CHAPTER 1

Obstetric services

OBJECTIVES

Having read this chapter, the practitioner should be able to:

- understand the relationship between the different professional groups involved in the management of the obstetric patient
- understand the function and importance of hand-held records and how to use them effectively

ORGANISATION OF OBSTETRIC SERVICES, EPIDEMIOLOGY OF OBSTETRICS AND GYNAECOLOGICAL EMERGENCIES AND ROLE OF THE AMBULANCE SERVICE, GENERAL PRACTITIONER AND MIDWIFE

The organisation

Obstetrics is a multidisciplinary specialty in which midwifery and medical staff work together to provide optimal care. The majority of care is performed in the out-of-hospital setting and by community midwives. Inpatient antenatal care is now uncommon and not usually for long periods. Similarly, the postnatal length of stay for all women, even those with Caesarean section, has also been reduced, with the majority of care occurring in the community.

General practitioners (GPs) have in recent years become less and less involved in all aspects of pregnancy care, although there are still a small number who are involved in care in labour.

Place of delivery

Women undergo a risk assessment prior to delivery to help them choose where to deliver. This assessment is undertaken by their
midwife in conjunction with medical staff, if required, and will involve assessment of previous medical history, previous obstetric history and the progress of the current pregnancy. They will then be offered advice to help them choose the place of birth.

A woman may choose to have a home delivery, deliver in a midwifery-led unit which may or may not be attached to a consultant-led unit or in a consultant-led unit. Although in the majority of cases women ‘choose’ the appropriate place to deliver, midwives have a duty of care to support the woman’s final choice of place for delivery even if there are factors that make this a high-risk decision. Occasionally this causes difficulties, for example, in home delivery where access is poor, there is no phone signal or the home environment is less than ideal. Some women with a high-risk pregnancy also request home delivery.

**Mode of delivery**
The majority of deliveries are uncomplicated but the national Caesarean section rate is 23%. However, this rate varies significantly between units (range 15–30%). Caesarean section is major surgery and can have significant associated risks for both mother and baby.

**Common 999 emergencies**
- labour +/− delivery (term or preterm)
- bleeding antenatally or postnatally (including miscarriage) and postoperative gynaecological haemorrhage
- abdominal pain other than labour
- eclampsia (this is now less common, 2:10,000 cases due to the use of magnesium sulphate in hospital in at-risk cases; however, this does mean that one of the more common places to have a fit, will be in the community)
- prolapsed umbilical cord

**Transfer**
This occurs where risk factors develop before or during labour and after birth that necessitate moving the woman or baby from one location to another.

Transfer may be required from all places of delivery.

**Transfer from home delivery**
The commonest reasons for transfer are concerns about the progress of labour, fetal or maternal well-being, or neonatal well-being.
Transfer from midwifery-led unit
The commonest reasons for transfer are concerns about labour progress, fetal or maternal well-being, or neonatal well-being.

Transfer from a consultant-led unit
The commonest reason for transfer is the need to access a neonatal cot for the fetus either because the unit they are in does not have the appropriate neonatal facilities or all the cots are full. Occasionally women need to be moved to other units for maternal specialist care.

In all these scenarios, a midwife (or medical staff) will accompany the women and will be an invaluable source of advice and knowledge if problems occur during transfer. See Table 1.1 for the roles undertaken by clinical staff.

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**Top tip**
If delivery is imminent, divert to the nearest unit rather than the planned unit.

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**Table 1.1 Roles of medical staff.**

<table>
<thead>
<tr>
<th>Clinical condition</th>
<th>Paramedic</th>
<th>Midwife</th>
<th>GP (if on scene)</th>
<th>Obstetrician (via telephone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess</td>
<td>Assess</td>
<td>Assess</td>
<td>Assist with ALS</td>
<td>Assist with ALS Obstetric support*</td>
</tr>
<tr>
<td>Assist with ALS</td>
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<td></td>
<td></td>
<td>Advice on treatment</td>
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<tr>
<td>Obstetric expertise</td>
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<tr>
<td>Advice on most appropriate receiving unit</td>
<td>Advice on most appropriate receiving unit</td>
<td>Advice on most appropriate receiving unit</td>
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<tr>
<td>Advice on timing/need for transfer</td>
<td>Advice on timing/need for transfer</td>
<td>Advice on timing/need for transfer</td>
<td></td>
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<tr>
<td>Obstetric expertise</td>
<td>General issues</td>
<td>Obstetric expertise</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Some GPs have specific expertise in obstetrics.
CHAPTER 1

Roles

Top tip
Many features of the clinical management of an obstetric patient during secondary transfer are similar to that required in the home or during primary hospital admission. For example, remember to transport the patient in the 15–30° left lateral tilt position.

Top tip
Scoop and run is often the way forward with obstetric emergencies.

Further information on the management of inter-hospital transfers generally and neonatal transfers specifically can be found in the STaR (P. Driscoll et al. 2006) and PaNSTaR (S. Byrne et al. 2008) textbooks respectively.

Admissions procedures
These depend on local policies. Obstetric patients are usually admitted directly to the maternity unit, such as a triage or assessment unit or labour ward. In the case of major trauma, obstetric patients should be transferred to the emergency department. In the case of medical problems admit via medical pathways.

In many units, cases with early pregnancy problems will be admitted to the gynaecology department via an early pregnancy assessment unit.

USING PATIENT HAND-HELD RECORDS
Most maternity units in the UK provide women with their own maternity hand-held notes (see Fig. 1.1). Women are reported to feel better informed by holding responsibility for these notes, and are more involved in their maternity care. Carrying these notes also gives them increased satisfaction in the promotion of communication between themselves and health care providers (DH 2006).

Many instances of adverse perinatal and maternal mortality and morbidity are potentially avoidable, and are often linked to a lack of communication (Elbourne et al. 1987). The hand-held maternity notes are, therefore, an important link for health care providers to improve care and reduce error.
Although there is widespread variation in maternity hand-held notes throughout the UK, the general principles apply throughout:

- The front cover will display the woman’s name, address, named midwife, consultant and GP.
- Information within the notes for the woman to read, including appropriate advice line numbers, screening tests and routine visits.
- The notes will identify whether the woman is on the low- or high-risk pathway of care. This is dependent on factors identified within this pregnancy or previous pregnancies and current medical condition.
- The antenatal section will display all screening tests performed, routine antenatal visits, scan results and fetal growth monitoring.
- There will be a section for the woman to complete a birth plan, in discussion with her midwife.
There is a labour and postnatal section, which also includes detailed information regarding the baby, such as condition at delivery, findings on the neonatal examination and details on feeding.

All investigations and screening tests will be reported.

Most hand-held notes have an alert page or box. This will identify any complications or potential complications, and may show a plan of care to address these complications. Any health professional can and should annotate this page.

There will be a section for correspondence between health care professionals, identifying potential problems and formulating plans of care. Any health professional can and should annotate this page.

Ambulance crews attending an obstetric patient who has not been transported to hospital should leave a copy of their patient report form in the hand-held records. It is paramount that the hand-held notes accompany the woman for all hospital admissions and routine antenatal visits. However, the notes may not have been issued to a woman in very early pregnancy if she has not booked through her midwife. It is still worth checking with her.

### SUMMARY OF KEY POINTS

It is important that you are aware of the roles of other health care professionals in the care of the obstetric patient. Remember that any health professional can and should annotate the alert page in the patient’s hand-held notes.