a midwife or obstetric doctor.

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Nurses and doctors are not expected to, nor should they, undertake assessments which require specialised skills or are outside their scope of practice i.e. vaginal examination, listening to fetal heart, abdominal palpation.

The following KEMH guidelines may offer some general guidance:

- First stage of Labour.
- Second Stage of Labour and Birth.
- Labour: Third Stage.
- Postnatal: Immediate Care of Mother in Labour and Birth Suite Following Birth
- Neonatal care

Where Regional Resource Centre midwifery support is obtained, the midwife is to guide the required practices for both clinical and administrative processes for the mother / newborn prior to their transfer to the designated birthing site.

2.7 Use of community midwives or CHNM

WACHS employed community midwives / CHNM who have indicated they would be willing to attend (if available) to provide support during an imminent birth may be called in to attend for the birth. If available, these staff will often be the most skilled and experienced to provide support for the woman, baby and hospital staff during these situations.

Community midwives / CHN (with a midwifery qualification) are to communicate their willingness, or otherwise, to be contacted regarding emergency birth situations to the Director of Nursing at the commencement of employment.

Sites are to consider providing professional development support and clinical placements for community midwives / CHN (with a midwifery qualification) to maintain their confidence in imminent birth and/or maternity emergencies where they express a desire to do so.

2.8 Immediate postnatal care waiting transfer

Postnatal observations are to be recorded for the mother (Maternal Observation Response Chart (MORC MR140B) and Newborn Observation Response Chart (NORC MR140D) for a minimum of:

- 15/60 for the first two hours,
- hourly twice and
- then two hourly twice (if within normal range).

More frequent observations may be required depending on maternal and newborn condition.

Plans to transfer to the most appropriate maternity service for post-birth care and assessment should continue, with obstetric advice regarding the need for medical and/or midwifery escort (if not via RFDS or Newborn Emergency Transport Service [NETSWA]).

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Postnatal transfer is to occur as soon as possible, even when the mother and baby appear to be well or don't require any obstetric or paediatric intervention.

Documentation for the unplanned birth

To enable the receiving maternity sites to complete the below WA legislated birth documentation, the responsible nurse, midwife or doctor from the unplanned birth site must provide the receiving site with:

- a completed copy of each of the below listed documents
- advice that the legislated document requirements has either been completed for the birth or will require completion by the receiving site midwife.

The unplanned birth site is to complete the:

- Labour and Birth summary sheet (MR71)
- Mother's Medication Chart (MR170A)
- Paediatric Medication Chart (MR170D)
- Maternal Observation Response Chart (MR140B)
- Newborn Observation Response Chart (MR140D)
- Detailed account of the event in the patient's progress notes (both mother and baby)
- Email advice to the Operations Manager and Regional Nurse Director
- Datix Clinical Incident Management System (Datix CIMS) form.

Further documentation required by WA legislation to be completed by the receiving maternity hospital:

- A Notification of Case Attended (NOCA) form must be completed by the nurse, midwife or doctor who attends the birth. Non-maternity sites can obtain this form via:
  - by emailing birthdata@health.wa.gov.au, **or**
  - the WA Health Notification of Case Attend Form (MR15) on the Midwives Notification System website.
- A Birth registration form, Part A needs to be completed by health care professional who delivered the child.
- A Centrelink Parent Pack Newborn Child Declaration completed by the doctor, nurse or midwife present at the birth.
- A Personal Health Record (Child Health purple book) with mother and baby birth details.

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2.9 Education resources for Emergency Department Nurses and Medical practitioners who may attend an Unplanned Imminent Birth

Nursing staff and non-obstetric doctors working in Emergency Departments are required to familiarise themselves with the:

- contents of the Emergency Birth Equipment Box (Appendix 1)
- Imminent Birth Quick Reference Guide (Appendix 2)
- Women and Newborn Health Service Resuscitation Algorithm for the Newborn (Appendix 3).

LMS resources

- Teaching resources (lesson plans etc.) for a one day 'Emergency unplanned birth' workshop are located on the WACHS Learning Management System.
- Each region must allocate staff development resources to provide this training to identified sites on a regular basis, and ensure ED nurses and doctors have access to the training as required.
- Some useful video resources are available via the LMS which offer opportunities for nurses and non-obstetric doctors who wish to increase their confidence during imminent unplanned birth.

Newborn resuscitation programs are available for ED staff working via:

- the WACHS Learning Management System
- the Statewide Obstetric Support Unit (SOSU) e-learning package
- the Neonatal Resuscitation Program offered by KEMH
- nationally recognised Advanced Paediatric Life Support programs

Responsibilities

Each **Regional Director of Nursing and Midwifery** is to determine the requirements for non-birthing site senior nurses to have a midwifery qualification or training in assistance with an imminent unplanned birth. This is to include consideration of the specific needs at sites where unplanned, imminent births are not rare i.e. Fitzroy Crossing, some Wheatbelt sites.

Regional Medical Directors are to determine the emergency obstetric skills training and upskilling requirements for VMP GP, SMO, DMO and FACEM providing emergency medical services at non birthing sites.

All sites are to have available via close on-call, as a minimum, one health professional with Advanced Life Support competence (including paediatrics) at all times.

Clinicians working at non-birthing service sites must be confident and competent in the use of ETS and associated equipment.

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3. Definitions

CHNM	Child Health Nurse Midwife
DMO	District Medical Officer
ETS	Emergency Telehealth Service
FACEM	Fellow of the Australian College of Emergency Medicine
GP	General Practitioner
KEMH	King Edward Memorial Hospital
Normal birth	Singleton pregnancy, cephalic presentation (head first) between 37 and 42 weeks gestation
NETSWA	Newborn Emergency Transport Service
RFDS	Royal Flying Doctor Service

4. Roles and Responsibilities

The On-Call Regional Obstetrician, where available, is to provide guidance to the site staff, dependent on the available local expertise and the individual patient circumstances including gestation, antenatal history, current clinical assessment and co-morbidities.

The Onsite Director of Nursing or Senior Clinical Nurse is to assume the role of Emergency Coordinator.

The senior medical and nursing staff are to assist with care of women giving birth if necessary.

Available local Community Midwife or CHNM is to be called to lead the labour and birth care, supported by the hospital staff.

The lead site clinician is to provide the ISoBAR handover of care for the woman and her baby to the receiving maternity site.

All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

5. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

Health Record Management Policy

7. Evaluation

Each unplanned birth or presentation in labour at term to a non-birthing site is to be reviewed for compliance with all components of this policy by the Director of Nursing, or on request, the region's senior midwife / obstetrician.

Feedback with respect to this policy and implementation is to be referred to the WACHS Obstetrics and Gynaecology Clinical Advisory and Patient Safety Group.

All unplanned emergency births are to be reviewed by the regional obstetric governance committee for preventability and where it is determined that health care or lack of health care could have or did lead to unintended harm then the incident is to be notified as a clinical incident into the DATIX Clinical Incident Management System

8. Standards

National Safety and Quality Health Service Standards: 1.1c, e, and f; 1.7b and c; 1.20c; 1.25a; 1.27a; 6.1a, b and c; 6.8f; 8.1a, b and c; 8.6c.

9. Legislation

Nil.

10. References

Nil.

11. Related Forms

MR140B Maternal Observation and Response Chart
MR140D Newborn Observation and Response Chart (N-ORC)
MR170A WA Hospital Medication Chart – Adult Short Stay
MR71 WACHS Labour and Birth Summary

12. Related Policy Documents

KEMH First stage of Labour
KEMH Second Stage of Labour and Birth
KEMH Labour: Third Stage
KEMH Neonatal care
KEMH Postnatal: Immediate Care of Mother in Labour and Birth Suite Following Birth
WACHS Assessment and Management of Interhospital Patient Transfers Policy
WACHS Kimberley Obstetric Patient Referral - Admission and Transfer Criteria to a Higher or Tertiary Level of Care Procedure for WACHS Kimberley Birthing Sites
WACHS Maternal and Newborn Care Capability Framework Policy
WACHS Resuscitation, Education and Competency Assessment Policy

13. Related WA Health System Policies

WA Health Notification of Case Attend Form (MR15)

14. Policy Framework

Clinical Governance, Safety and Quality

15. Appendices

Appendix 1: Emergency Birth Box for Non-Maternity Sites
Appendix 2: Imminent Birth Flow Quick Reference Guide
(Note: See separate editable version for sites to enter local contact details)
Appendix 3: Resuscitation Algorithm for the Newborn

This document can be made available in alternative formats on request for a person with a disability

Contact:	WACHS Coordinator or Midwifery		
Directorate:	Nursing and Midwifery Services	EDRMS Record #	ED-CO-16-37069
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Appendix 1: Emergency Birth Box for Non-Maternity Sites (Check monthly including all expiry dates)

NAME OF SITE: ______________________________________DATE: ______________

Equipment for Actual birth		**COMMENTS**
• Sterile delivery bundle (*obtained from nearest birthing site*) contains: ○ 1 bowl (for placenta) ○ 1 bowl (for collecting and weighing blood loss) ○ 2 metal clamps (for clamping cord) ○ 1 cord scissors ○ 1 yellow cord clamp ○ Drapes	**1**	
• Sterile gloves (latex free)		
• Plastic apron + goggles (eye protection)		
• Large disposable under-pads for under mother's bottom (or lots of bluies)		
• Neonatal resuscitation bag and mask (in case baby not breathing at birth)	**1**	
• Newborn Resuscitation Algorithm	**1**	
• WACHS Policy Imminent Birth Flow Chart	**1**	
• Towels (to dry baby and then a fresh one to keep baby warm)		
In case of perineal repair (by dr with obstetric experience or MW only):		
• Lignocaine 1%	**2**	
• tagged large surgical packs or tagged sterile tampons (obtain from nearest birth site or theatres)	**3**	
• 2/0 vicryl rapide (cutting edge)	**1**	
• Disposable suture set	**1**	
To manage haemorrhage (≥ 500mls following birth):		
• Syntocinon 10 iu – light sensitive	**5**	
• Ergometrine 0.5mcg – light sensitive. Stored in fridge	**1**	
• Misoprostol 200mcg	**8**	
• 14G cannula x 2 (cannulate both arms for rapid volume infusion) • IDC equipment – catheter, syringe, bag, lubricant (full bladder most common cause of PPH)	**2**	
Record post birth obs mother and baby (min 15/60 first two hours, half hourly twice, hourly twice then two hourly twice)**:**		
• Maternal Observation and Response Chart (MORC MR 140B)	**1**	
• Neonatal Observation and Response Chart (NORC MR 140 D)	**1**	

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Extras:		
• Gloves (sterile, latex free) - 6.0, 6.5, 7.0, 7.5, 8	**2ea**	
• Syringe 10mL	**2**	
• Needles 23 G	**2**	
Documentation (obtain a copy of each from the nearest birthing site):		
• Labour and Birth Summary **(MR72)**	**1**	
• Vaginal birth care plan **(MR80)**	**1**	
• Newborn Care Plan – complete the birth history page **(MR75)**	**1**	

Please check the appropriate box after each use of the checklist	
No action required	
Minor problem(s) corrected	
Disposable supplies replaced	
Major problem(s) identified. ACTION(S) TAKEN	
Name	
Signature	
Designation	

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Appendix 2: Imminent Birth Flow Quick Reference Guide

Adapted from: Qld Health, Office of the Chief Nursing Officer, Emergency Birth Management Guideline.

IMMINENT BIRTH

NORMAL BIRTH IS NOT AN EMERGENCY:

- ❑ Remain calm and reassure the woman, breath calmly with her
- ❑ The baby will come of its own accord, just prepare to receive the baby.

IF TIME – ASK ABOUT:

- ❑ How many weeks pregnant?
- ❑ When did the contractions start?
- ❑ Has there been any vaginal fluid or bleeding?
- ❑ Has the baby been moving today?

SIGNS OF SIGNIFICANCE:

- ❑ Contractions coming every 3 to 4 minutes
- ❑ Uncomfortable urge to push or open bowels
- ❑ Baby's head visible at the vulva

CALL FOR HELP

Each site is to insert contact details and phone details below:

- ❑ < Local midwife (Community Health or DON) or obstetric doctor >
- ❑ < Nearest birthing site, regional centre or ETS on 1800 422 190 >

PREPARE FOR BIRTH:

- ❑ Obtain and open the emergency birth kit
- ❑ Warm the room and warm some bath towels
- ❑ Put on a plastic apron, gloves and eye protection

POSITION THE WOMAN COMFORTABLY:

- ❑ Either on all fours, kneeling, side-lying or semi-recumbent – DO NOT LIE HER FLAT ON HER BACK
- ❑ Don't encourage pushing, let her push with her own natural urges

ALLOW THE BABY TO COME NATURALLY - YOU DON'T NEED TO HELP

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AT THE BIRTH:

- ❑ If there is cord around the baby's neck – don't cut it - allow the baby to birth through the cord loops (you may loosen it as the baby comes)
- ❑ Note the exact time of birth
- ❑ Place and keep the baby skin-to-skin on mum's chest (keeps baby warm and relaxed by her heartbeat)
- ❑ Dry the baby off and cover in a warm, dry towel

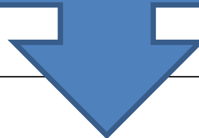
AFTER THE BIRTH:

- ❑ Once the cord has stopped pulsating, double clamp and cut between the two clamps (can ask her partner to cut it)
- ❑ Monitor baby's breathing, colour and heart rate in good light regularly (use the NORC MR140D)
- ❑ Keep the mother warm
- ❑ Monitor the mother's pulse, BP and PV loss regularly
- ❑ Regularly check the tone of the mother's uterus is firm (at umbi level)

MANAGEMENT OF BIRTH OF THE PLACENTA

NORMAL BIRTH IS NOT AN EMERGENCY:

- ❑ Up to 500ml of blood loss is normal (weigh the blood loss from birth)
- ❑ The placenta should birth under the mother's own efforts naturally
- ❑ The placenta will usually come within 60 minutes of the baby



AFTER BIRTH OF THE BABY:

- ❑ Keep the baby skin-to-skin on mum's chest
- ❑ Encourage her to breastfeed (helps contractions to deliver the placenta)
- ❑ Position mum comfortably / observe for bleeding
- ❑ The cord may be cut once it has stopped pulsating

OBSERVE FOR SIGNS OF PLACENTAL SEPARATION:

- ❑ Fundus becomes firm
- ❑ Further trickle of PV blood
- ❑ The remaining cord gets longer
- ❑ Can encourage mum to bear down if she feels cramps or a desire to do so

BIRTH OF THE PLACENTA:

- ❑ Upright positions help i.e. on commode or toilet with bowl in situ
- ❑ Emptying her bladder will help contract the uterus
- ❑ Keep the placenta in a sealed container to send with mum (for the receiving maternity site to confirm it is complete)
- ❑ After the placenta, check the top of the uterus abdominally to see if it is firm and contracted – usually at the level of the umbilicus & central

CALL AN OBSTETRIC DOCTOR OR MIDWIFE IF:

- ❑ blood loss is > 500ml
- ❑ placenta not delivered within 60 minutes of baby
- ❑ increasing maternal HR and/or falling BP
- ❑ before giving any oxytocic medications

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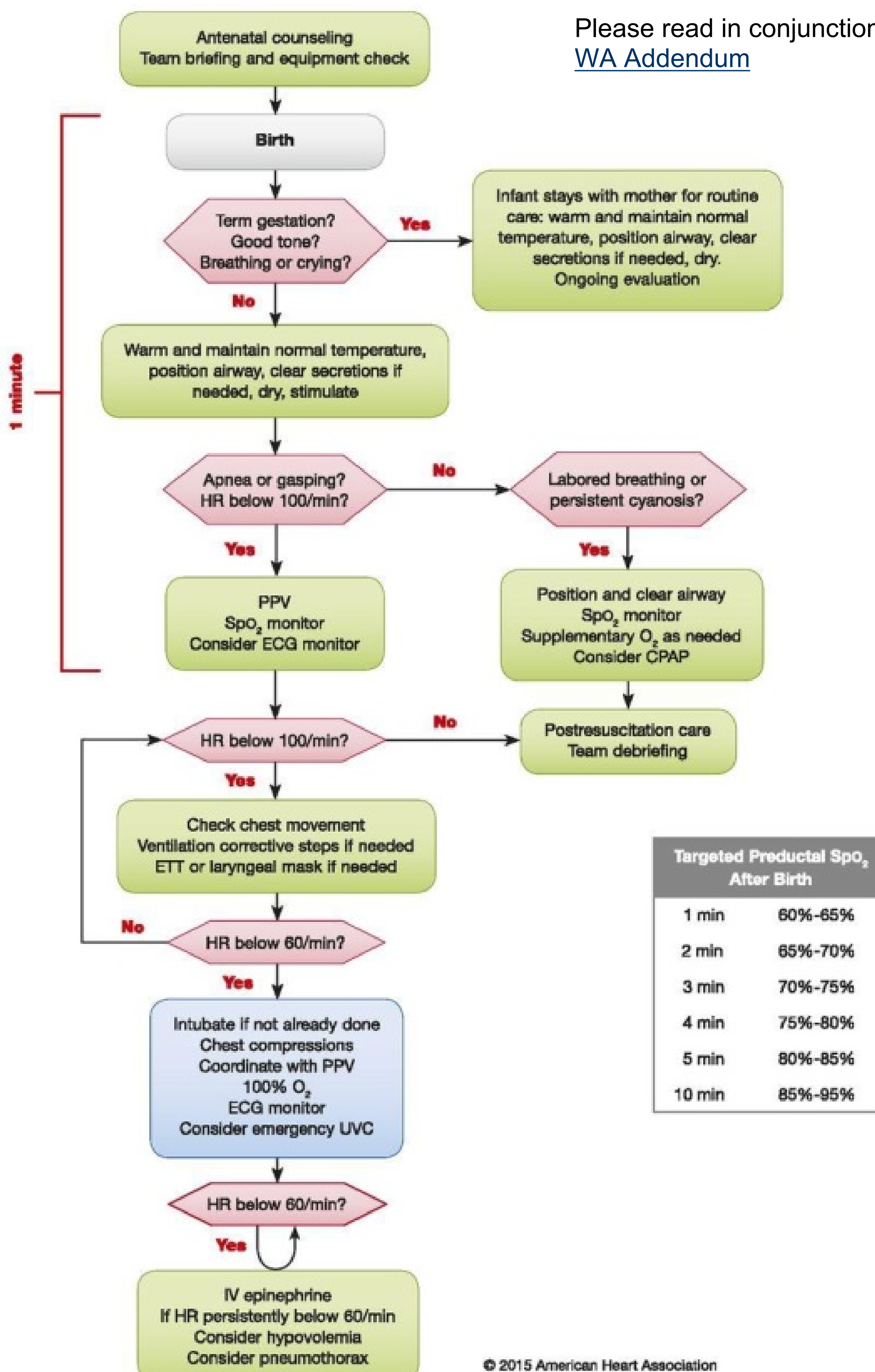
Appendix 3: Resuscitation Algorithm for the Newborn

Please read in conjunction with WA Addendum



Source: Women and Newborn Health Service Resuscitation Algorithm for the Newborn

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