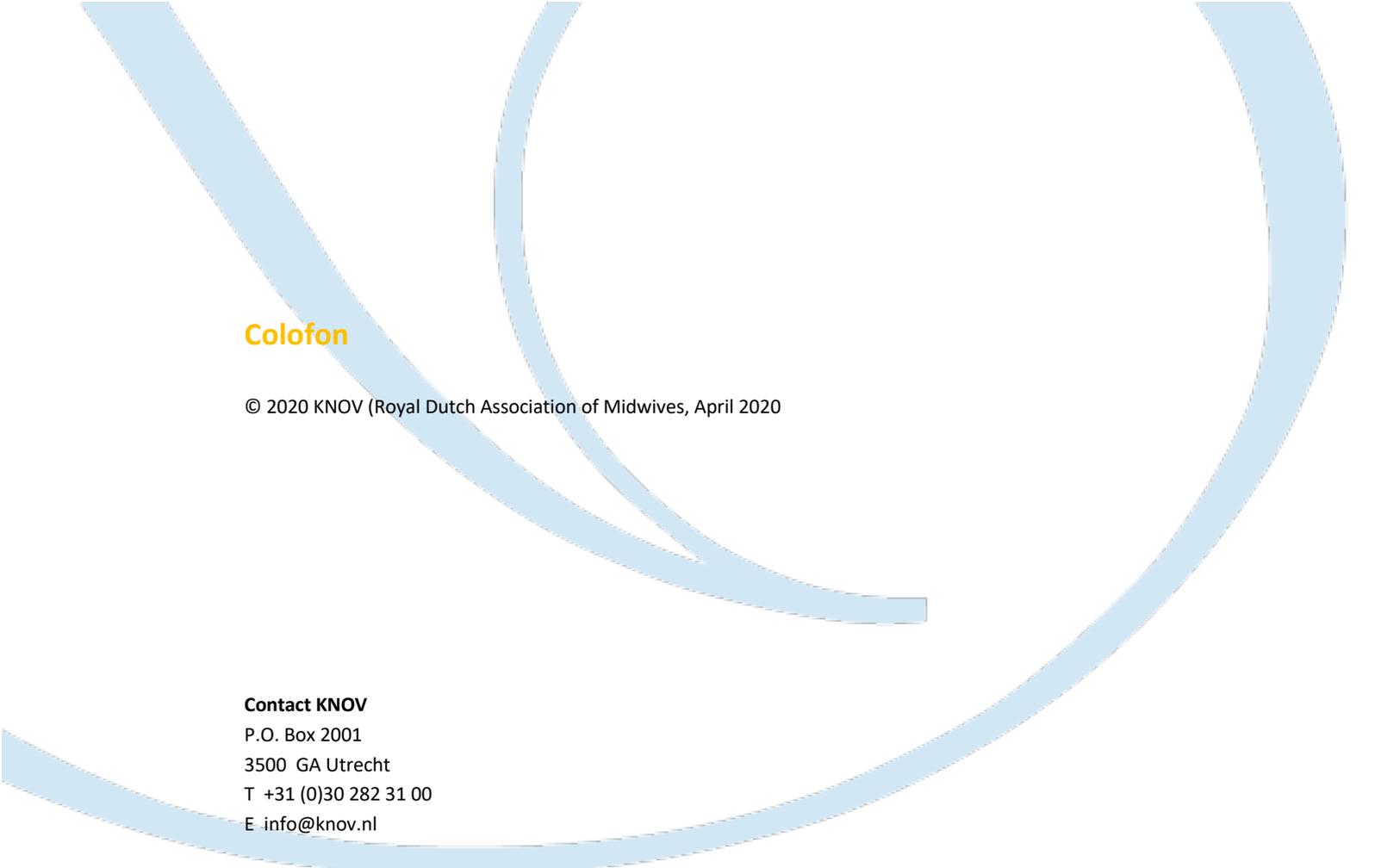




Planning Natal Phase 3 Red

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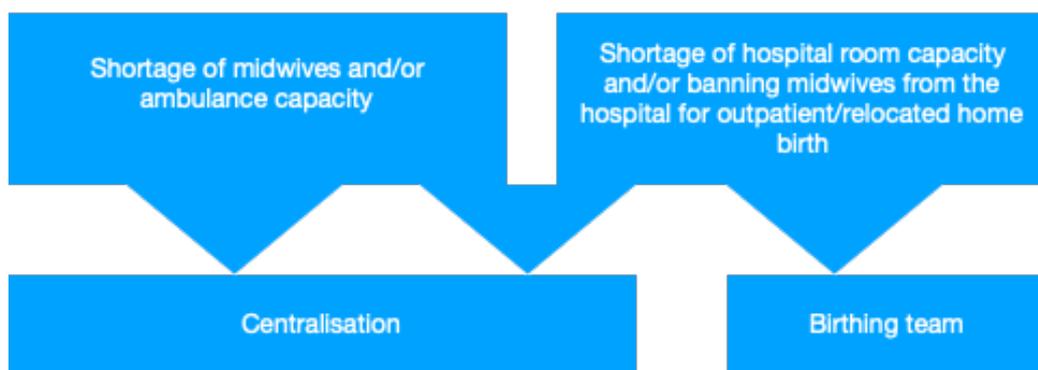
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Planning Natal Phase 3 Red

This plan describes two solutions to different scenarios that occur in phase 3:

1. Centralisation of care: all normal births take place in one location.
2. Working in birthing teams: Women who are expected to have an uncomplicated birth, can choose to give birth in a pop-up birth centre with a fixed team of community midwives, or with their own community midwife at home.

This figure shows the scenarios that leads to either centralisation of care or working with a birthing team.



Phase 3: Centralisation of care

1.1 Reason

The centralisation of natal care can be a follow-up to a number of situations:

- ➔ There is a shortage of midwives
- ➔ There is a shortage of ambulance staff, which means that the safety of a home birth can no longer be guaranteed (ROAZ)
- ➔ A hospital bans midwives from the hospital to limit contacts and to reduce the spread of the virus

When is the centralisation of care based on a lack of midwife capacity necessary?

Do not wait until the services are no longer available. Anticipation is essential when the region starts to expect that a practice cannot provide continuity of care, despite the support of locum practitioners/colleagues from other practices or consultation hours.

It is essential that the working conditions to ensure continuity do not cause an additional burden, increasing the risk of absence of midwives. That is also why the buddy practice system is not recommended; practices should centralise when a region is no longer able to provide sufficient locum services. The practices that do not have continuity problems will be essential to complement the services at the central centre.

Midwifery Alliance

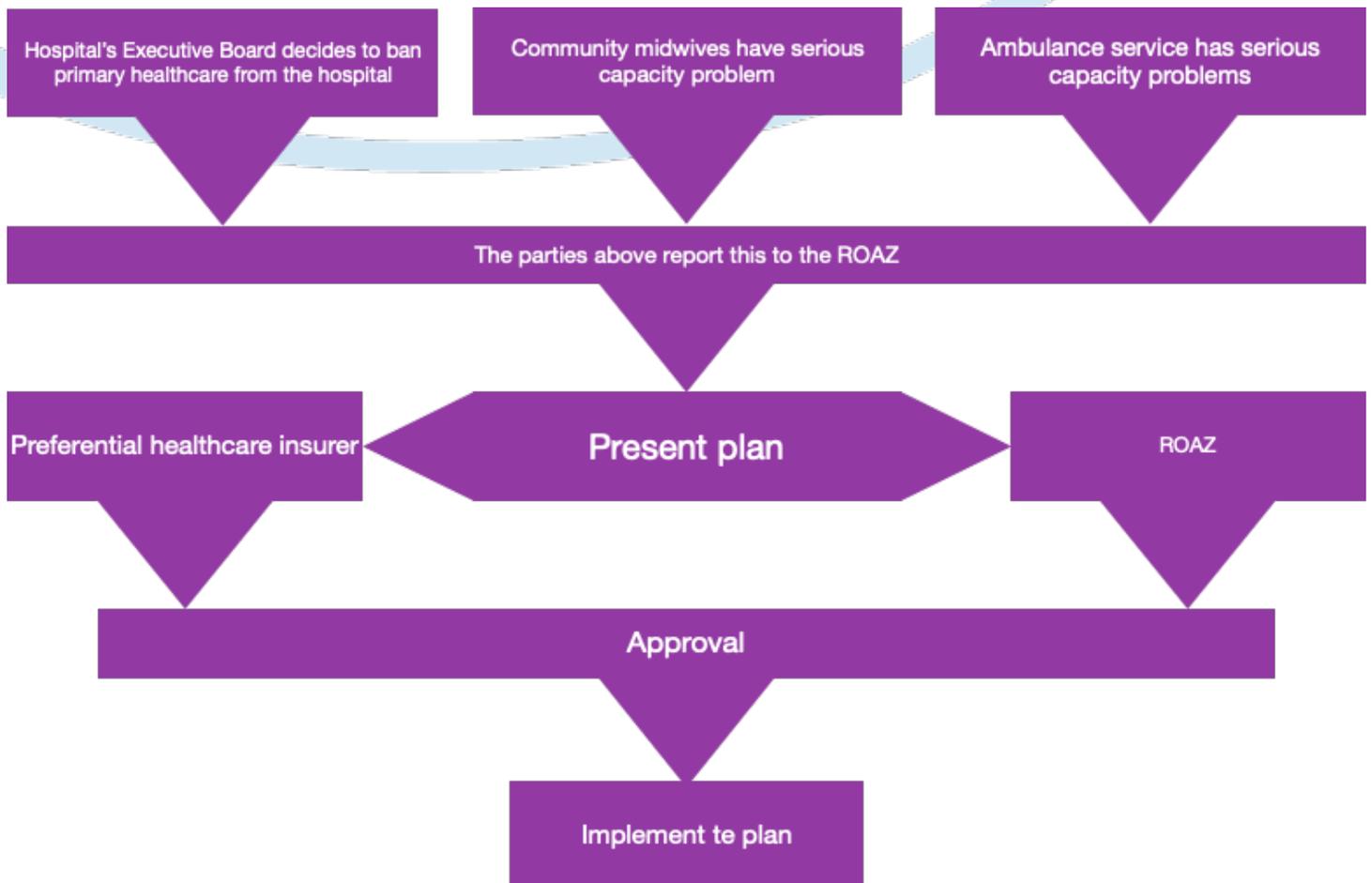
Do not lose sight of the Alliance when adjusting the organisation of care. Align some aspects in the integrated care chain on time. Consider the consequences of decisions within the chain.

1.2 Decision-making

Parties involved in decision-making are:

- Community midwives
- Executive Board of the relevant hospital/obstetricians
- Preferred healthcare insurer
- Regional acute care (ROAZ)

It is necessary to include these parties in the decision-making process, also to obtain the capacity to finance this.



1.3 The following example (letter) to the ROAZ can be adapted to your own regional situation:

Subject line: Temporary emergency birthing services

[Description of reason]

The outpatient birthing rooms may be closing. The ambulance services may also be too overburdened to be relied upon. The urgency experienced by midwives at this time is tremendous and the unrest among pregnant women is increasing due to media reports that state that the hospital only treats patients with the coronavirus, etc.

The proposal is not to wait until this care can no longer be delivered. We suggest not to wait until this happens, but to anticipate that it will happen eventually.

Emergency facility

The proposal is to create a temporary emergency facility for births during the corona outbreak as soon as possible. Initially, this would require [xxxxx] birthing rooms, to be scaled up as needed to multiple rooms. The hotel is close to the hospital which, if a medical need should arise, would only mean a 3-minute drive. The approach is and remains to offer as many home births as possible unless the ambulance service can no longer secure the transport, or the regional absenteeism among midwives and/or maternity assistants is so high that the arrival time cannot be guaranteed.

The results:

- The hospital no longer has the burden of births and can free up capacity for corona patients and ambulance services.
- This also unburdens the ambulance services (shorter trips).
- Midwives and maternity assistants are unburdened in case shortages in their capacity arise
- There is a guaranteed place for pregnant women with a treatment indication or other reasons for being close to a hospital.
- Pregnant women are guaranteed a place at the centre in the coming weeks.
- Limited traffic of healthy people at the hospital.

Implementation

Birthing rooms are set up at the site. [xxxxxx] has been contacted, and there is a plan for the adjustment of the birthing rooms. We are ready to set up the rooms and are expected to open within 1 day. Primary healthcare continues to support the primary healthcare indications, and secondary healthcare the secondary healthcare indications. There is currently no care level between primary and secondary healthcare (1.5).

Finances

The implementation budget (the additional costs involved in the development and organisation) was agreed yesterday by the preferred healthcare insurer, subject to the ROAZ's agreement to this step. It was decided with healthcare insurers that the costs of the outpatient births that take place at the centre will be settled with the hospital. Concrete agreements will be made at a later stage.

ROAZ decision

To continue to ensure proper and safe care in the [xxxxxx] region, we strongly urge ROAZ to agree to and give the go-ahead for this step as soon as possible, enabling us to open the emergency facility.

1.4 Communication in the integrated care chain and with pregnant women after the decision to centralise

In addition to communicating within the ROAZ (hospital/ambulance), the following target groups should also be considered when communicating:

1. Maternity care

Discuss with the maternity care organisations their concrete and minimal basic needs to provide assistance during births at the central location. Involve them in the process.

2. Pregnant women

Communicate in the media about the unburdening of hospitals and the anticipation of a shortage of midwives, to reach a large target group. Let the KNOV PR advisors advise you about this. Let this be a joint message issued by the hospital, secondary healthcare/obstetricians and midwives. Also include the recommendation of home birth in case of a low-risk pregnancy (if the capacity of midwives/maternity assistants permits this). Communicate with the pregnant women about the situation and options during their telephone consultation. If necessary, communicate this in advance by email. Create a routing flyer, making sure the pregnant women can find the birthing location when this is no longer based at the hospital.

3. Alliance (Midwifery Partnership)

Reach agreement about whether centralisation includes primary healthcare indications or also location/medium-risk/treatment indications. This depends partly on the reason and location of the treatment. How to unburden secondary healthcare?

1.5 Location

Contact possible locations. Once again, anticipation is essential. Is there a hospital location with birthing rooms available, or is this a hospital location without birthing rooms? Or do you have to relocate to a location outside the hospital, which will have an impact on the location status/treatment indication status? Is there a location just for births or possibly also for prenatal care? Does this have to be the same location, or are practices available for follow-up care? Consider working with a 'dirty' and a 'clean' practice, to save on the use of PPE and cleaning capacity. If possible/necessary, use a corona midwife.

Criteria for weighing and regional differences:

- Inside or outside the hospital?
- Only outpatient/relocated home births or also location/treatment indication births?
- Access (elevator, ground floor)
- Prenatal care or only natal care, or both?
- What type of care can be provided, only outpatient indications or also location indications? This depends, among other things, on the distance from the hospital.

- How many rooms are needed?
 - In case of births only: the number of births per day/1.7= and round this up.
 - In the case of births and emergency cases: the number of births per day/1.5= and round this number up.
- Birthing room:
 - Functional furnishings: bed/shower/floor
 - Materials (instruments/disposables) autoclave, etc., maternity care package from home, spare maternity care package on site.
 - PPE
 - Birthing beds
 - Bed linen, towels and their distribution
- Phone number available 24/7. Mobile phone
- Laptop, Wi-Fi, printer
- Relaxation/administration room for the midwives
- Room cleaning
- Can this be scaled up when all births have to take place at the birthing location/hospital?
- Is a birthing pool needed (only in case of a symptoms-free pregnancy)?

1.6 Corona PPE policy

Provide care according to the flow chart on the KNOV website.

How to handle room cleaning and PPE? A document about this will follow soon.

1.7 Finances

- The financial calculation for the use of the room by own midwife *will follow*
- The financial calculation for the location, ICT, mobile phone and materials
- The financial calculation of administration costs

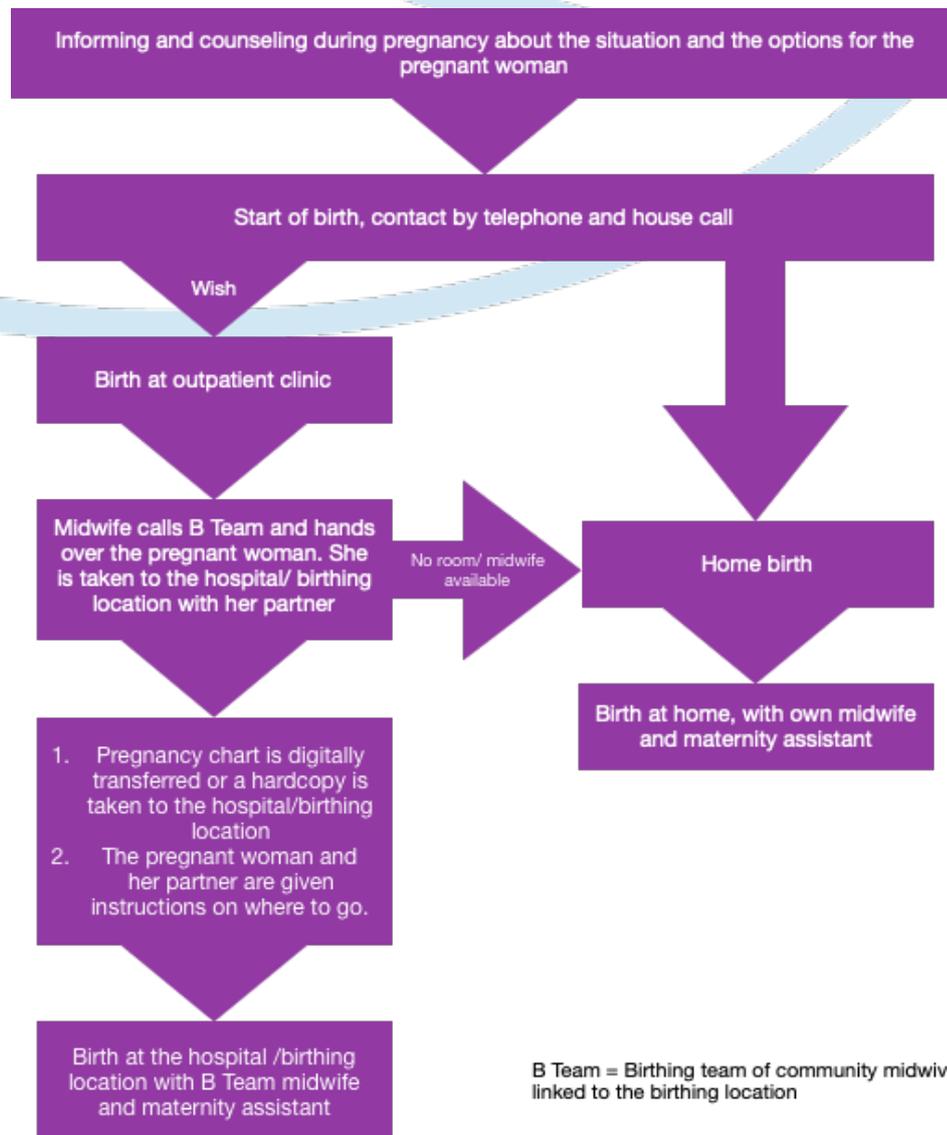
1.8 Legal aspects

Decision-making responsibilities, legal aspects of the birthing centre (*information will follow*)

Phase 3: Working in Birthing Team (B Team)

Care may be provided by a birthing team because the presence of midwives at the hospital is restricted or because too many midwives have fallen ill. In that case, most pregnant women will have a home birth with their own midwife. The midwives birthing team will only take care of the women that initially chose to give birth in an outpatient clinic. This requires additional capacity from the midwives!

When a birthing team is set up because there is a shortage of midwives, home birth is no longer possible. At that moment, there is a location where all the births in primary healthcare will take place.



B Team = Birthing team of community midwives linked to the birthing location

1.9 Deployment of midwives in the B Team

Their deployment depends on the expected number of births. Assess the expected number and use this to estimate the number of midwives required.

Will they be working on a 24-hour shift, or a 12-hour or 8-hour shift? The number of shift hours depends on the number of hours the midwives expect to be working per 24 hours. In case of 40 pregnancies at term per month, the midwives are expected to work 8 hours per day. Aim for an average of 8-10 hours per shift. Also, make arrangements about substitution and what to do when the birthing location/hospital is full. Also, arrange replacement back-up when one of these midwives is ill.

Use a plan that is familiar to the practices and regional coordinators.

If there is a shortage of midwives, is it possible to scale up the number of rooms so that all births can take place at the birthing location/hospital?

1.10 Communication in the integrated care chain and with pregnant women

In addition to communicating within the ROAZ (hospital/ambulance), it is also essential to communicate with:

- **Maternity care**
Depending on the cause, it may be necessary for maternity care to also set up defined teams for birthing assistance.
- **Alliance (Midwifery Partnership)**
Do not lose sight of the Alliance when adjusting the organisation of care. Align certain elements in the integrated care chain on time. Consider the consequences of decisions within the chain.

1.11 Data exchange medical content

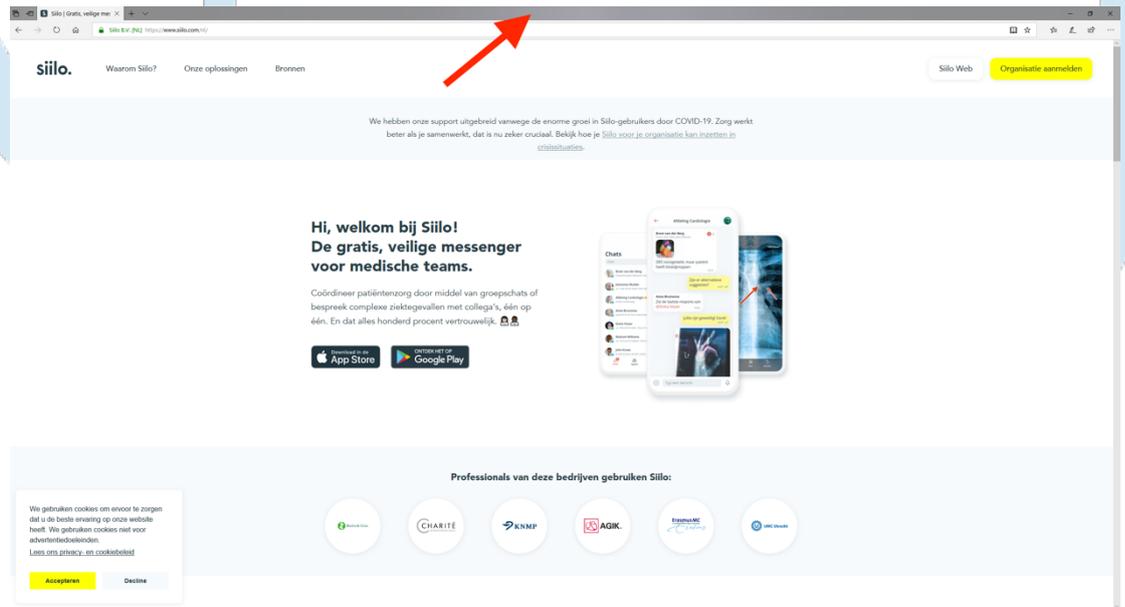
Despite the exceptional situation we are now in, it is still relevant to handle data carefully (GDPR). It is still essential to consider how medical data/pregnancy charts and birth plans are delivered to the birthing team midwife at the birthing location, and how the birthing report is similarly sent back by the B Team midwife. We also recommend a telephone hand-over of the data to the client's own midwife/practice.

Various options for this are still being explored and elaborated. One option can be to share the pregnancy chart and the birthing report via Siilo. This is conditional on both the sending and receiving midwives having a Siilo account.

Quick guide for Siilo internet use:

1. Save the pregnancy chart on the computer (PC/MAC)
2. Open the browser and type in the following address: web.siilo.com
3. There will be a QR code on the site. Scan this with the Siilo app using the camera on the phone.
4. The Siilo website is now linked to your account.
5. For a Windows PC: Click on the dark bar at the top of the screen. See the arrow and drag it all the way to the right of the screen. This is done by left-clicking on the bar and

dragging it to the right.



6. For a Mac: Put the two windows side-by-side.
7. Open the explorer/finder and search. Place this screen on the left side of the screen in the same way as the browser screen. Find the file you want to share.
8. In Siilo, click the icon of the person you want to share the document with.
9. Move your mouse over the file and drag it to the Siilo chat window.
10. Click on the Send button top left on the pop-up window.
11. If you want to send multiple files, repeat steps 7 through 10.

1.12 Finances

The midwives of the B Team keep track of how many hours they work and for which practice. Recommendations for settlement/fee will follow.

