G5	Standard	Maternity moving and handling (M&H)

Systems are in place to cover all reasonably foreseeable handling situations in **maternity services,** including emergency evacuation from **birthing pools.**

Justification

Rationale

It is desirable to allow choice for the mother, within the midwife's professional judgement, whenever possible. During the three stages of labour a midwife may find herself at risk of compromising her own safety and therefore that of the mother and unborn baby.

In a hospital setting ergonomics design of the environment, the provision of appropriate manual handling equipment and height adjustable beds/ cots and trolleys is essential. This will also ensure the midwife can adopt safer postures whilst monitoring and assessing the progress of the labour and supporting mother and baby during and after birth. Comfortable furnishings should allow the mother to feel that the process is as natural as possible.

Holistic risk assessments should be carried out before using a birthing pool. Managers should ensure local guidelines/ criteria are in place and that they are followed when deciding within the team and with the mother, the suitability of using the birth pool.

If a woman decides on a home birth then an environmental risk assessment should be carried out and documented in the birth plan.

Giving birth is a natural process and it should be remembered that pregnancy is not an illness, it is an altered health status; although maternal collapse and other complications are rare it should always be remembered that a woman could very quickly require help in an emergency. All obstetric staff are responsible for keeping themselves up to date with emergency handling techniques and therefore knowing what to do in a life threatening situation, and be capable of using manual handling equipment appropriately.

Post-natally, comfortable seating arrangements should be in place to allow the midwife/ midwifery assistant to help a mother fix the baby to the breast.

Authorising Evidence

HSWA(1974); CNST (2011/12); Equality Act (2010); MHSWA(2000); MHOR(2004); LOLER (1998); PUWER (1998)

Links to other published standards & guidance

Burns E & Kitzinger S (2000); HSC & HSAC (1998); Maidstone & Tunbridge Wells NHS Trust (2006); MHRA (2008) MDA 2008-002; MHRA (2008) MDA 2008-026; NPSA (2008); Northumbria Healthcare NHS Trust (2006); RCM (1999); RCM (2009); RCN (2000); Ruszala et al (2010); Thompson, E (2000); WHO (2003)

Cross reference to other standards in this document

A1,3-5,10-15; B; C; D1-14,16; E; F; G1-4,6,8,15,16,22,27,40 ; H; K2

Appendices

4, 12-14, 16, 21, 22, 25-27

Verification Evidence

- requirements for compliance to achieve and maintain this standard

- An agreed approach, informed by evidence-based best practice, documented in the M&H policy, is disseminated to all staff within the service and embedded within their practice
- Generic assessments are carried out and developed into SOPs and protocols, which are implemented including the use of a birthing pool
- Risk of injury to patients and staff is minimised by ensuring that: - a thorough assessment is carried out prior to movement; mothers are encouraged to move themselves; suitable beds are provided; correct techniques and equipment are used; an environment conducive to good care is provided, facilitating a natural birthing process for mothers and allowing safer postures for staff; emergency evacuation from the birthing pool is planned and practised

G5 Protocol - Maternity (M&H)

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1. Introduction and Background

Women planning pregnancy may seek advice and guidance from healthcare staff regarding their own health in order to ensure the best possible start for their babies. Maternal handling should therefore be considered from conception through to the birth of the baby and beyond.

A disabled woman, or a woman considered morbidly obese, should be able to access the same information and treatment as an able bodied woman. A duty of care and legislation such as the Equalities Act (2010) should ensure that parent-craft sessions, antenatal classes and clinics take place in accessible buildings. Care staff should be able to provide support to women who have problems with mobility. Some mothers may have special needs and all should be done which is reasonably practicable to ensure those needs are met in a safe and dignified manner. Consideration should also be given in terms of cultural and religious needs (Equality Act, 2010).

Scans and tests may present problems for someone with mobility needs. Any woman who gains weight and changes body shape will find difficulties in coping with getting on and off treatment/ examination couches, narrow seats etc. in later stages of pregnancy. Height adjustable equipment, small steps and grab rails may enable the woman to help herself. Some scans are done with a full bladder so a disabled toilet with suitable SWL, should be nearby. Access to a commode for some women with special needs may be necessary.

The World Health Organisation reports an increase in the number of obese people (WHO Global Strategy on Diet, Physical Activity and Health 2003) An increase in the number of larger women should be expected and it is important to consider the safe working load of equipment when purchasing. Items such as hoists must be marked with a safe working load and checked by a competent person every 6 months (LOLER, 1998). When the initial assessment of the woman's health is done the midwife must ensure that relevant persons within the organisation are notified, including the manual handling department if specialist bariatric equipment is required. This equipment must be made available when the woman is admitted. (See G15, Bariatric protocol).

2. Management, organisation, supervision and support

Midwives can feel isolated particularly if they work in the community. If the midwife needs help regarding manual handling issues, managers must be prepared to provide resources required as far as reasonably practicable. Experienced midwives with relevant qualifications act as supervisors for less experienced midwives. Support from other professionals is crucial for the midwife in order to reduce stress. Stress can have a detrimental effect on the

musculoskeletal health of the midwife because muscles under tension are more prone to injury.

Women may have social care needs and many will require a multidisciplinary approach to ensure good health during pregnancy.

There must be a system to call for assistance in the event of a midwife requiring help, or an emergency.

3. Staffing levels

The midwife co-ordinating the labour ward should be supernumerary. There should be 1:1 care for all women in established labour with higher ratio for women in higher need categories.
There must be adequate support staff.
In post-natal wards there must be adequate staffing to enable support to be given to women who want to breast feed (RCM, 2009 and RCN 2000).

For supine lateral transfers in theatre a minimum of four-five people are required.

If a birthing pool is used a midwife must be in attendance at all times. In some units without a hoisting facility it is the practice to ensure one midwife is able to get into the pool in an emergency if required, in agreement with infection control practitioners. We would strongly recommend hoisting facilities are available.

4. Staffing Competencies (after Benner, as cited in Ruszala et al, 2010)

Novice - Possible groups

- Nursing students
- Midwifery students
- Medical students
- Birth partners.

Advanced Beginner - Possible groups

- Midwifery students coached by a mentor who has experience of manual handling
- Conversion students who have nursed patients in a clinical setting.

Competent

- Minimum of 2-3 years experience, aware of positions adopted by women in labour. Able to assess and plan manual handling activities and reduce risk of injury. May lack experience in being able to see an overall picture. For example may recognise a woman with mobility problems in antenatal clinic but not have experience in coping and finding solutions to more complex handling needs.

Proficient

- Understands problems as a whole and takes a holistic approach. For example midwifery risks manager.

Expert

- A person with a wealth of experience who has intuition. Able to recognise a problem without going through process of analysis. Movement of the woman becomes fluid and highly proficient. For example Manual Handling Adviser.

5. Environment

Birth in hospital in a controlled environment may be very different to a person's home. Risk assessment must take place in the home before the decision is made that a home birth is suitable.

Often mothers will be accompanied by a partner and possibly other children. Space for buggies should be considered as should space for other equipment.

6. Communication and information systems regarding initial referral and entry to the system

A woman with mobility/ moving and handling needs should be identified and this must be clearly documented in her notes as early as possible during routine antenatal appointments. Women may be first seen in A&E departments, GP surgeries, Health Centres etc. so other agencies must be prepared to notify the maternity service as soon as possible if the mother requires support with moving and handling.

Mothers are given a choice, whenever possible, of their requirements for the birth of their baby. Consideration must be given if that choice will be limited because the lack of foresight of manual handling needs, such as no hoist available for a birth pool for a well mother who is a wheelchair user.

A system should be in place to ensure all relevant departments are aware if a Bariatric mother has been identified on booking. It is particularly important that a mother with a high BMI is monitored throughout her pregnancy.

Mothers (and partners) should be shown the environment and possible equipment prior to admission.

7. Treatment planning

The expectation is for a normal delivery. With a planned Caesarean section the mother should be able to transfer onto the theatre table independently but will require sliding equipment for moving off after delivery.

If a caesarean section is planned the mother will not be fully mobile immediately after the baby's birth, particularly following epidural injection.

There must be a system in place for reasonably foreseeable emergency situations such as cord prolapse management, a delivery that is not progressing normally or a mother with a high BMI.

8 & 10.Moving and Handling Tasks, Methods, Techniques and Approaches

Midwives and doctors should be particularly aware of their own postures when examining, assessing and monitoring the progress of the pregnancy. It is important to adjust the height of equipment and avoid stooping and twisting. Saddle seats, forward support seating, balance balls, cushions and kneel pads can reduce the risks. Mirrors will enable the midwife to monitor progress of a woman in a squatting position or using a birth stool (Thompson, E 2000; Maidstone and Tunbridge Wells NHS Trust 2006).

Sonographers should consider a second scanning monitor positioned so the woman can view without the sonographer having to adopt an awkward posture. Transducers should be lightweight and easy to manoeuvre.

An epidural tends to be a lighter anaesthetic so the mother can usually move herself if the midwife/ midwifery assistant bends the mother's knees and stabilises the mother's feet. Use of disposable slide sheets may facilitate independent movement. However, women who've had a spinal, which is a heavier anaesthetic, do tend to have problems moving themselves and will require sliding to promote tissue viability.

If a general/ spinal anaesthesia is given a lateral transfer board and slide sheet will be required for a lateral transfer. The woman will also require slide sheets for moving in bed until the anaesthetic wears off. A hoist may be required for larger women for situations where slide sheets and full length sliding boards are inappropriate.

If the epidural is given in the sitting position (for example a Bariatric woman) then a suitable surface (preferably with brakes) should be considered for the woman to lean on.

Mothers are encouraged to choose their delivery position/s. This could be kneeling on the floor, in which case the midwife must be aware of postural constraints. A kneeling pad and a pillow on top of her heels will make the position a little more comfortable.

For positioning a woman in case of shoulder dystocia/ cord prolapse/ haemorrhage/ emergency evacuation from a building there must be a known system in place.

In a birthing pool the midwife will be required to monitor mother and baby and assess progress of labour whilst the mother is in the water. This may require the midwife to adopt an unstable position whilst leaning over the edge of the pool.

In the case of emergency such as maternal collapse, the woman will need to be evacuated from the pool immediately. A hoist and shower sling or handling netting as well as a trolley and slide sheet will be required. The mother must be moved to a place of safety away from water if a defibrillator is used.

When assisting with breastfeeding it is important for the midwife to avoid stooping, either by kneeling, using forward support seating, a ball or saddle seat and encouraging the mother, if on the bed, to move to the edge, closer to the midwife. In a hospital setting, adjust bed height and use the rising backrest.

Falls may occur as a result of the mother fainting because of standing up too quickly, or following an epidural where leg muscles have not fully returned to normal. It is important to test leg strength prior to allowing the mother to stand up.

When the end of the delivery bed is removed, it must be remembered that it can weigh up to 8kg. The removal and insertion requires risk assessing and the resultant safe system of work must be available to relevant staff. Over the course of a shift this can also become a repetitive movement.

9. Moving and Handling Assessment

An able bodied woman should be encouraged to move herself.

A disabled woman should have an individualised risk assessment so that her needs may be met. A Woman with symphysis pubis dysfunction may be using crutches and may require additional equipment provision e.g slide sheets.

Following a Caesarean section a woman will require lateral transfer from operating table to bed/trolley, generally using a long sliding board and slide sheets.

If an epidural is given, the woman may require assistance/ support whilst she is on bed rest and in the recovery stage.

After a spinal, a lateral transfer is usually performed as for a Caesarean section.

11. Handling Equipment

Equipment and furniture should be purchased using sound ergonomic principles and following a risk assessment (RA).

The products included in this list are shown to provide information on what is available on the market. Other manufacturers may make similar or better products. The inclusion of a product here does not mean it is endorsed by NBELG. You must apply your knowledge and RA skills in choosing any product to use with your expectant mothers. Both mothers and all products should be risk assessed for the specific situation in which they are to be used.

Maternity beds examples;

Hill Rom – Affinity http://www.hillrom.com
Huntleigh/Arjo – Birthright http://www.huntleigh-healthcare.com/
Linet-Ave delivery bed http://linet.uk.com/
Stryker- LD304 http://www.stryker.co.uk/

Birth Pools;
Active pools http://www.activebirthpools.com
Home Pools https://www.birthpoolinabox.co.uk
Blue Lagoon http://www.bluelagoonbirthpools.co.uk

In the case of birth pools with high sides, non-slip steps with handrails should be supplied.

Slide sheets;
Hospital Direct http://www.patient-handling.com
Select Healthcare www.selecthealthcare.co.uk

Consideration should be given to hoists, type of sling and a range of sizes, hand blocks and rope ladders.

12. Other equipment and furniture

Body Balls;
NRS -http://www.nrs-uk.co.uk

Saddle Seats;
Bambach http://www.bambach.co.uk
Beautelle http://www.beautelle.co.uk

Forward support seating;
Hag Capisco

Kneeling pads;
any gardening shop

Following a Caesarean section the mother will require a chair with arms to assist with independent standing and sitting and access to a stool to make breast feeding more comfortable. Consideration should be given for special breast-feeding chairs. If they have arms, it is advisable that they can be lowered. Chairs should be on 'house-keeping' wheels to allow the chair to be moved to another location if necessary.

13. Risk Rating

To carry out a 'suitable and sufficient' assessment, each task should be evaluated as part of the assessment process, so that the level of risk is quantified. Such assessments should be used, wherever possible, in the design of a safe system of work, and in highlighting any residual risks.

Various systems exist, but it is suggested that the NHS risk management 5x5 matrix, with 0-25 scale, is used for an overall evaluation of risk (NPSA, 2008) (see CD1, appendix 9 in folder 5). It is in common use, simple to use with 5 levels of risk, determined by a calculation of the likelihood or probability of an adverse event occurring multiplied by the severity of consequences or impact should it occur.

Likelihood/Probability (0-5) x Severity of Consequences or Impact (0-5) = 0-25

The values below are based on this system. Calculations lead to the following possible scores or ratings: -

1 – 6 = Low; 8 – 12 = Medium; 15 – 16 = High; 20 = Very High; 25 = Extreme

These ratings can then be used to alert staff, to prioritise action and justify any necessary expenditure to make the situation safer, on the basis of reasonable practicability. Options can be evaluated by considering risks, costs, and actions planned or taken, to reduce the level of risk to the lowest level that is reasonably practicable, which can thus be demonstrated.

Generally midwives will be caring for people who are able to move themselves. They must consider their own postures and minimise risks whenever possible by using height adjustable furniture and assessing each task using a manual handling risk assessment tool such as T.I.L.E.O.

A disabled mother should be considered as an individual and an individual manual handling risk assessment is required.

In the maternity setting postural risks for midwives and other staff are likely to be as significant, if not more, than those associate with M&H. For assessing postural risks and those associated with tasks other tools are available, such as RULA (Hignett S & McAtamney L, 2006), REBA (Hignett S & McAtamney L, 2000) and OWAS (Karhu et al, 1977). These not only look at postures but forces.

14. Alerting the Manual Handling Team

The manual handling team should be consulted whenever concerns are raised during routine antenatal appointments regarding moving and handling. Specialist equipment can then be arranged for the time of the labour and birth of the baby, bearing in mind that not all babies arrive on time.

15. Referral to and involvement of other specialists

The mother will require a scan during the pregnancy, sometimes more than one.

Obstetrics, Gynaecology, Paediatric specialties, tissue viability and diabetic adviser/ nurse may also be involved.

16. Transport

Seat belts may be difficult to use if the woman is very large so extension straps may be required if a woman is transported to hospital via ambulance.

17. Discharge and transfer planning

Usually the family will arrange their own transport. If the baby needs to be transferred to a specialist unit, equipment used tends to be bulky and unwieldy. (Giraffe incubators for example) Staff will require training in moving inanimate loads safely.

If a baby needs transporting to a SCBU by ambulance it should be remembered that some babies need specialist equipment to support them, which can be very heavy.

18. References

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HSC (1998) *L113 Safe use of lifting equipment Lifting Operations and Lifting Equipment Regulations 1998 ACOP and guidance* Sudbury: HSE Books Regs 5, 7-10

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MHRA (2008) MDA 2008-002 *Birthing beds Huntleigh Healthcare Birthright and Hoskins Birthcare*

MHRA (2008) MDA 2008-026 *Birthright birthing bed mattresses manufactured by Huntleigh Healthcare*
http://www.mhra.gov.uk/Publications/Safetywarnings/MedicalDevicesAlerts/ retrieved 7 October 2011

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RCM (2009) *Guidance Paper on Staffing Standards in Midwifery Services Guidance paper* London: RCM in particular 2.1-2.3

RCN (2000) *RCN Code of Practice for Patient Handling* London: RCN

Thompson, E (2000) *Safer Birthing Positions choices for the mother and her attending midwife*

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Summary/ Key Messages

- **The intention of the entire strategy and standards document is to contribute to the improvement of: -**
  - The quality of care - 'patient experience' (dignity, privacy and choice)
    - clinical outcomes
  - Patient/ person safety
  - Staff health, safety and wellbeing
  - Organisational performance – cost effectiveness and reputation, etc.

- **The standard for G5 is:**

Systems are in place to cover all reasonably foreseeable handling situations in maternity services, including emergency evacuation from birthing pools.

- **Skilful M&H is key**

- **Special points for G5 are: -**
  - **An agreed approach, informed by evidence-based best practice, documented in the M&H policy, is disseminated to all staff on the unit and embedded within their practice**
  - **Generic assessments are carried out and developed into SOPs and protocols, which are implemented including the use of a birthing pool**
  - **Risk of injury to patients and staff is minimised by ensuring that:**
    - **a thorough assessment is carried out prior to movement**
    - **mothers are encouraged to move themselves**
    - **suitable beds are provided**
    - **correct techniques and equipment are used**
    - **an environment conducive to good care is provided, allowing a natural birthing process for mothers and allowing safer postures for staff**
    - **emergency evacuation from the birthing pool is planned and practised**