SOP PAUSES Risk Assessment – A tool to support regular holistic risk assessment in the intrapartum period

Summary statement: How does the document support patient care?	This SOP supports learning from a serious Incident. It will ensure that staff are aware of the possibility of becoming task focused and that continuous risk assessment of the whole clinical picture is needed in the intrapartum period regardless of birth environment and risk status.
Staff/stakeholders involved in development:	Clinical Governance Lead Fetal Well-Being Midwives Band 6 midwives Transformation Lead Deputy Transformation Midwives
Division:	Women and Children's
Department:	Maternity
Responsible Person:	Chief of Service
Author:	Claire Parr- Clinical Governance Lead Laura Spicer- Transformation lead
For use by:	Midwifery staff caring for labouring women and people.
Purpose:	When fully embedded it should reduce the likelihood of staff becoming task focused when caring for women and people in labour. It should encourage staff to take a full holistic view of the situation following the acronym, including their own wellbeing, with the aim of escalating concerns without delay.
This document supports:	Ockenden Report 2020 and 2022
Key related documents:	*WH & SRH* CG1116 Fetal Monitoring Guideline CG1196 Care in Labour Guideline *RSCH & PRH* MP037 Fetal Heart Monitoring Guideline MP035 Care of Women and People in Labour
Approved by & date:	JOGG: 20th September 2023 Date uploaded: 20th September 2023
Ratified by Board of Directors/ Committee of the Board of Directors	Not Applicable – Divisional Ratification only required
Ratification Date:	Not Applicable – Divisional Ratification only required
Expiry Date:	March 2026
Review date:	September 2025
If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team	
Reference Number:	SP23007

Version	Date	Author	Status	Comment
1.0	January 2023	Claire Parr Laura Spicer	Archived	New SOP
1.1	September 2023	CE Team	LIVE	Merged approval of SOP

The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician.
If in doubt contact a senior colleague or expert.

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PAUSES Risk Assessment – A tool to support regular holistic risk assessment in the intrapartum period Standard Operating Procedure (SOP)

1.0 Aim

- Promote a change in practice following shared learning from serious incidences locally and nationally.
- Reduce the likelihood of staff becoming task focused and/or confirmation bias when caring for women and people in labour.
- Encourage staff to pause and undertake a full holistic view of the situation.
- Support staff to escalate concerns identified during the risk assessment, to the appropriate person.
- Document the review in a structured and consistent way.
- Enable staff to consider their own wellbeing.

2.0 Scope

- Student Midwives
- Midwives
- Labour ward co-ordinators
- Obstetricians

3.0 Responsibilities

- To access, read, understand and follow this guidance.
- To use their professional judgement in application of this guideline.

4.0 Abbreviations used within this SOP

SOP - Standard Operating Procedure	**CTG -** Cardiotocograph
WH - Worthing Hospital	**RSCH -** Royal Sussex County Hospital
SRH - St Richard's Hospital	**PRH -** Princess Royal Hospital
SI - Serious Incident	**EFM -** Electronic Fetal Monitoring
PROM - Prolonged Rupture of Membranes	**MOC -** Manager on Call
MLU - Midwifery Led Unit	**MIS -** Maternity Information system eg Badgernet

5.0 Introduction

National reports such as the Ockenden Report (2022) highlighted a number of concerns around care provided to women and people in the intrapartum period. Locally, serious incidents have identified human factor issues resulting in a delay in escalation which leads to a failure in expediting birth. This has resulted in unexpected poor outcomes for mother and birthing parent or baby. Investigations found that staff became task focused and/or suffer from confirmation bias and have not recognised the emerging pattern of abnormal observations; symptoms; deterioration, because of this.

The Ockenden Report (2022) learned that:

- Concerns were not appropriately escalated, leading to direct impact on the safety and quality of care provided to women and people. All midwives and medical staff have a duty to call for help if they consider that a clinical situation requires the direct input of a consultant.
- A lack of documentation regarding decision-making by the labour ward coordinator was often evident when the labour ward coordinator was asked to attend a room for review of a case.
- Care may have resulted in harm to mothers and birthing parents and babies due to failure in escalation to the most appropriate professional in a timely manner. This starts with the allocated midwife not escalating to the labour ward coordinator. The coordinator in turn fails to escalate to the consultant, when the trainee is either busy or is performing practice against guidance.
- A number of the MLU cases reviewed reflected some of the wider issues found on the labour ward relating to failures in appropriate escalation and consultant obstetric review once transfer to the consultant-unit was achieved. In a number of cases there was inappropriate risk assessment and management of labour when women and people presented with a history of reduced fetal movements. The wider clinical picture was not always appropriately assessed and acted upon.
- Further evidence of poor escalation, failure to involve the consultant obstetrician and to respect women and people's wishes in relation to mode of birth were evident.
- In a significant number of cases the review team found evidence that the poor outcomes in mothers and birthing parents and babies were caused mainly because clinicians failed to recognise women and people at high risk of medical complications. They failed to respond adequately to problems arising during labour, failed to make appropriate clinical decisions and failed to respond in a timely manner to signs of impending serious complications. There were many instances of poor communication between doctors and midwives which led to inappropriate and delayed clinical decision-making.

This tool has been designed with the aim of addressing the fundamental root cause at the centre of these concerns; to support effective and on-going holistic risk assessments during labour regardless of birth environment and risk status of the individual at the start of labour. This tool has been developed to ensure that staff review the situation every two hours and four hourly with another clinician.

6.0 Documentation

To be documented within MIS in the labour assessment

- Labour Assessment.
    - **General Details section**
        - Managing? free text - Notes

***** DO NOT RECORD IN CLINICAL NOTE *****

7.0 Guidance

P A U S E S

To be completed for all women and people – 2 hourly by allocated midwife and 4 hourly with another clinician.

P: Partogram

- Is it up to date? Is Fresh eyes up to date?
- Are maternal and birthing parent observations normal?
- Is there a good quality continuous CTG on-going or are you using IIA (Intelligent intermittent auscultation). Is there evidence of a rising baseline?
- Is the fluid balance chart up to date in and out?
- What colour is the liquor? Is there PROM?
- Is progress within normal limits?

A: Analgesia

- Is the environment comfortable and tailored to maternal and birthing parent needs?
- Is current analgesia sufficient? Should other pharmacological or non-pharmacological methods be considered?

U: Uterine activity

- How frequent are the contractions? Is there adequate resting tone?
- Is this synthetic prostaglandin driven?
- Are you able to listen for full minute following contraction, before next contraction?
- Have the contractions spaced out - do you need Syntocinon?
- Is Toco recording accurately?

S: Situation over last hour

- Has anything changed in last hour - any new risk factors?
- Woman and person's perspective. Do they have questions? Have they been part of discussions? Do they understand the plan and have they given consent
- Is there evidence of 2nd stage – do you need to change your monitoring to reflect this

E: Escalation

- What is your plan? And what is the timeframe for this plan?
- Is the current place for care and level of monitoring appropriate? Are you in the right place?
- Are the team aware of the progress (if at home have you called the co-ordinator?)

S: Staff

- Have you had a break? Have you had a drink? Do you need the loo?
- Have you any concerns?
- Do you feel able to escalate – consider MOC

8.0 Monitoring

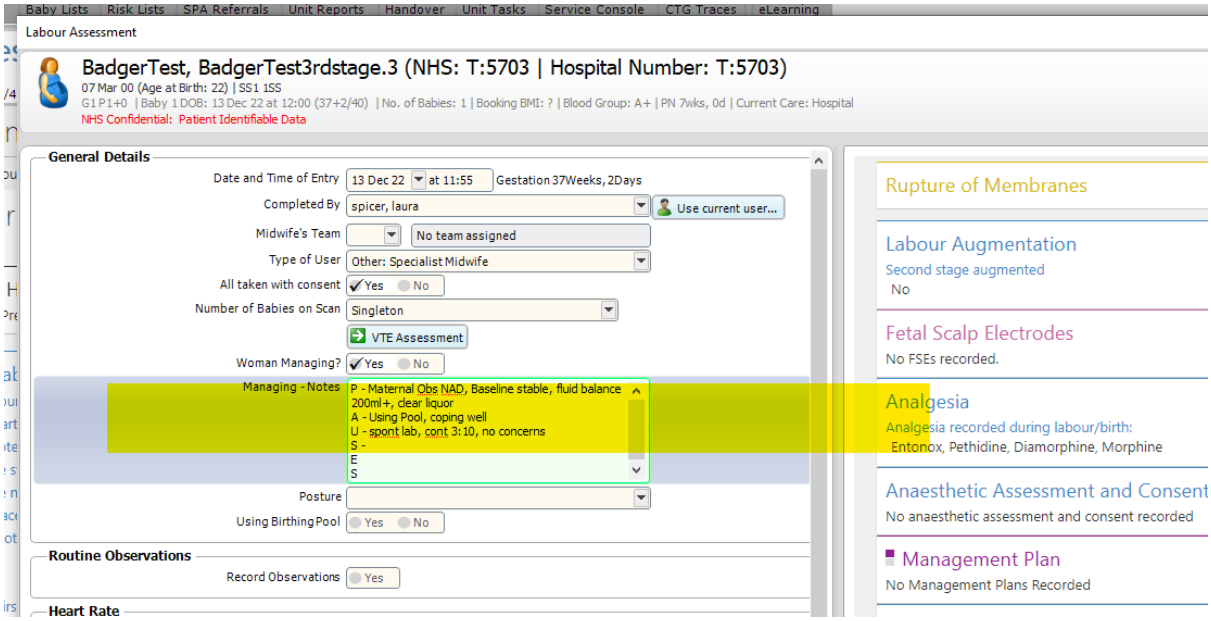
Audit to be carried out within 3 months of commencement to ensure that it is being used in practice. Followed by regular, on-going review, monitoring the impact of the tool on maternal and neonatal outcomes.

Staff feedback will be collated to assess the frequency of its use alongside monitoring outcomes.

9.0 References

Department of Health. Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust (December 2020)
Department of Health. Final findings, conclusions and essential actions from the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust (March 2022)
NICE. Intrapartum care for healthy women and babies (December 2022)

Appendix 1: Examples



- **P** – Maternal observations NAD, Baseline stable, fluid balance +200ml, clear liquor
- **A** – Using pool, coping well
- **U** – Spontaneous labour, contracting 3:10, no concerns
- **S** – Involuntary pushing with contractions. Will transition to 2nd stage monitoring
- **E** – No escalation required currently
- **S** – No concerns