LAYOUT AND CONTENT

The bag has been designed with human factors principles in mind, and separated into easy-to-grab, colour-coded sections with labels.

ZIPPED FRONT POCKET

PPE and Disposal Section

- Sterile delivery pack x 1 (extras included on the front of the delivery pack: episiotomy (mayo) scissors x 1, cord clamp x 2, sterile drape x 1)
- Inco pads x 10
- 1 box of non-sterile gloves
- 1 litre, purple-topped sharps box x 1
- 2.5 litre, red-topped, placenta disposal container

INSIDE THE BAG

3rd Stage PPH Drugs Section

RH Negative Mother Section

Adult Resuscitation Section

Cannulation and IV Fluids Section

Postnatal Section

Labour Section

Suturing Section

Catheterisation and Cord Prolapse Section

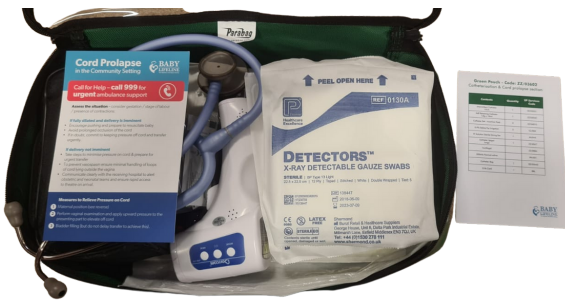
Neonatal Resuscitation Section

Paperwork Section
Located at the Back

COMPACT FOR EASY TRANSPORTATION

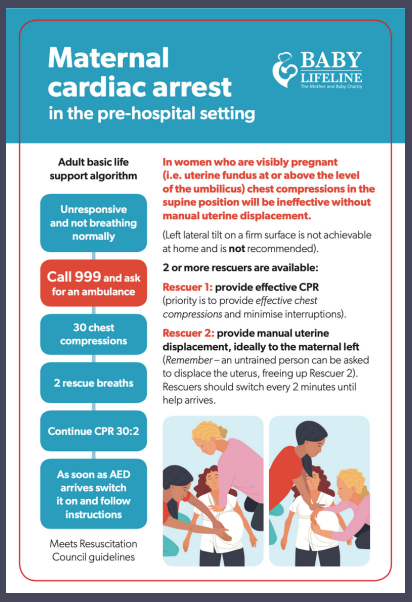
OPTIONAL TROLLEY

EASILY REMOVED POUCHES



PROMOTING BEST PRACTICE

We have developed evidence-based crib cards, which are in the emergency sections to optimise care.



Maternal cardiac arrest
in the pre-hospital setting

BABY LIFELINE

Adult basic life support algorithm

- Unresponsive and not breathing normally
- Call 999 and ask for an ambulance
- 30 chest compressions
- 2 rescue breaths
- Continue CPR 30:2
- As soon as AED arrives switch it on and follow instructions

Meets Resuscitation Council guidelines

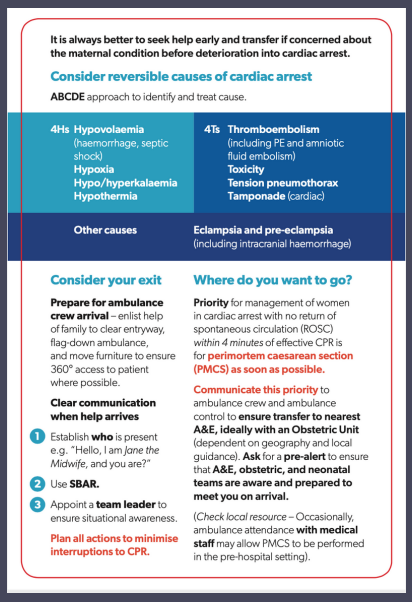
In women who are visibly pregnant (i.e. uterine fundus at or above the level of the umbilicus) chest compressions in the supine position will be ineffective without manual uterine displacement.

(Left lateral tilt on a firm surface is not achievable at home and is **not** recommended).

2 or more rescuers are available:

Rescuer 1: provide effective CPR (priority is to provide *effective chest compressions* and minimise interruptions).

Rescuer 2: provide manual uterine displacement, ideally to the maternal left (*Remember* – an untrained person can be asked to displace the uterus, freeing up Rescuer 2). Rescuers should switch every 2 minutes until help arrives.



It is always better to seek help early and transfer if concerned about the maternal condition before deterioration into cardiac arrest.

Consider reversible causes of cardiac arrest

ABCDE approach to identify and treat cause.

4Hs **Hypovolaemia** (haemorrhage, septic shock) **Hypoxia** **Hypo/hyperkalaemia** **Hypothermia**	**4Ts** **Thromboembolism** (including PE and amniotic fluid embolism) **Toxicity** **Tension pneumothorax** **Tamponade** (cardiac)
Other causes	**Eclampsia and pre-eclampsia** (including intracranial haemorrhage)

Consider your exit

Prepare for ambulance crew arrival – enlist help of family to clear entryway, flag-down ambulance, and move furniture to ensure 360° access to patient where possible.

Clear communication when help arrives

1. Establish **who** is present e.g. "Hello, I am *Jane the Midwife*, and you are?"
2. Use **SBAR.**
3. Appoint a **team leader** to ensure situational awareness.

Plan all actions to minimise interruptions to CPR.

Where do you want to go?

Priority for management of women in cardiac arrest with no return of spontaneous circulation (ROSC) *within 4 minutes* of effective CPR is for **perimortem caesarean section (PMCS) as soon as possible.**

Communicate this priority to ambulance crew and ambulance control to **ensure transfer to nearest A&E, ideally with an Obstetric Unit** (dependent on geography and local guidance). **Ask** for a **pre-alert** to ensure that **A&E, obstetric, and neonatal teams are aware and prepared to meet you on arrival.**

(*Check local resource* – Occasionally, ambulance attendance **with medical staff** may allow PMCS to be performed in the pre-hospital setting).

Cord Prolapse
in the Community Setting

BABY LIFELINE

Call for Help – call 999 for urgent ambulance support

Assess the situation – consider gestation / stage of labour / presence of contractions:

If fully dilated and delivery is imminent

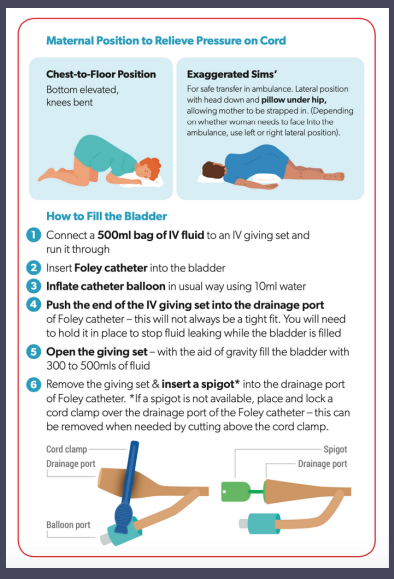
- Encourage pushing and prepare to resuscitate baby
- Avoid prolonged occlusion of the cord
- If in doubt, commit to keeping pressure off cord and transfer urgently.

If delivery not imminent

- Take steps to minimise pressure on cord & prepare for urgent transfer
- To prevent vasospasm ensure minimal handling of loops of cord lying outside the vagina
- Communicate clearly with the receiving hospital to alert obstetric and neonatal teams and ensure rapid access to theatre on arrival.

Measures to Relieve Pressure on Cord

1. Maternal position (see reverse)
2. Perform vaginal examination and apply upward pressure to the presenting part to elevate off cord
3. Bladder filling (but do not delay transfer to achieve this).



Maternal Position to Relieve Pressure on Cord

Chest-to-Floor Position
Bottom elevated, knees bent

Exaggerated Sims'
For safe transfer in ambulance. Lateral position with head down and **pillow under hip,** allowing mother to be strapped in. (Depending on whether woman needs to face into the ambulance, use left or right lateral position).

How to Fill the Bladder

1. Connect a **500ml bag of IV fluid** to an IV giving set and run it through
2. Insert **Foley catheter** into the bladder
3. **Inflate catheter balloon** in usual way using 10ml water
4. **Push the end of the IV giving set into the drainage port** of Foley catheter – this will not always be a tight fit. You will need to hold it in place to stop fluid leaking while the bladder is filled
5. **Open the giving set** – with the aid of gravity fill the bladder with 300 to 500mls of fluid
6. Remove the giving set & **insert a spigot*** into the drainage port of Foley catheter. *If a spigot is not available, place and lock a cord clamp over the drainage port of the Foley catheter – this can be removed when needed by cutting above the cord clamp.

Cord clamp
Drainage port
Balloon port
Spigot
Drainage port