

NHS Borders

Local Report ~ *January 2007*

# Maternity Services



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## **Maternity Services**

The maternity services standards apply to specific areas of the service. The clinical standards cover the period of time between confirmation of pregnancy, through until the baby is 6–8 weeks old. The project group developed five standards, covering: core principles; pre-conception and very early pregnancy; pregnancy; childbirth; and postnatal and parenthood. This report presents the findings from the peer review of performance against the standards.

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# 1 Setting the scene

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. We do this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

## About this report

The ‘Clinical standards for maternity services’ were published in March 2005. These standards are being used to assess the quality of services provided by NHSScotland nationwide.

This report presents the findings from the peer review of **NHS Borders**. This review visit took place on **19 April 2006**, and details of the visit, including membership of the review team, can be found in Appendix 2.

## 1.1 How the standards were developed

In June 2002, a maternity services project group was established and chaired by Dr Jane Magill, Director, Robert Clark Centre for Technological Education, University of Glasgow. Membership of the maternity services project group includes both healthcare professionals and members of the public (see Appendix 3).

Members of the maternity services project group are involved in the quality assurance process of:

- developing standards
- reviewing performance against the standards throughout Scotland, using self-assessment and external peer review, and
- reporting the findings from the review.

When developing the maternity services standards, a Scotland-wide consultation process was undertaken. The views of health service staff, women (pre and postnatally), and the public were sought, and all the relevant evidence available at the time was taken into account. Draft standards were also piloted in NHS Highland, NHS Lanarkshire and NHS Lothian in June 2004.

## 1.2 How the review process works

The review process has two key parts: local self-assessment followed by external peer review. First, each NHS board assesses its own performance against the standards. An external peer review team then further assesses performance, both by considering the self-assessment data and visiting the NHS board to validate this information and discuss related issues. The review process is described in more detail below (see also the flow chart on page 9).

### Self-assessment by NHS boards

On receiving the standards, each NHS board assesses its own performance using a framework produced by NHS QIS. This framework includes guidance about the type of evidence (eg guidelines and audit reports) required to allow a proper assessment of performance against the standards to be made.

The NHS board submits the data it has collected for this self-assessment exercise to NHS QIS before the on-site visit, and it is this information that constitutes the main source of written evidence considered by the external peer review team.

### External peer review

An external peer review team then visits and speaks with local stakeholders (eg staff, patients and carers) about the services provided. Review teams are multidisciplinary, and include both healthcare professionals and members of the public. All reviewers are trained. Each review team is led by an experienced reviewer, who is responsible for guiding the team in its work and ensuring that team members are in agreement about the assessment reached.

The composition of each team varies, and members have no connection with the NHS board they are reviewing. Both of these factors facilitate the sharing of good practice across NHSScotland, and ensure that each review team assesses performance against the standards rather than make comparisons between one NHS board and another.

At the start of the on-site visit, the review team meets key personnel responsible for the service under review. Reviewers then speak with local stakeholders about the services provided. After these meetings, the team assesses performance against the standards, based on the information gathered during both the self-assessment exercise and the on-site visit. The visit concludes with the team providing feedback on its findings to the NHS board. This includes specific examples of local initiatives drawn to the attention of the review team (recognising that other such examples may exist), together with an indication of any particular challenges.

### **Assessment categories**

Each review team assesses performance using the categories ‘met’, ‘not met’ and ‘not met (insufficient evidence)’, as detailed below.

- **‘Met’** applies where the evidence demonstrates the standard and/or criterion is being attained.
- **‘Not met’** applies where the evidence demonstrates the standard and/or criterion is not being attained.
- **‘Not met (insufficient evidence)’** applies where no evidence is available for the review team, or where the evidence available is insufficient to allow an assessment to be made.

A final category **‘not applicable’** is used where a standard and/or criterion does not apply to the NHS board under review.

### 1.3 Reports

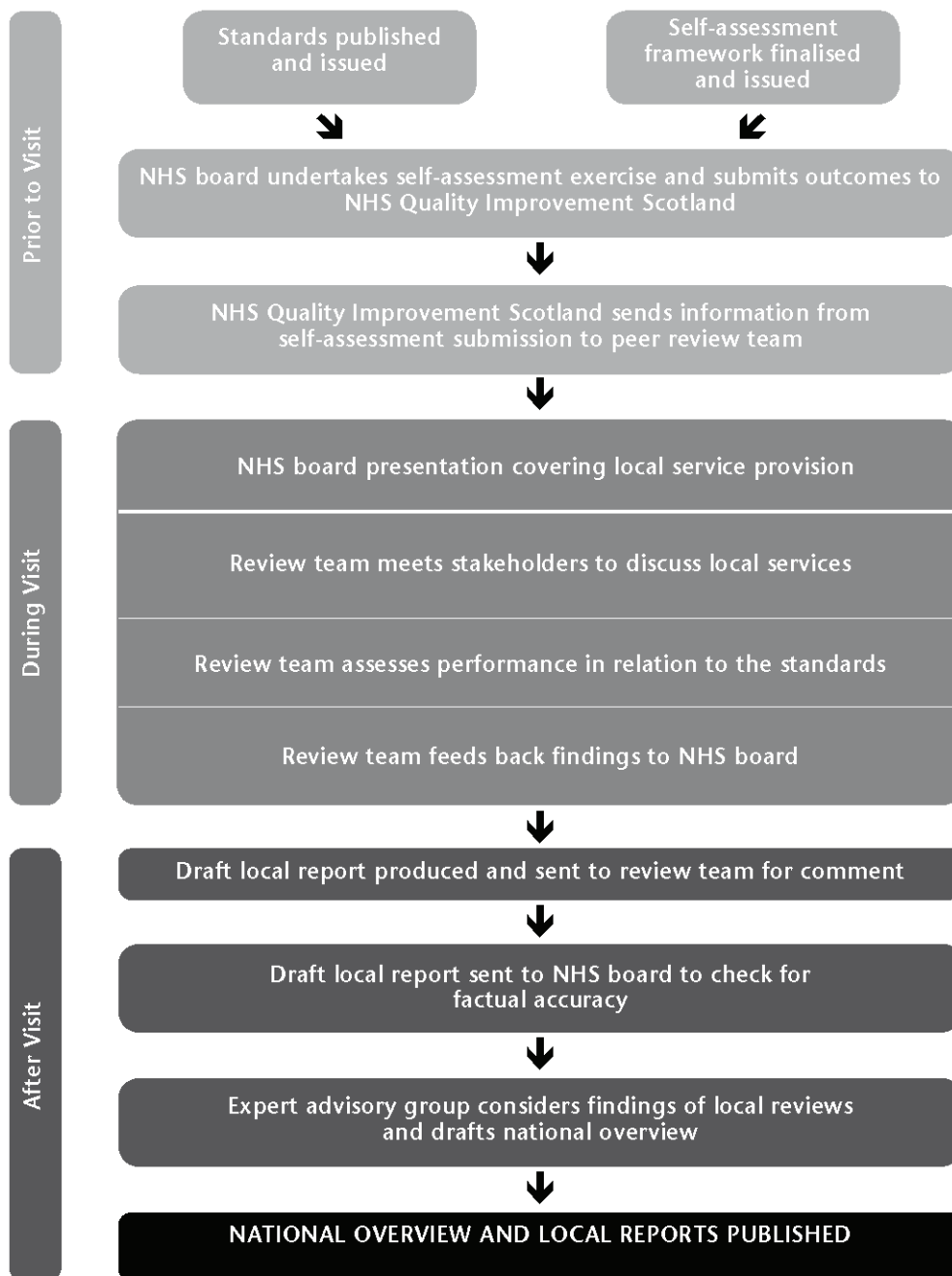
After each review visit, NHS QIS staff, with clinical input as appropriate, draft a local report detailing the findings of the review team. This draft report is sent to the review team for comment, and then to the NHS board to check for factual accuracy. The local report is published only after all the visits for that topic have been undertaken nationwide.

Once a national review cycle is completed, the expert advisory group convenes to examine review findings and make recommendations. The group then oversees the production of a national overview of service provision across Scotland in relation to the standards. This document includes both a summary of the findings (highlighting examples of local initiatives and challenges for the service) and recommendations for improvement.

Part of the remit of NHS QIS is to report whether the services provided by NHSScotland, both nationally and locally, meet the agreed standards. This does not include reviewing the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered and subsequently reported.

**Please note – all reports published are available in print format and on the NHS QIS website.**

## The review process



## 2 Summary of findings

### 2.1 Overview of local service provision

The Borders is situated in south-east Scotland and has a population of around 109,270. The majority of the population live in rural areas, and the largest towns in the region are Galashiels and Hawick. The proportion of older people in the population is higher than the national average, whereas levels of illness and deprivation are relatively low.

#### Local NHS system and services

Borders NHS Board is responsible for improving the health of the local population and for the delivery of the healthcare required. It provides strategic leadership and has responsibility for the efficient, effective and accountable performance of the NHS in the Borders.

The NHS board has responsibility for the operation of clinical services, and the employment of those delivering these services. NHS Borders delivers hospital and primary care/community health services. Mental health services are both hospital and community-based. There is one community health and care partnership (CHCP), Borders Community Health Partnership. A CHCP is a way of organising non-acute care where an NHS board maximises its ability to support integration across health services and with other agencies such as social services.

The NHS board is also accountable for both continuously improving the quality of health services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish (framework of clinical governance).

Further information about the local NHS system can be accessed via the website of NHS Borders ([www.show.scot.nhs.uk/bhb](http://www.show.scot.nhs.uk/bhb)).

#### Service organisation

Information obtained from a scoping study exercise undertaken in 2005 indicated that there are 15 NHS boards within Scotland that provide maternity services.

In NHS Borders, all maternity services are provided across primary and secondary care settings throughout the NHS board area, with specialist/tertiary services being provided by the regional service within NHS Lothian.

There is one maternity unit within Borders General Hospital, Melrose which is supported by a community midwifery service. The number of births has remained relatively static over the last 5 years as illustrated in the following table.

NHS Borders	Number of births				
	2001	2002	2003	2004	2005
Borders General Hospital	1,025	980	984	1,031	999
Home births	6	5	10	7	12
Other (eg born before arrival)	4	3	5	8	2
<b>Total births</b>	<b>1,035</b>	<b>988</b>	<b>999</b>	<b>1,046</b>	<b>1,013</b>

## 2.2 Summary of findings against the standards

A summary of the findings from the review, including examples of local initiatives drawn to the attention of the review team, is presented in this section. A detailed description of performance against the standards/criteria is included in Section 3.

### Core Principles

NHS Borders has a consultant-led maternity service. The director of integrated health services is responsible for maternity services at Board level and the Board's lead clinician has operating responsibility for the service throughout the NHS Borders Board area.

Service staff devised a maternity services strategy for NHS Borders and, at the time of the review visit, a draft strategy had been distributed to Board staff for consultation.

The Board has a maternity services liaison committee (MSLC) which has been established to provide multidisciplinary and local public involvement in the provision of maternity services throughout NHS Borders.

There is a system in place between the Board and the Scottish Ambulance Service for the transfer of women during pregnancy, childbirth and with their newborn babies to the maternity unit at Borders General Hospital. Local arrangements are in place between the Board and the South of Scotland Neonatal Transfer Team for the specialised transfer of neonatal babies who require to be transferred from Borders General Hospital to a neonatal intensive care unit (NICU) facility in another NHS Board area. The review team would however recommend, that current arrangements are formalised into a reference guideline to facilitate locum and new members of staff who may be less familiar with local arrangements for contacting these services.

There is an audit system in place to monitor aspects of maternity care, and the Board contributes to a range of local and national audit programmes. The review team commended the Board on its self-medication policy and the audit undertaken to monitor the self-medication programme.

The review team commended the Board's commitment to providing a range of training programmes for various staff groups involved in the provision of maternity services.

Borders General Hospital has high dependency facilities, adult intensive care and clinical expertise on-site and there is a fast access route for all obstetric women who require these facilities. There is also a special care baby unit (SCBU) facility and provision to stabilise babies who require transfer to a NICU facility in another NHS Board area.

The review team commended the Board on the content and format of local information leaflets provided to women throughout the antenatal and postnatal stages and would encourage the Board to produce more local information leaflets to highlight the range of maternity services provided locally by NHS Borders.

### Example of a local initiative...

NHS Borders has produced a parents support service information leaflet which details: the midwife's name; health visitor's name; GPs name; surgery address; telephone numbers and names of other midwives working in the team. The leaflet also contains information on the roles of the community midwife and health visitor during pregnancy and after discharge from hospital following the birth of the baby. There is a baby's health checklist to help parents recognise symptoms if their baby is becoming unwell and details on how to contact the service should this situation arise. A list of helpline telephone numbers is also included for parents to obtain further information from a range of support organisations.

In general, the review team acknowledged the high standard of care provided throughout the maternity service which was reflected in the volume of compliments received in the form of feedback from mothers who used the service.

### Pre-conception and Very Early Pregnancy

Pre-conception advice and services are readily accessible and provided to women with diabetes, and their management is based on SIGN Guideline 55: Management of Diabetes. Women with a personal or family history of significant illness can be referred or self-refer to the weekly specialist high risk obstetric clinic held at Borders General Hospital for pregnancy management and advice, if required.

There are formal arrangements in place throughout NHS Borders for women who experience complications in early pregnancy to self-refer to the early pregnancy assessment service (EPAS). The assessment unit operates during normal working hours on weekdays with out-of-hours service provided through the gynaecological ward.

### Example of a local initiative...

NHS Borders provides a pregnancy assessment service at Borders General Hospital on an 8.30am–4.30pm, Monday–Friday basis. All women experiencing early pregnancy concerns and/or complications are seen at the morning clinic and all women in later stages of pregnancy are seen at the afternoon clinic. The review team considered it good practice for early pregnancy complications to be seen at a different time to women who are more advanced in their pregnancy to avoid any potential distress for women who have experienced an early pregnancy loss.

Ultrasound scanning facilities are available and provided 24 hours a day.

### Pregnancy

Antenatal education is provided to all pregnant women in NHS Borders with classes tailored to suit specific groups, for example, teenage women and those with special needs. Individual education is also given where appropriate. While the review team

recognised that antenatal education is provided, the organisation and delivery of the education programme is not co-ordinated throughout the Board area by a designated lead. The review team encouraged the Board to consider a structured board-wide approach to parent education.

Postnatal reunion classes are provided across NHS Borders. The information given during the education session tends to be variable in content and the review team encouraged the Board to include relevant core topics into a written programme of education for delivery at the reunion classes.

In NHS Borders, women have access to screening services and antenatal diagnostic testing, and Anti-D prophylaxis is offered to all rhesus negative women in line with national recommendations. The review team commended the Board's comprehensive information leaflet on rhesus haemolytic disease of the newborn, which clearly explains the condition and the benefits of giving Anti-D injections to pregnant women identified as at risk of rhesus disease.

The Board's routine antenatal care of women is currently outwith the guidance recommended in 'A Framework for Maternity Services in Scotland'. Antenatal visits are provided on a monthly basis up to 28 weeks of pregnancy and then fortnightly until delivery.

Women can move between different levels of care and professionals, and are managed according to their level of risk. However, it was noted that while women are assessed by a consultant obstetrician at approximately 16 weeks of pregnancy, this practice is variable between consultants. The review team encouraged the Board to consider implementing a standard practice that involved midwives in the initial risk assessment in line with national recommendations.

### **Childbirth**

The Board ensures that women in established labour and during childbirth receive one-to-one midwifery care. This is provided by well-managed staffing rotas, in addition to further support being available from midwives in the postnatal ward or from the midwifery bank if required. An on-call rota system allows for two trained midwives to be present for planned home births.

Policies for the management of key labour practices are accessible to all staff. Policies are currently reviewed by a consultant obstetrician; however, the review team would encourage the Board to consider adopting a multidisciplinary approach to review and management of these.

Women receive information on pain management techniques available during antenatal education and through ongoing discussions with the midwife throughout the duration of their pregnancy. All women are supported in their choice of pain control.

### Example of a local initiative...

The Board uses a validated pain assessment tool during labour to assess and monitor pain levels. This tool is used to continually assess pain through to the postnatal period and forms part of the maternity observation chart. The review team considered this a good practice approach in pain assessment and management.

NHS Borders provides a 24-hour anaesthetic service. There is a lead consultant anaesthetist with responsibility for the organisation and management of the anaesthetic service, however, there is no consultant obstetric anaesthetist for the service, although it was noted that current arrangements work well in practice.

Obstetric emergencies were reported to be managed within a 30-minute period. However, at the time of the visit, there were no audit data available to confirm this.

### Postnatal and Parenthood

The Board has a postnatal care plan to ensure that all postnatal checks and examinations have been completed for mothers and babies. In addition, there are guidelines in place for the aftercare and management of all women who have had an instrumental delivery or a caesarean section.

### Example of a local initiative...

NHS Borders has developed a parenting observation tool in addition to general observations noted in casenotes for parents where additional support and intervention is considered helpful. The tool helps staff to formally assess how parents are managing with their newborn baby and identifies areas where the additional support and intervention is needed.

The review team considered this an example of good practice working.

NHS Borders is currently working towards achieving UNICEF/WHO Baby Friendly status. At the time of the review visit, there was not an infant feeding advisor in NHS Borders and this was highlighted as a challenge for the Board. Midwifery staff have, however, undertaken training courses to support women in this area and the review team commended the range of information provided to women to assist them to make informed choices regarding their chosen method of feeding their babies. In addition to the information provided in leaflets and videos, midwifery staff provide practical support to mothers to ensure that feeding is established prior to being discharged from hospital. Following discharge, community midwifery staff continue to provide support on baby feeding as part of community postnatal care. The review team acknowledged the Board's success of achieving high breastfeeding rates and commended staff involved in supporting women in breastfeeding their babies.

The review team considered the Board to have a good practice approach to ensure that every effort is made to prevent babies being admitted to SCBU facilities due to heat loss.

#### **Example of a local initiative...**

In addition to ensuring that all newborn babies are delivered in a warm room, dried quickly with heated towels and have parental 'skin to skin' contact, Borders General Hospital labour ward also has a 'heated cot' for any baby requiring re-warming. The review team highlighted the good practice in place and acknowledged the achievement of no babies being admitted to SCBU for re-warming.

All babies are clinically examined immediately following birth. A more detailed examination is conducted prior to discharge which is undertaken by either a paediatrician, or a midwife who has successfully completed examination of the newborn training. The review team acknowledged the Board's commitment to providing a multi-professional approach to the examination of the newborn and would encourage the Board to involve midwifery staff in all aspects of care in line with national recommendations, in particular, in early pregnancy care, in terms of booking appointments and risk assessment which currently has a high level of consultant involvement.

The Board has a comprehensive discharge process in terms of practical arrangements for discharge and in transferring information on women and their babies between the maternity unit and community care. Community midwifery and health visitor care provides continuity of care once mothers and their babies return home.

Overall, the review team perceived the Board to provide a high standard of care in the provision of maternity services throughout NHS Borders. The Board is actively involved in regional working and in particular, has good evidence-based practice of this with NHS Lothian.

## 3 Detailed findings against the standards

### Standard 1(a): Standard 1 ~ Core Principles

#### Standard Statement

*Accountability: There are clear lines of responsibility for the planning and delivery of maternity services, with evidence of public involvement.*

#### NHS Borders

#### Essential Criteria

*1a.1: There is a named individual at NHS Board director level with responsibility for maternity services.*

#### STATUS: Met

The director of integrated health services is the named individual at NHS Borders Board level with responsibility for maternity services.

*1a.2: There is a named clinician at both Primary and Acute NHS Operating Division level with responsibility for maternity services.*

#### STATUS: Met

The Board's lead clinician for maternity services has operational responsibility for maternity services throughout NHS Borders.

*1a.3: There is a current, dated, documented NHS Board strategy, developed by stakeholders, which sets out how maternity services are planned, developed and implemented, in line with Scottish Executive Health Department (SEHD) policies for women-centred care.*

#### STATUS: Not met

A formal strategy outlining how the NHS Borders maternity service is planned, developed and implemented in accordance with national guidelines was not in place at the time of the review visit. However, the review team acknowledged the work of various staff groups involved in the provision of maternity services to produce a draft strategy document for NHS Borders. The Board reported that the draft document had been circulated to the Board's executive team for consideration. The review team would encourage the Board to finalise the strategy.

*1a.4: There is evidence of a range of public involvement activities in the planning of all maternity services.*

**STATUS: Met**

There is a maternity services liaison committee (MSLC) which involves local public participation and multidisciplinary maternity staff representation to inform the Board on the planning and delivery of maternity services throughout NHS Borders. The Board provided the review team with a copy of committee meeting minutes highlighting the range of activities covered by the MSLC.

## Standard 1(b): Standard 1 ~ Core Principles

### Standard Statement

*Risk Management: All healthcare professionals are aware of the importance of risk assessment and management of pregnant women, and take action to minimise avoidable adverse clinical incidents, including during transfer and access to services.*

### NHS Borders

### Essential Criteria

*1b.1: Assessment: There is a system to ensure that all critical incidents are reported, investigated and analysed, resulting in changes in practice, where necessary.*

### STATUS: Met

The review team considered the Board to have a good practice approach to ensuring that all critical incidents are reported, investigated and analysed. The Board has a risk management strategy in place which outlines NHS Borders risk management process. There are also formal guidelines for the investigation of incidents, as well as specific reporting criteria for obstetrics incidents which are in accordance with The Royal College of Obstetricians and Gynaecologists guidelines. In addition, there is a clinical risk team consisting of senior midwifery staff supported by the Board's clinical risk management facilitator and a supervisor of midwives. The team holds meetings on a regular basis and analyses trends and identifies areas of the service where developments can be progressed. The review team was provided with an example of how changes in practice are made as a result of an incident being reported, investigated and analysed.

*1b.2: Assessment: A compliments, comments and complaints procedure is in place to enable women to express views about their pregnancy and childbirth experience.*

### STATUS: Met

The Board has an established system to log compliments, comments and complaints. Suggestion boxes are sited throughout Borders General Hospital, Melrose including the obstetrics and gynaecology unit. The review team was informed that staff are encouraged to deal with any comments and concerns as they are received to resolve any concerns and alleviate any anxieties patients may have. More formally, a complaints procedure folder is held in the maternity unit and there are standard forms available to all staff to enable them to record complaints from patients. All written complaints are acknowledged within 24 hours and are formally responded to within 21 days. Patients can also discuss any concerns and/or complaints with the Board's complaints officer; this can be done in person or by telephone, email, fax or letter.

The Board reported that twelve times more compliments are received than complaints, and verbal comments are also noted to identify any trends in service provision. The review team commended the robust system which enables women to express their views about their pregnancy and childbirth experience, and the Board's system to acknowledge, analyse, respond and, where necessary, change practice to facilitate good practice working.

*1b.3: Assessment: There are local guidelines agreed between the NHS Operating Division and the Scottish Ambulance Service, for the safe transfer of women during pregnancy, childbirth and with her newborn baby in the postnatal period.*

**STATUS: Not met**

There was not a written guideline in place between the Board and the Scottish Ambulance Service for the transfer of a woman during pregnancy, childbirth and with her newborn baby in the postnatal period. However, the review team identified good informal arrangements in place between these two organisations for the safe transfer of women and babies. The Scottish Ambulance Service transfers pregnant women to the maternity unit at Borders General Hospital as well as hospital to hospital transfers when necessary. The Board is also supported by the South of Scotland Neonatal Transport Team for the transfer of neonatal babies who require to be transferred from Borders General Hospital to a neonatal intensive care unit (NICU) in another NHS Board area. Board staff reported that the current system works well and, in view of this, the review team recommended that the Board prepares a guideline to formalise current working arrangements.

*1b.4: Referral: Formal arrangements exist for women and their babies to access a network of specialist services.*

**STATUS: Met**

Formal arrangements exist for women and their babies to access a network of specialist services ranging from: allied health professions (AHPs); anaesthesia and intensive care; imaging; laboratory medicine; medicine; neonatology; obstetrics; perinatal pathology; surgery, and psychiatry services.

Referrals to AHPs can be made by both medical and midwifery staff. In addition to formal referrals, a physiotherapist with a special interest in obstetrics visits the postnatal ward on a daily basis, Monday–Friday.

A consultant anaesthetist is on-call at Borders General Hospital at all times with the provision of a second anaesthetist on-call from home, if required. The review team was informed that due to the size of the maternity service in NHS Borders, if a pregnant woman has high risk factors, consultant anaesthetists will already be aware of the case and will be expecting an admission. A hospital theatre and adult intensive

care facilities are situated next to the labour ward. The Board reported that there is excellent access to intensive care as required and good working links between anaesthetic and intensive care unit (ICU) staff. In addition, a named consultant anaesthetist co-ordinates communication between the anaesthetics team and labour ward staff.

Obstetric ultrasound is carried out in the obstetrics unit and gynaecological ultrasound is carried out in both the obstetrics unit and radiology department. CT and MRI scanning facilities are also available as required at Borders General Hospital.

Laboratory medicine, bacteriology, biochemistry, blood transfusion and haematology are all on the same floor as the obstetrics and gynaecology department.

There is an on-call medical team in the hospital's department of medicine. The medical consultant responsible for diabetic services provides a joint clinic with an obstetrician where pregnant women with impaired glucose tolerance and diabetes can attend for treatment and care management throughout their pregnancy.

Borders General Hospital has a special care baby unit (SCBU) which is located next to the labour ward. The unit provides special care facilities for babies 32 weeks and above. Infants under 32 weeks gestation at Borders General Hospital are stabilised for transfer to a neonatal unit facility in another NHS Board area.

There is an obstetrics unit within Borders General Hospital which provides a full range of obstetric services.

A perinatal pathology service is provided to NHS Borders by the regional service at the Royal Hospital for Sick Children, Edinburgh. Perinatal mortality meetings are held on a regular basis and are attended by pathology staff and paediatricians from both sites.

The department of surgery is located on the same floor as the labour ward and a consultant surgeon is on-call at all times to facilitate the obstetric service.

There is a well-established integrated psychiatry team to support all women who require this area of the service. In addition, there is an integrated care pathway for perinatal mental health which was implemented by the Board in January 2005. The Board reported that all midwives and health visitors have attended a study day regarding perinatal mental health and the Board has best practice guidelines and integrated care pathway folders in the labour and postnatal ward to provide information as required.

*1b.5: Referral: All women with risk factors for their pregnancy are offered assessment by a consultant obstetrician.*

**STATUS: Met**

The Board reported that it is local practice for all pregnant women to be seen by a consultant obstetrician during pregnancy. Consultant staff hold community clinics throughout NHS Borders and perform ultrasound scanning for pregnant women in their local community clinics. Pregnant women see a consultant at their initial booking appointment. Consultants plan the woman's care on an individual basis in accordance with the woman's risk factors.

*1b.6: Training and Audit: There is an audit system in place to monitor important aspects of maternity care.*

**STATUS: Met**

There is a comprehensive audit system in place to monitor aspects of maternity care. In particular, the review team commended the self-medication policy which also facilitates the dispensing and discharge practice. Casenote audits are undertaken annually and self-medication practice is audited on a 6-monthly basis to monitor effectiveness of the system and to make improvements where possible. In addition, the Board contributes to a range of national audit programmes.

*1b.7: Training and Audit: All healthcare professionals directly involved in childbirth are competent in basic adult obstetric, neonatal resuscitation and immediate care.*

**STATUS: Met**

The review team commended the system in place for all healthcare professionals directly involved in childbirth to gain competence in basic adult, obstetric and neonatal resuscitation and immediate care.

The Board's resuscitation officer provides basic life support training for midwives. At the time of the review visit, six midwives had completed this training. These midwives provide basic life support training for their colleagues in the labour ward. There is also an annual emergency obstetric study day which includes training in basic life support and obstetric emergencies.

Senior labour ward and community midwifery staff attend newborn life support (NLS) training, Scottish Multiprofessional Maternity Development Programme (SMMDP) and advanced life support in obstetrics (ALSO) training courses on a regular basis. A records of all training is maintained in the labour ward. Training is also recorded in personal development plans. NHS Borders provides 15 hours allocated study time for each midwife every year which the review team considered

good practice. The Board reported that all 'G' grade midwifery staff practicing in the labour ward have attended and achieved ALSO and NLS and some of these midwives are now instructors for these courses.

The review team was informed that in addition to this allocated study time, midwives regularly attend training in their own time. There are good communication links between labour ward and ICU staff. A specialist intensive care nurse organises intensive care study days which are also available to midwifery staff.

Training in basic adult, obstetric and neonatal resuscitation skills and immediate care is provided to senior house officer staff as part of their induction programme. Consultant medical staff have attended a Scottish Care Obstetric Teaching and Training in Emergencies (SCOTTIE) course and, at the time of the review visit, one consultant had also attended a Managing Obstetric Emergencies and Trauma (MOET) course.

Study days are organised on a regular basis and a place is allocated to each midwife to provide education and training on a range of topics including all obstetric emergencies and neonatal resuscitation. Midwives who provide training are also supported to attend study days to update their knowledge and skills. Weekly and monthly clinical update sessions covering a range of topics from: maternal resuscitation; shoulder dystocia; postpartum haemorrhage; pregnancy induced hypertension; breech; malpresentation; malpositions; neonatal resuscitation; and interpretation of cardiotocographs are available for all medical and midwifery staff to attend in addition to regular labour ward skills updates.

The review team acknowledged the Board's commitment to providing training and development opportunities for all staff directly involved in the provision of maternity care, however, considered this criterion not met. While the Board provides a commendable range of training opportunities, it was acknowledged that not all members of staff directly involved in childbirth attend these courses.

*1b.8: Clinical Complications: A clinical risk assessment process for individual women, including a communications strategy, is in place, which addresses escalating risk.*

**STATUS: Not met**

A risk assessment process is in place for individual women which starts at a woman's booking appointment and will be reviewed at her subsequent consultant appointment. In circumstances where a woman's risk escalates throughout her pregnancy, her care will be managed and referrals made in accordance with her individual risk factors. While the Board has a communications strategy, the review team considered this criterion as not met as there was no document outlining how risk should be communicated. The review team was informed however that, in practice, communications and referral pathways are normally unrestricted and flexible.

*1b.9: Clinical Complications: A policy is in place for the identification of women who are at risk of domestic abuse, and staff are trained in assessment, communication skills and support of such women.*

**STATUS: Met**

The Board has guidelines in place for the identification of women who are at risk of domestic abuse. In addition, Scottish Women's Aid training programmes have been organised for staff which outline the scope of domestic abuse and its impact on those who experience it. There are various levels of training to provide staff with the knowledge and confidence to identify and assist patients who are in this situation. Women experiencing domestic abuse may also be referred to the Board's Sure Start midwife for additional support.

The review team found the Board to be proactive in its approach to identifying women who are at risk of domestic abuse. Information on domestic abuse issues is prominently displayed in all areas of the maternity unit, including private areas where women will be on their own, for example, ladies toilets should they wish to take down a telephone helpline number in confidence.

The Board has summarised its guidelines for domestic abuse into a flow chart for staff which the review team considered a good practice approach.

*1b.10: Clinical Complications: High dependency facilities and clinical expertise are available within the obstetric unit for all women in level II and level III consultant-led units.*

**STATUS: Met**

Borders General Hospital has high dependency facilities and clinical expertise available on the same floor as the obstetric unit and adjacent to the obstetric operating theatre. The Board reported that there is adequate capacity within the unit to accommodate patients requiring this level of care.

*1b.11: Clinical Complications: There is a defined rapid access route for women to adult intensive care and expertise in all level II and level III consultant-led units.*

**STATUS: Met**

The Board reported that there is a rapid access route for women to adult intensive care facilities. The unit is situated beside the obstetric operating theatre and as with high dependency facilities, access to an intensive care bed is as required. The review team was informed that there are excellent communications links between the units and access to adult intensive care facilities is seamless for obstetric women as it is co-ordinated by the consultant anaesthetist on-call who is also the on-call anaesthetist for the obstetric service.

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The Board also reported that there is an action plan in place to convert the recovery ward into an additional ICU facility should the adult intensive ward become full and unable to accommodate any additional patients.

*1b.12: Clinical Complications: Adult intensive care facilities and specialist medical back-up are available on-site in all level IIc and level III consultant-led units.*

**STATUS: Met**

Adult intensive care facilities and medical back-up are available on-site and are located immediately next to the obstetric operating theatre and the labour ward areas within Borders General Hospital.

*1b.13: Clinical Complications: Where full adult intensive care facilities are not currently available on-site in level IIc and level III consultant-led units, a strategy is in place outlining the process and timescale to achieve this.*

**STATUS: Not applicable**

This criterion is not applicable to working practice at NHS Borders as Borders General Hospital has full adult intensive care facilities on-site.

*1b.14: Clinical Complications: Units that do not have adult intensive care facilities, advanced imaging and cardiology on-site, must have protocols in place for the care of women with significant medical or obstetric illness to ensure that they are delivered in a unit that can provide these resources on-site.*

**STATUS: Not applicable**

This criterion is not applicable to working practice at NHS Borders as Borders General Hospital has full adult intensive care and advanced imaging facilities on-site.

*1b.15: Clinical Complications: Neonatal intensive care unit (NICU) facilities are available on-site in level IIc and level III consultant-led units. Where NICU facilities are not available on-site, a strategy is in place outlining the process and timescale to achieve this.*

**STATUS: Not met**

Borders General Hospital is a level IIc maternity unit. However, full NICU facilities are not available on-site. Instead the unit has two cots which can be used to ventilate babies whilst awaiting transfer to NICU facilities at the Simpson Centre for Reproductive Health (SCRH), Edinburgh. The neonatal transport service transfers all babies from Borders General Hospital to the NICU facility at SCRH. The review

team commended the information leaflet provided to parents whose babies require the facilities provided by the neonatal transport service. The information leaflet details the service provided by the transport team, directions for parents to travel to the NICU facility at SCRH and contact details for the neonatal unit in Edinburgh.

*1b.16: Clinical Complications: Special care baby unit (SCBU) facilities are available on-site in all level II and level III consultant-led units and there is a defined rapid access route to NICU in all level II and level III consultant-led units.*

**STATUS: Met**

SCBU facilities are available on-site at Borders General Hospital. The Board reported that SCBU staff support midwifery colleagues and attend complicated deliveries in theatre to assist midwifery colleagues with immediate care of the newborn baby. NHS Borders uses SCRH guidelines for the management of babies in its care and conforms to information provided by BLISS, the national charity for the newborn regarding the management of care for babies who are born prematurely.

*1b.17: Clinical Complications: Where there is provision of NICU and SCBU facilities, these conform to agreed national guidelines.*

**STATUS: Met**

The Board reported that its SCBU facilities conform to regional neonatal unit guidelines.

## Standard 1(c): Standard 1 ~ Core Principles

### Standard Statement

*Information, Communication and Support: All women are fully informed of the different options available to enable them to take an informed and active role in planning their care, and in the decision-making involved in providing this care. Healthcare professionals are skilled in supporting women in the decision-making process.*

### NHS Borders

### Essential Criteria

*1c.1: There is a named healthcare professional identified for each woman, who leads and plans her contact with maternity services.*

### STATUS: Met

The review team was informed that each woman has a named community midwife and a named consultant obstetrician. This information is recorded in the handheld multidisciplinary casenote which contains a care plan for the woman's pregnancy, birth and postnatal care.

*1c.2: Women are provided with information in order to make an informed decision about the chosen place of birth for their baby.*

### STATUS: Met

Women are provided with comprehensive information in order to make an informed decision about the chosen place of birth for their baby. The Board reported that the option of having a home birth is not actively promoted but will be facilitated if requested. The review team commended the Board's information leaflet for parents considering a home birth. Women who wish to deliver in other NHS Board areas due to geographic location are provided with information on the maternity unit facilities at that hospital. Verbal information is provided on a one-to-one basis between the woman and her community midwife. This is supported with information leaflets. SCRH has a DVD for women in the NHS Borders area who wish to deliver their baby in the SCRH.

*1c.3: There is evidence that professionals obtain informed consent for interventions and investigations, and this is documented.*

### STATUS: Met

There is a system for obtaining informed consent for interventions and investigations. Informed consent is required at various stages during a woman's pregnancy, delivery and in the postnatal period. In some cases, written consent is

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required, for example, pregnancy and newborn screening. In other circumstances, for example, physical examination, verbal consent is recorded. Consent is documented in the woman's casenotes and information regarding the baby is also documented in child health records.

The Board reported that women are fully informed of the reasons for specific interventions and investigations throughout pregnancy and will be provided with additional information from clinical and medical staff if additional support is required to assist with making an informed decision.

The Board informed the review team that work has been undertaken to create one NHS Borders policy to incorporate consent in the acute and primary care setting. At the time of the review visit, this policy was at a draft stage for consultation.

*1c.4: All women are given the opportunity to reflect on their birth experience.*

**STATUS: Met**

The review team considered the Board to have a good system for women to reflect on their birth experience. Midwives who deliver a woman's baby follow-up her care and will speak to the woman to provide an opportunity to discuss her birth experience. Women who have undergone a theatre delivery are followed-up by the consultant anaesthetist or a member of the pain team in addition to a review by midwifery staff. Women can also arrange further discussions with a midwife, if required.

*1c.5: Training on how to communicate information in an effective and sensitive manner, is provided to all healthcare professionals.*

**STATUS: Met**

The Board reported that communications skills training is included as part of the education programme for midwifery and medical staff and is a key part of the induction process.

*1c.6: There is a policy for supporting and informing parents bereaved during pregnancy, or soon after giving birth.*

**STATUS: Met**

The Board has a policy for supporting and informing parents bereaved during pregnancy or soon after giving birth. The review team considered the information provided to parents at this time to be comprehensive and the system in place for bereaved parents to be supportive in terms of the one-to-one care provided.

Bereaved parents are also provided with contact details for relevant organisations which can provide ongoing additional support.

*1c.7: Information giving (verbal, written and other media) is monitored and evaluated.*

**STATUS: Met**

The Board monitors information provided to parents on an ongoing basis. In particular, information provided to parents who have experienced a pregnancy loss is reviewed through a local support group with representation from midwifery staff and the hospital chaplain.

## Standard 1(d): Standard 1 ~ Core Principles

### Standard Statement

*Partner and Family Involvement: All maternity services and healthcare professionals recognise the important role of the partner/family, and ensure that they are encouraged and supported to be involved in pregnancy and childbirth.*

### NHS Borders

### Essential Criterion

*1d.1: There is evidence that partner/family/friend involvement occurs, (including information provision for partners and families and open/flexible visiting times for partners and children).*

### STATUS: Met

Community midwives encourage partner/family involvement from the antenatal stage through to delivery. The Borders General Hospital maternity services leaflet outlines arrangements for antenatal, labour and postnatal care as well as arrangements for going home. The leaflet states that a birth partner of the woman's choice is welcome to stay with the woman through to the baby's delivery. The leaflet also provides some practical information for birth partners in terms of what clothing to wear and facilities accessible to them during their time in the hospital. The Board reported that there is a flexible approach to visiting for partners and families.

## Standard 1(e): Standard 1 ~ Core Principles

### Standard Statement

*Record-keeping: A structured and accurate record of all events during the antenatal, childbirth and postnatal periods is maintained for every woman and child (known as a 'unified record').*

### NHS Borders

#### Essential Criteria

*1e.1: All women have a unified handheld record.*

#### STATUS: Not met

Pregnant women in NHS Borders hold a Borders handheld maternity record. However, it does not contain information on laboratory results, referral/result letters, etc. Although staff reported that midwives can access this information on results from GP files, the review team considered that this should be included in the handheld maternity record. The review team, therefore, considered the Board not to meet this criterion.

*1e.2: The SMR02, Scottish birth record and birth notification General Register Office for Scotland (GROS), is completed for all women and newborn babies in line with current standards.*

#### STATUS: Met

The SMR02, Scottish birth record (SBR) and birth notification General Register Office for Scotland (GROS) are completed for all women and newborn babies. The Board reported that correctly completed forms are processed by the medical records department and information is transferred to the Information Services Division (ISD), Edinburgh. Midwives are trained to complete all sections of the SBR and there is a system in place to cross check this process to ensure all information is complete and accurate.

## Desirable Criterion

*1e.3: The national unified handheld record and national electronic record are completed for all women and newborn babies.*

### **STATUS: Not applicable**

The review visit to NHS Borders took place shortly after the official launch of the national unified handheld maternity record. As the review team considered the time between the launch of the national record and this review visit to be insufficient to measure progress in this area, it concluded this criterion was not applicable at this stage of the review process.

## Standard 2(a): Standard 2 ~ Pre-conception and Very Early Pregnancy

### Standard Statement

*Pre-conception Services: All women with a poor obstetric/medical history, a previous poor fetal/maternal outcome, or where there is a family history of significant illness, have access to specific pre-conception services.*

### NHS Borders

#### Essential Criterion

*2a.1: There is a specific pre-conception service for women with diabetes which is based on the SIGN guideline for diabetes.*

#### STATUS: Met

Pre-conception services based on the SIGN guideline for Diabetes are provided for women with diabetes. A dedicated multidisciplinary team provides care and management for women with Type 1 diabetes. Women can access this service directly or through the diabetic services team. There is also a dedicated consultant physician who provides diabetic pre-conception care.

#### Desirable Criterion

*2a.2: There are specific pre-conception services for women with a personal or family history of significant illness (eg epilepsy, neural tube defect, chromosomal abnormality).*

#### STATUS: Met

There is a weekly consultant-led high risk obstetric clinic held at Borders General Hospital to provide specific pre-conception services for women with a personal or family history of significant illness. GPs can request an early referral for their patients to this clinic. Additionally, women can self-refer to the clinic by contacting the midwife in charge of the pregnancy assessment unit.

## Standard 2(b): Standard 2 ~ Pre-conception and Very Early Pregnancy

### Standard Statement

*Early Pregnancy Complications: All women who experience complications in early pregnancy have access to an early pregnancy assessment service.*

### NHS Borders

### Essential Criteria

*2b.1: There are formal arrangements in place for referral to the early pregnancy assessment service, which allows any healthcare professional to access the service directly.*

### STATUS: Met

The Board has formal arrangements for any healthcare professional to refer women to the early pregnancy assessment service (EPAS). The pregnancy assessment unit operates on an 8.30am–4.30pm, Monday–Friday basis. An out-of-hours service is also provided through the gynaecological ward.

*2b.2: There are formal arrangements in place for referral to the early pregnancy assessment service, which allows women with previous early pregnancy problems to self-refer.*

### STATUS: Met

Women can access the EPAS directly. Community midwives and GPs can also refer women to the assessment unit. An out-of-hours service is also provided.

*2b.3: Women who experience early pregnancy complications are cared for in a dedicated area distinct from the general gynaecology or antenatal ward.*

### STATUS: Met

The Board reported that women who experience early pregnancy complications in the first 12 weeks of pregnancy are cared for in a dedicated area of the gynaecological ward and women who experience complications after 12 weeks of pregnancy are cared for in a dedicated single room in the labour ward at Borders General Hospital.

*2b.4: Women who miscarry have access to a choice of management options (surgical/medical/expectant).*

**STATUS: Met**

Women who miscarry have a choice of surgical, medical and expectant management options. All three options are available at Borders General Hospital. The Board reported that the majority of women choose medical management while very few women choose surgical management.

*2b.5: There is prompt access (within 24 hours) to ultrasound facilities with trained staff in secondary and tertiary services.*

**STATUS: Met**

The Board provides 24-hour access to ultrasound facilities 7 days a week. Ultrasound facilities are provided by the pregnancy assessment unit on an 8.30am–4.30pm, Monday–Friday basis. The out-of-hours service is provided by the registrar on-call who has access to the ultrasound facilities in the pregnancy assessment unit outwith these times. NHS Borders provides ultrasound training for all obstetric registrar staff.

**Desirable Criterion**

*2b.6: Telemedicine is used to promote regional networking, and to expedite the reporting of results.*

**STATUS: Not met**

The Board reported that telemedicine facilities are available at Borders General Hospital and can be used in the provision of maternity services as required. However, in practice, telemedicine facilities are not used in the provision of maternity services at Borders General Hospital.

## Standard 3(a): Standard 3 ~ Pregnancy

### Standard Statement

*Education Programme: All maternity services provide comprehensive programmes of education for childbirth and parenthood to women and their partners and families.*

### NHS Borders

### Essential Criteria

*3a.1: There is a written syllabus of education that targets specific groups, and is in a user-friendly format. The syllabus outlines the aims, themes and outcomes of the education programme.*

### STATUS: Not met (insufficient evidence)

The Board has a document which outlines topics covered in parent education classes and informed the review team that in addition to these classes, early antenatal classes are held monthly for women between 14 and 18 weeks gestation. The Board schedules these classes to provide information to women on musculoskeletal changes which the body undergoes in pregnancy and reviews exercises to deal with aches and pains resulting from these changes. The Board also provides antenatal education classes to specific groups, for example, teenage pregnancies as well as on an individual basis where appropriate. While there is a system in place for antenatal education, there is not a programme of antenatal education co-ordinated throughout NHS Borders Health Board area. One member of staff is responsible for co-ordinating a programme of antenatal education at Borders General Hospital, while community midwives organise classes in their local area. In view of this, the review team considered the evidence insufficient in relation to this criterion.

*3a.2: There is a lead named co-ordinator, with recognised training and development to undertake the role, who takes responsibility for the programme on a service-wide basis.*

### STATUS: Not met

The review team was informed that, at the time of the review visit, there was not a named co-ordinator responsible for the antenatal parent education programme on a Board-wide basis. One member of staff co-ordinates the education programme at Borders General Hospital and midwifery teams organise classes in their individual community areas.

## Desirable Criteria

*3a.3: The Ready, Steady, Baby book is provided to all women on confirmation of pregnancy.*

### STATUS: Met

The Board reported that the Ready, Steady, Baby book is provided to women at their booking appointment.

*3a.4: Parent education programmes include a postnatal reunion.*

### STATUS: Met

The Board provides a postnatal reunion session for women, however, reported that while classes are provided they tend to be on an informal basis in terms of topics covered. The review team would encourage the Board to include relevant core topics for discussion as part of the reunion programme.

## Standard 3(b): Standard 3 ~ Pregnancy

### Standard Statement

*Screening Services: All women have access to screening services and antenatal diagnostic testing.*

### NHS Borders

### Essential Criteria

*3b.1: All women who are identified in the screening programme as at risk of rhesus disease are managed and treated according to an agreed protocol.*

### STATUS: Met

The Board works in accordance with national recommendations for antenatal screening. Anti-D prophylaxis is offered to all rhesus negative women at 28 and 34 weeks gestation. The review team commended the Board's information leaflet on rhesus haemolytic disease of the newborn, in terms of context and clarity of information provided.

*3b.2: The antenatal care and investigation of women conforms to the guidance set out in Table 14, page 40 of A Framework for Maternity Services in Scotland.*

### STATUS: Not met

The Board highlighted to the review team that the antenatal care and investigation of women is currently outwith the guidance recommended in 'A Framework for Maternity Services in Scotland' and that a more traditional approach is taken in the provision of antenatal care in that antenatal visits are provided on a monthly basis up to 28 weeks gestation and then fortnightly to delivery. This allows for only one antenatal ultrasound scan and the review team would encourage the Board to conform to national recommendations and guidance in the provision of antenatal care.

## Standard 3(c): Standard 3 ~ Pregnancy

### Standard Statement

*Antenatal Care: All maternity services provide antenatal care delivered by a network of professionals, such that each woman is managed by a midwife, GP or obstetrician according to her level of risk, and as locally as possible.*

### NHS Borders

### Essential Criteria

*3c.1: Each maternity service has an explicit plan for antenatal care for all women, taking account of risk, which acknowledges that women can move in either direction between different levels of care and lead professionals.*

### STATUS: Not met

There are arrangements in place for antenatal care for all women which take account of risk. The Board reported, however, that all women are assessed by a consultant obstetrician at approximately 16 weeks gestation and the review team noted that practice can vary between consultants. The review team would recommend that one system is in place, with greater midwifery involvement in initial risk assessment in accordance with national recommendations. The review team was informed that the current system does, however, enable women to move between consultant and midwifery-led care.

*3c.2: Women are offered the opportunity to be involved in the development of their birth plan, including the chosen place of birth of their baby.*

### STATUS: Not met

Women are provided with an opportunity to be involved in preparing their birth plan. However, the Board reported that women are not proactively offered a choice regarding their preferred place of birth but all options would be discussed as requested.

*3c.3: The routine pattern of antenatal care for pregnant women is no more than nine visits for a primigravida and eight visits for a multigravida.*

### STATUS: Not met

The routine pattern of antenatal care for pregnant women is currently outwith the recommended number of visits.

## Standard 4(a): Standard 4 ~ Childbirth

### Standard Statement

*Care Planning and Birth: All women receive an agreed plan of care throughout labour in line with current professional standards consistent with their risk assessment and their chosen place for childbirth.*

### NHS Borders

### Essential Criteria

*4a.1: Each woman receives one-to-one midwifery care during established labour and childbirth by a trained midwife, or trainee midwife under supervision.*

### STATUS: Met

The Board reported that the service is operated to ensure that all women receive one-to-one midwifery care during established stages of labour and childbirth. Should a situation arise where demand on the service is particularly high, additional support can be obtained from the postnatal ward or midwifery bank staff.

*4a.2: For planned home births there is a minimum of two trained professionals present, one of whom is a midwife.*

### STATUS: Met

There are very few requests for the home birth service throughout NHS Borders. However, the Board reported that there are always two midwives in attendance for all planned home births. Community midwives operate an on-call rota system to provide adequate staffing levels to support the home birth service.

*4a.3: There are agreed multidisciplinary, evidence-based policies for the management of all key labour practices, when care deviates from the norm.*

### STATUS: Met

The Board has policies in place for the management of: induction of labour; breech presentation; perineal repair; caesarean section; prophylactic antibiotics for caesarean section; placenta praevia; postaglandins and oxytocin use; thromboembolism and thromboprophylaxis; water birth; epidural analgesia; fetal monitoring; multiple pregnancy; diabetes; pre-eclampsia and eclampsia; women who decline blood products; haemorrhage; prolapsed cord; rupture of the uterus; shoulder dystocia;

neonatal resuscitation; adult resuscitation; retained placenta; and intrauterine death. Policies are currently reviewed by a consultant obstetrician, however, the review team would recommend a multidisciplinary systematic approach to policy creation, review and management.

## Standard 4(b): Standard 4 ~ Childbirth

### Standard Statement

*Pain Management: All women, regardless of their specific location, are informed about, and offered the range of pain management techniques during childbirth, and are supported in their choice of pain control.*

### NHS Borders

### Essential Criteria

*4b.1: All women receive information about, and have access to, a range of pain management techniques which include: transcutaneous electrical nerve stimulation (TENS); oral and intramuscular analgesia; inhalational analgesia; and the use of water for pain relief. Epidural analgesia is available in consultant-led units.*

### STATUS: Met

Women are provided with information regarding pain management during antenatal education and discussions with midwifery staff during pregnancy in completing care plans. Discussions regarding pain relief are followed-up by midwifery staff during a woman's progression of labour. The Board reported that women have access to the following range of pain management techniques: transcutaneous electrical nerve stimulation (TENS); oral analgesia; intramuscular analgesia; Entonox; the use of water for pain relief; and epidural analgesia.

*4b.2: All women, who have epidural analgesia or an operative delivery, have their pain assessed using a pain assessment tool.*

### STATUS: Met

The review team commended the pain assessment system in place for all women who have epidural analgesia or an operative delivery. The Board use a validated pain assessment tool to monitor pain during labour and also in the postnatal period.

### Desirable Criterion

*4b.3: Epidural analgesia is available at all times in consultant-led units.*

### STATUS: Met

Consultant anaesthetists work on an on-call basis at Borders General Hospital to ensure that epidural analgesia is available at all times.

## Standard 4(c): Standard 4 ~ Childbirth

### Standard Statement

*Anaesthesia: During childbirth all women have access to anaesthesia that conforms to current professional standards.*

### NHS Borders

### Essential Criteria

*4c.1: There is a lead consultant obstetric anaesthetist with responsibility for the organisation and management of the specialist anaesthetics service within consultant-led units.*

### STATUS: Not met

There is a lead consultant anaesthetist at Borders General Hospital who co-ordinates the obstetric anaesthetic service. There is not, however, a consultant obstetric anaesthetist for the service. Obstetric staff commended the commitment and service provided by anaesthetic colleagues to maternity services, and reported that the current system and arrangements work very well in practice.

*4c.2: Arrangements are in place in consultant-led units, to ensure that a specialist anaesthetic service is available at all times during childbirth.*

### STATUS: Not met

Arrangements are in place to ensure that an anaesthetic services is available at all times during childbirth. However, the Board reported that, in practice, a specialist anaesthetic obstetric service could not be provided solely for maternity services at Borders General Hospital. Instead, anaesthetic services are prioritised as part of maternity care and consultant anaesthetists are allocated to cover obstetric care on a daily basis in addition to their general duties and commitments. There is a dedicated anaesthetist for elective caesarean sections and there are two anaesthetists available at all times on a bleep system.

*4c.3: All specialist anaesthetic services comply with NHS QIS anaesthesia standards and Royal College of Anaesthetists (RCA) guidelines.*

### STATUS: Met

The review team acknowledged the Board's commitment to comply with the NHS QIS anaesthesia standards and the guidelines issued by the Royal College of Anaesthetists (RCA). The Board has an action plan to follow-up on the NHS QIS

anaesthesia review visit in October 2004. The review team confirmed from observation of the plan that the Board is meeting this criterion.

*4c.4: There is a system in place to ensure that anaesthetic and theatre services respond rapidly to obstetric emergencies and expedite delivery in the event of maternal or fetal compromise.*

**STATUS: Met**

The Board has an established system to ensure that anaesthetic and theatre services respond rapidly to obstetric emergencies and expedite delivery in cases of maternal or fetal compromise. There is a dedicated obstetric operating theatre located near the labour ward. A senior midwife in the labour ward carries a bleep to be notified regarding obstetric emergencies. Porter staff also carry a specific bleep system to facilitate immediate response to emergency situations. Theatre preparation trays are located in the labour ward and the labour ward protocol outlining the emergency process is located throughout the ward at work station desks. Theatre staff prioritise their operating lists in accordance with emergency situations.

*4c.5: There is a system in place to ensure that 'decision to delivery' intervals and perceived urgency are monitored.*

**STATUS: Not met**

The review team noted that the Board audited this process during 2003 and 2004. However, there was not a system in place to audit the process during 2005 or for any future audit to be undertaken.

**Desirable Criterion**

*4c.6: The time from informing the anaesthetist to the start of an emergency operative delivery should not normally exceed 30 minutes except if there is a risk to maternal health.*

**STATUS: Not met (insufficient evidence)**

The Board reported that, in practice, the time from informing the anaesthetist to the start of an emergency operative delivery does not normally exceed 30 minutes. However, in the absence of audit data to verify the process, the review team considered there to be insufficient evidence in response to this criterion.

## Standard 5(a): Standard 5 ~ Postnatal and Parenthood

### Standard Statement

*Care of Women: All women receive appropriate care and assessment from giving birth to the 6-week postnatal check.*

### NHS Borders

### Essential Criteria

*5a.1: All women are assessed immediately after giving birth by a suitably qualified member of the birth team.*

### STATUS: Met

All women are assessed immediately after giving birth by a midwife. Women who have experienced any obstetric complications will also receive a medical assessment. The Board has a postnatal care plan for mothers and babies which contains details of the assessment to be followed to ensure a complete assessment is provided for all women and their babies. There are also obstetric postoperative monitoring guidelines in place for all post-caesarean section patients as well as a guideline for monitoring patients following instrumental delivery under spinal anaesthetic with diamorphine. Staff follow a neonatal nurse-led transitional care guideline for babies who require additional specialised care.

*5a.2: All women are assessed prior to transfer to community care and/or within 24 hours of giving birth, by a midwife.*

### STATUS: Met

All women at Borders General Hospital are assessed by a midwife prior to discharge from the ward. The Board has guidelines outlining this process. In addition to postnatal discharge guidelines, there are guidelines for the 6-hour discharge of the newborn.

*5a.3: There is ongoing assessment for the recognition of complications, eg infection, haemorrhage, thromboembolism and anaesthetic problems.*

### STATUS: Met

The review team considered there to be a good system in place for ongoing assessment to recognise development of postnatal complications. Staff work to an established standard of care and have been provided with training study days regarding medical complications and perinatal mental health. All women receive a daily physical check from midwifery staff. This is followed-up by a formal assessment

on day four with appropriate care management as required. The review team commended the system of the formal day four follow-up assessment in addition to daily checks and highlighted this as good practice in the provision of maternity services at Borders General Hospital.

*5a.4: Women receive information on contraception within 2 weeks of childbirth.*

**STATUS: Met**

Information on contraception is provided and discussed as part of the postnatal discharge process. This is followed-up by midwifery staff in the community. There is a family planning clinic for women who wish to attend. Contact telephone numbers and clinic consulting times are provided in the information leaflet provided to women. Alternatively, women can discuss contraception with their health visitor or GP.

## Standard 5(b): Standard 5 ~ Postnatal and Parenthood

### Standard Statement

*Infant Feeding: Maternity services promote, support and sustain breastfeeding. Women are informed of its benefits, while being supported in their chosen mode of feeding.*

### NHS Borders

### Essential Criteria

*5b.1: There is evidence that the maternity service adheres to the principles of, or is working towards, the UNICEF/WHO Baby Friendly status.*

### STATUS: Met

The Board has undertaken considerable work to progress towards achieving UNICEF/WHO Baby Friendly status. At the time of the review visit, work in this area was focused on staff training regarding awareness of UNICEF/WHO Baby Friendly principles. The review team would encourage the Board in its continued efforts to achieve UNICEF/WHO Baby Friendly status.

*5b.2: Women are provided with readily accessible information and support in their chosen method of feeding, including access to peer support groups.*

### STATUS: Met

The review team considered there to be a good range of information provided for women on their chosen method of feeding their baby. Information leaflets are provided at bedside areas. In addition to written information, there is a selection of breastfeeding videos available in Ward 17 of Borders General Hospital for women and their partners to watch, if they wish. Information is also provided on local breastfeeding support groups which are held weekly in Selkirk, Kelso and Galashiels. These support groups are provided by trained breastfeeding counsellors.

Women are supported in the maternity unit by midwifery staff in their chosen method of feeding. All mothers (breast and bottle feeding) are assisted at early feeds and as required until feeding is established. Women who choose to bottle feed their babies are provided with individual instruction on how to prepare and store feeds. Mothers who choose to breastfeed their babies are provided with individual support and information. Mothers continue to be supported in their chosen method of feeding their baby by their community midwife.

## Desirable Criteria

*5b.3: Each NHS Board area has an infant feeding advisor to provide education and training to healthcare professionals who support women in their chosen method of feeding.*

### STATUS: Not met

At the time of the review visit, there was not an infant feeding advisor for NHS Borders. The Board informed the review team that an application for funding for this post was in progress. However, midwifery staff had attended a 3-day UNICEF/WHO Baby Friendly breastfeeding course to support women who choose to breastfeed their babies.

*5b.4: Admission rates for babies due to inadequate nutrition are monitored.*

### STATUS: Not met

There was not an audit process in place to monitor admission rates for babies due to inadequate nutrition. However, Board staff reported that a case review had been undertaken which confirmed that the number of admissions for inadequate nutrition was very low in relation to the number of babies born in the unit. The review team would recommend that a system is established to monitor admission rates on an ongoing basis.

## Standard 5(c): Standard 5 ~ Postnatal and Parenthood

### Standard Statement

*Care of Babies: All babies receive appropriate care and assessment from birth until 6 weeks post birth.*

#### NHS Borders

#### Essential Criteria

*5c.1: Steps are taken to minimise the number of infants who require re-warming or avoidable admission to SCBU.*

#### STATUS: Met

The Board reported that a series of steps is taken to minimise the number of infants who require re-warming or avoidable admission to SCBU. It is general practice to always have the resuscitaire heater switched on in anticipation of a delivery and the labour ward room temperature is maintained at approximately 26 degrees centigrade. In addition, there is a heated cabinet in the labour ward to ensure towels are warm prior to drying newborn babies. Midwifery practice ensures that babies are dried quickly with warm towels and 'skin to skin' contact is initiated. All babies are fed in the labour ward prior to transfer to the postnatal ward. There is a heated cot available in the labour ward for any baby who requires it.

*5c.2: All babies are clinically examined immediately following birth by a suitably qualified member of the birth team.*

#### STATUS: Met

The review team was informed that all babies are clinically examined immediately following birth. This examination is normally conducted by a midwife who was in attendance at the baby's delivery to ensure continuity of care unless a paediatrician or special care baby nurse has reason to be involved in the management of the baby's care. The Board has guidelines in place for examining newborn babies.

*5c.3: All babies are clinically examined prior to discharge from hospital and/or within 72 hours of birth, by a suitably qualified healthcare professional.*

#### STATUS: Met

The Board reported that all babies are clinically examined by a paediatrician, or a midwife qualified in examination of the newborn, prior to discharge from the maternity unit. Should mothers require an early 6-hour discharge during the day, the baby will receive its examination prior to discharge. For all discharges after hours, the

parents are given an opportunity to return to the unit the next day to have the baby examined, or, arrangements can be made for the family's GP to conduct the examination. A formal record of who undertakes the examination is maintained by maternity service staff.

*5c.4: There is ongoing assessment, including recognition of group B streptococcal infection and jaundice.*

**STATUS: Not met**

The Board has guidelines for the management of group B streptococcal infection and the review team was informed that all babies at risk of group B streptococcal infection have 4-hourly observations over a 24-hour period.

The Board does not have a specific protocol for the identification and management of jaundice. However, recognition for jaundice in babies forms part of routine observations. An individual care plan is devised for all babies as required. The review team noted that while there is not a protocol in place, all babies with jaundice at Borders General Hospital are managed successfully.

## Standard 5(d): Standard 5 ~ Postnatal and Parenthood

### Standard Statement

*Transfer Standard: The transfer of women and their newborn babies into the community is planned to facilitate continuing effective care.*

### NHS Borders

### Essential Criteria

*5d.1: A system is established to ensure that information on women and their babies in the postnatal period is collated and transferred between secondary and primary care in a reliable, timely and secure manner.*

### STATUS: Met

The Board has a comprehensive process in place to ensure that information on women and their babies in the postnatal period is collated and transferred between secondary and primary care. Handheld postnatal notes are checked by hospital midwives and are then provided to women to take home for use by community midwives. Women also receive a formal discharge letter. The Board operates a discharge record book which contains a summary of relevant information regarding the woman and her baby. Community midwives contact the labour ward at Borders General Hospital on a daily basis to obtain details of discharges in their community area. Arrangements are then made to visit the mother and baby at home.

*5d.2: Guidelines for transfer and post transfer care are in place.*

### STATUS: Met

The review team considered the Board to have a good system in place to facilitate the transfer and post transfer care for women and their newborn babies. The process follows the discharge procedure which ensures all relevant documentation is complete and arrangements are made as appropriate to individual requirements.

## Appendix 1 – Glossary of abbreviations

### Abbreviation

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<b>AHP</b>	allied health profession
<b>ALSO</b>	advanced life support in obstetrics
<b>CHCP</b>	community health and care partnership
<b>EPAS</b>	early pregnancy assessment service
<b>GP</b>	general practitioner
<b>GROS</b>	General Register Office for Scotland
<b>ICU</b>	intensive care unit
<b>ISD</b>	Information Services Division
<b>MOET</b>	Managing Obstetric Emergencies and Trauma
<b>MSLC</b>	maternity services liaison committee
<b>NHS QIS</b>	NHS Quality Improvement Scotland
<b>NICU</b>	neonatal intensive care unit
<b>NLS</b>	newborn life support
<b>RCA</b>	Royal College of Anaesthetists
<b>SBR</b>	Scottish birth record
<b>SCBU</b>	special care baby unit
<b>SCOTTIE</b>	Scottish Care Obstetric Teaching and Training in Emergencies
<b>SCRH</b>	Simpson Centre for Reproductive Health
<b>SEHD</b>	Scottish Executive Health Department
<b>SIGN</b>	Scottish Intercollegiate Guidelines Network

<b>SMMDP</b>	Scottish Multiprofessional Maternity Development Programme
<b>SMR02</b>	Scottish Morbidity Record 2
<b>TENS</b>	transcutaneous electrical nerve stimulation
<b>UNICEF/WHO</b>	United Nations Children's Fund/World Health Organisation

## Appendix 2 – Details of review visit

The review visit to NHS Borders was conducted on 19 April 2006.

### Review team members

**Ms Irene Barkby (Team Leader)**

Divisional Director of Nursing, NHS Lanarkshire

**Mrs Yvonne Clark**

Clinical Manager Labour Suite & Delivery Services, NHS Lothian

**Dr Jill Duguid**

Consultant Anaesthetist, NHS Fife

**Dr Hilary MacPherson**

Associate Medical Director, NHS Forth Valley

**Mrs Linda Sharratt**

Public Partner, Dumfries & Galloway

**Mrs Anne Simpson**

Public Partner, Tayside

**Dr Laura Stewart**

Consultant Neonatologist, NHS Fife

### NHS Quality Improvement Scotland Staff

**Mrs Morag Kasmi**

Senior Project Officer

**Ms Sharon Keane**

Project Officer

**Mrs Fiona Dagge-Bell (Observer)**

Professional Practice Development Officer

During the visit, members of the review team met with local health service personnel including anaesthetists, health visitors, midwives, neonatologists, obstetricians, paediatricians, paramedics, AHPs and GPs.

## Appendix 3 – Maternity services project group members

### Chair

#### **Dr Jane Magill**

Director, Robert Clark Centre for Technological Education, University of Glasgow

### Project group members

#### **Ms Gill Allan**

Sister Midwife, NHS Tayside

#### **Mrs Frances Arnott**

Health Visitor, NHS Forth Valley

#### **Ms Irene Barkby**

LSA Midwifery Officer/Divisional Nurse Director – Acute, NHS Lanarkshire

#### **Dr Ian Bashford**

Senior Medical Officer, Scottish Executive Health Department

#### **Dr Jennifer Bennison**

Deputy Chair (Policy), Royal College of General Practitioners (Scotland)

#### **Professor Andrew Calder**

Consultant Obstetrician, NHS Lothian

#### **Ms Cynthia Clarkson**

Lay Representative, National Childbirth Trust

#### **Dr Corinne Love**

Consultant Obstetrician, NHS Lothian

#### **Dr John McClure**

Consultant Anaesthetist, Royal College of Anaesthetists, NHS Lothian

#### **Ms Dahrlene McMahon**

Paramedic, Scottish Ambulance Service

#### **Mrs Mathilde Peace**

Lay Representative, Lothian Health Council

#### **Dr Gillian Penney**

Clinical Senior Lecturer & Programme Director, Scottish Programme for Clinical Effectiveness in Reproductive Health, NHS Grampian

**Ms Nancy Robson**

Public Partner, Grampian

**Ms Joanne Thorpe**

Midwifery Team Leader, NHS Argyll & Clyde

**Dr Tom L Turner**

Consultant Paediatrician, NHS Greater Glasgow

Support from NHS QIS was provided by **Ms Jan Warner** (Director of Performance Assessment and Practice Development), **Mr Steven Wilson** (Team Manager), **Mrs Morag Kasmi** (Senior Project Officer), **Ms Sharon Keane** (Project Officer), **Dr Avril MacLennan** (Project Officer) and **Mrs Lorraine Inglis** (Project Administrator).

## Appendix 4 – Timetable of review visits

Organisation reviewed	Visit date(s)
NHS Argyll & Clyde	20 June 2006
NHS Ayrshire & Arran	7 June 2006
NHS Borders	19 April 2006
NHS Dumfries & Galloway	29 March 2006
NHS Fife	10 May 2006
NHS Forth Valley	17 January 2006
NHS Grampian	27 April 2006
NHS Greater Glasgow	25 May 2006
NHS Highland	16 March 2006
NHS Lanarkshire	2 February 2006
NHS Lothian	1 March 2006
NHS Tayside	16 February 2006
NHS Orkney	22 November 2005
NHS Shetland	8 November 2005
NHS Western Isles	6 December 2005









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