From the editorial suite

Season’s greetings to all our readers. Thank you for the huge support we have had in the first year of publication. We hope to wax stronger next year. Readers’ feedback, safety tips and improvement stories are welcome.

H1N1 winter flu: Urgent advice for providers of maternity services

Following a rise in influenza activity, the Department of Health has issued urgent advice for providers of maternity services. The influenza A H1N1 (2009) and B are the predominant viruses this season, and pregnant women are considered a high-risk group for severe H1N1 (2009) infection. Increased severity from influenza H1N1 (2009) infection in pregnancy is associated with pre-existing asthma, maternal smoking and obesity. The mortality rate is several times higher than that for non-pregnant women in the same age group. As in every year, the seasonal influenza vaccine for 2010-2011 contains three different flu virus strains. One of these generates immunity to the H1N1 (2009) flu virus.

Pregnant women in the high-risk groups for severe and complicated flu should be actively encouraged to have this trivalent vaccine.

All pregnant women who have not previously received the pandemic flu vaccine (during the pandemic of 2009-2010) should also be encouraged to have one dose of the seasonal flu vaccine, to protect them from infection with the influenza H1N1 (2009) virus.

The exception to this is those pregnant women who are immunocompromised. In this situation, if they have not previously received monovalent H1N1 vaccine then one dose of monovalent vaccine should be offered followed by one dose of seasonal vaccines four weeks later.

It is safe to give seasonal flu vaccine at any stage of pregnancy. Vaccination of pregnant women has been shown to provide protection for the first 4-6 months of life of the infant, through transfer of maternal antibodies.

For details, see http://www.rcog.org.uk/news/swine-flu-alerts

Obesity carries a higher risk of pregnancy problems, CMACE report confirms

The Centre for Maternal and Child Enquiries (CMACE) has just published the findings of a survey which showed that pregnancy outcomes for severely obese women are poorer when compared to the general population.

About 5% of the UK maternity population were severely obese. Only 55% of women with a BMI 35+ gave birth naturally. The caesarean section rate for singleton babies was 37%, which is 1.5 times higher than the rate in the general maternity population.

- The stillbirth rate in women with a BMI 35+ (8.6 per 1000 singleton births) was twice as high as the overall national stillbirth rate (3.9/1000 singleton births).
- Intrapartum stillbirths were three times higher than the overall national rate in England, Wales and Northern Ireland.
- Obese women were at least four times more likely to suffer from primary postpartum haemorrhage.
- They were also more at risk of developing venous thromboembolism (VTE) but fewer than 50% of the women at moderate or high risk of VTE were offered appropriate prophylactic treatment.

Significantly, each BMI unit increment was associated with a 6% increased risk of stillbirth and a 2.3% increased risk of induction of labour, caesarean section and primary postpartum haemorrhage – which means that even if they are unable to achieve a normal BMI, any reduction in BMI could help reduce the risk of complications.

For details, see Centre for Maternal and Child Enquiries (CMACE). Maternal obesity in the UK. Findings from a national project. London: CMACE, 2010
Professor Cathy Warwick, General Secretary of the Royal College of Midwives, has accused the Government of breaking its promise to increase staff to ensure labour wards were run safely. Prof Warwick was “very concerned” that the quality of care will fall and that safety could be compromised as many staff were being axed despite a rising birth rate.

At the general election David Cameron had pledged to increase the number of midwives by 3,000 if elected but it now appears that up to one in three maternity units is having to cut staff. The number of live births in England rose by 19 per cent between 2001 and 2009 to approximately 700,000 a year.

A report by the National Childbirth Trust (NCT) has blamed staff shortages for increasing numbers of postnatal mothers feeling isolated. The charity’s poll of more than 1,200 first time mothers found 59 per cent did not get the “emotional support” they felt they needed after giving birth – compared with 51 per cent in a similar survey a decade ago. Women who had undergone a caesarean section were the least happy about their experience.

Asked about the 24 hours following birth, 66 per cent said they had not received enough support, compared to 57 per cent of those who had a natural labour in hospital, and 24 per cent of those who gave birth at home. Mothers who had gone through traumatic labours said they had been left to cry themselves to sleep, while others said overstretched midwives had no time to offer a kind word of reassurance. In total, 42 per cent said there were not enough midwives to care for them, compared with 33 per cent, when the question was posed in 2000.
Snapshot review: Fetal Scalp Blood Sampling

The appropriate use of fetal scalp blood sampling (FBS) in labour could not only reduce the rate of Caesarean sections but also facilitate recognition and speedy delivery of babies at risk of perinatal brain injury. FBS should usually be done if a cardiotocograph is pathological.

What to do after FBS
- Dispose of sharps appropriately
- Explain result and management to woman/couple
- Document result (see below)
- If vaginal bleeding and/or fetal tachycardia occur, suspect continued bleeding from scalp
- Obtain paired cord blood at delivery

Organisational issues
- Is access to the gas analyser restricted to those who are trained and competent in its use?
- Does your unit have measures in place for regular quality control and quality assurance of the gas analyser?
- Are there formal back-up arrangements in the event of a breakdown or other problem with the gas analyser?

Post-FBS management
- **pH ≥7.25** Normal. Repeated no more than 1 hour later if the CTG remains pathological
- **pH 7.21 - 7.24** Borderline. Repeat FBS within 30 minutes or consider delivery if rapid fall since last sample.
- **pH ≤7.20** Deliver the baby

CNST requirements
The Clinical Negligence Scheme for Trust (Maternity) standards require maternity units to produce, implement and monitor local guidelines for the management of FBS and cord pH, which as a minimum must include:
- when FBS should be undertaken
- the documentation of FBS results in the health record
- the requirement and timing of repeated FBS with appropriate documentation of the process for referral to a consultant obstetrician where a third FBS is considered necessary
- when paired cord samples should be taken
- the documentation of paired cord sample results in the health record
- the process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.

Continued bleeding after FBS
This is not common but it may well be that most cases go unrecognised because they have not been severe enough. In severe cases reported in the literature, the baby has had profound anaemia, haemorrhagic shock and, in some cases, neonatal death. In some but not all cases, the bleeding has been due to an unrecognised coagulopathy.

Obstetricians and midwives should be alert to the possibility of continued bleeding after FBS. It is best to avoid multiple punctures and ensure that bleeding has stopped before the fetoscope is withdrawn.

Further reading:
Jaiyesimi RK, Hickey WP Fetal haemorrhage after fetal scalp blood sampling. Lancet. 1990;336(8718):819-20

Doing an FBS
- The procedure should be explained to the woman (and partner, if applicable), including the possible outcomes
- Consent should be obtained
- Avoid supine hypotension; a left lateral position is usually preferable
- Watch for continued bleeding from the puncture site [see Box]

When not to do FBS
- When the baby is premature (<34 weeks)
- When the baby has or may have a bleeding disorder, e.g. haemophilia
- When the mother has an infection which could be transmitted to the baby such as hepatitis virus, HIV or herpes simplex virus
- When acute compromise (e.g. prolonged bradycardia for >3 mins) mandates immediate delivery of the baby

At St Mary’s Hospital, Manchester, a purpose-designed sticker is used to document the FBS procedure, result and management. This promotes complete documentation and facilitates audit.

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Protecting patient safety through skilful anticipation

A study of maternity nurses has shown that they perceive ‘skilful anticipation’ as the prime route to prevention of patient safety incidents and enhancement of user experience. Skilful anticipation involves (a) understanding the current situation and (b) active consideration of the situation may evolve in the future and (c) determining what needs to be done in preparation for what may happen. It requires integration of experience, clinical and technical know-how, and knowledge of both the individual woman and the local context. Seeing the whole picture, preparing one’s self and the environment, knowing the woman, and knowing the staff were identified as conditions promoting skilful anticipation.


Variation in adjusted caesarean section rates among Trusts

A study based on administrative data has found there is large variation in caesarean rates around England and most of the differences are due to decisions taking in emergency situations. The research published in the BMJ found there were 620,604 births of single babies in 2008 with 24 per cent delivered by caesarean section. When the mothers’ characteristics and clinical factors were taken into account the rate varied from 15 per cent in some hospitals to almost one third in others. There was little variation in adjusted rates of elective caesarean section. NHS trusts, strategic health authorities and commissioners have been urged to examine the reasons for variation in caesarean section in their regions and how the consistency of care for pregnant women can be improved.


Feedback: Retained swabs revisited

“Like every unit we have struggled to sort this one out. I won’t bore you with the details but all staff are very poor at counting swabs and blame all sorts of things. We have got round this by banning small raytecs from our delivery & suture trolleys. Now we supply 5 large wipes with tails. Easy to count to five and Very difficult to lose even if you stuff it into the vagina. Since we introduced this 3 years ago no lost swabs”.

In Manchester, small swabs have also been replaced by large ones and the same has been done in London. It is worth noting, however, that this may not necessarily be the answer.

The NPSA notes that the reported incidents on their database include retention of large swabs (up to 30cm x 30cm).