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The 4st Cambodia Midwife Update Symposium

រួមគ្នាថែទាំសុខភាពមាតា និងទារកជុំវិញកំណើត

Together, Caring for Maternal and Perinatal Health

28th February, 2026 at Technology Institute

Asst.Prof. Virya Koy, RN, MSNc., MHPEd. PhD.

- Deputy Director of Department of Hospital Services
- Chief Nursing Officer/Nursing Focal Person in Cambodia for WHO-WPRO
- Adjunt Professor, School of Nursing, Pittsburg University
- Tel: 85577616196
- Email: virya2403koy@gmail.com
- ORCID: https://orcid.org/0000-0003-1385-8535
- Scopus ID: 56764673300

Ensuring Patient Safety

in Midwifery Practice

For Mothers & Neonates

A Comprehensive Guide for Clinical Midwifery Professionals

Evidence-Based Standards | Safe Practice | Quality Care

Presentation Overview

20 slides covering essential safety domains in midwifery practice

01 Introduction & Safety Framework

02 Risk Assessment in Maternal Care

03 Safe Intrapartum Care

04 Postpartum Maternal Safety

05 Neonatal Immediate Care

06 Neonatal Resuscitation

07 Infection Prevention & Control

08 Medication Safety

09 Hemorrhage Management

10 Pre-eclampsia / Eclampsia

11 Safe Transfer & Referral

12 Documentation & Communication

13 Interprofessional Collaboration

14 Patient Education & Consent

15 Emergency Preparedness

16 Mental Health Safety

17 Nutritional & Supportive Care

18 Quality Improvement

19 Ethical & Legal Considerations

20 Key Takeaways & Conclusion

Introduction to Patient Safety in Midwifery

Why safety is the cornerstone of quality midwifery practice

800

women die daily from preventable childbirth causes

WHO Global Report 2023

2.5M
neonatal deaths
annually worldwide

Patient Safety Defined

A framework of organized activities that reduces harmful events caused by medical care.

Midwifery Scope

Encompasses antenatal, intrapartum, postnatal care, and newborn care up to 28 days.

Global Mandate

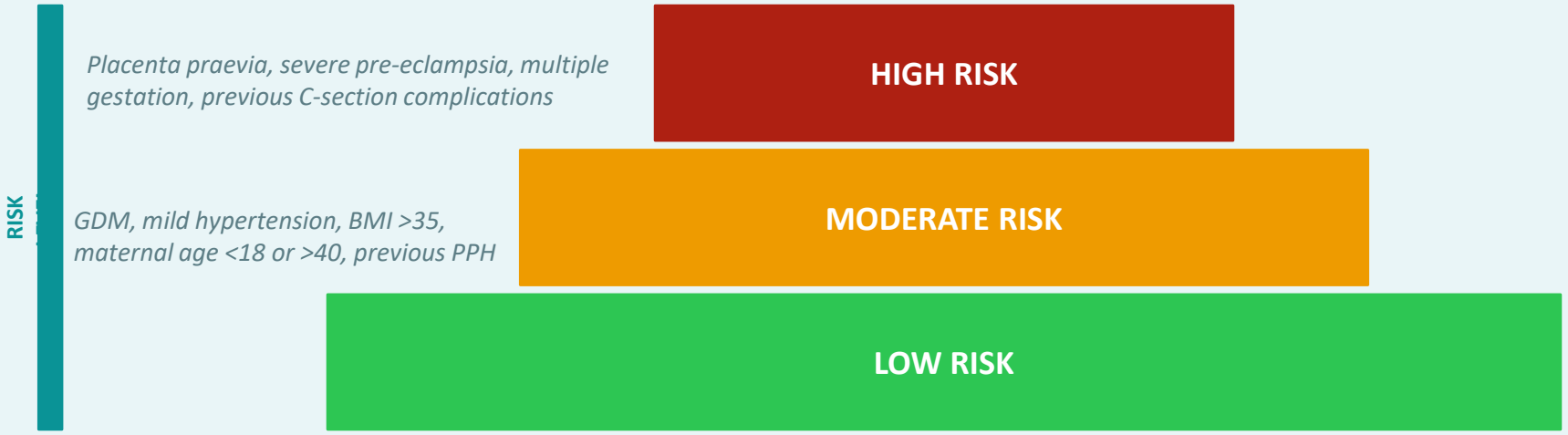
WHO, ICM, and national bodies mandate evidence-based safe practices for every birth.

Safety Culture

Proactive identification of risk, open communication, and continuous improvement.

Risk Assessment in Maternal Care

Identifying and stratifying risk from first contact through delivery



Key Tools: MEOWS Chart | Waterlow Score | Edinburgh Postnatal Depression Scale | Kleihauer-Betke Test

Safe Intrapartum Care

Evidence-based practices during active labour and delivery

01

Continuous Fetal Monitoring

CTG for high-risk; intermittent auscultation for low-risk. Document findings every 15–30 min. Escalate decelerations promptly.

02

Active Labour Management

WHO partograph use reduces prolonged labour. Augmentation only when clinically indicated with senior review.

03

Infection Control During Delivery

Sterile technique for all invasive procedures. Prophylactic antibiotics for GBS-positive mothers.

04

Pain Management Safety

Epidural requires anaesthetic consent, monitoring of maternal BP, and continuous FHR assessment.

05

Active Management of Third Stage

Oxytocin 10 IU IM within 1 min of birth. Controlled cord traction. Assess uterine tone.

06

Perineal Care & Repair

Structured assessment of tears (Grade I–IV). Aseptic repair with appropriate suturing technique.

Postpartum Maternal Safety

Critical observations and care in the immediate and extended postnatal period

0–2 Hours
Recovery Phase

2–24 Hours
Early Postnatal

Day 2–7
Community Care

Day 7–28
Extended Review

Vital Signs Monitoring

BP, pulse, temp, RR every 15 min for first 2 hours post-delivery, then hourly until stable. Alert if: systolic >160 or <90 mmHg.

Uterine Assessment

Uterine fundal height and tone assessment every 15 min. Bimanual compression for uterine atony.

Lochia Observation

Normal flow: rubra (0–4 days) → serosa (4–10 days) → alba (10–28 days). Report offensive odour or excessive loss.

Wound & Perineal Care

Daily assessment for signs of infection: erythema, swelling, dehiscence. Adequate analgesia and hygiene.

Thromboembolic Risk

Mobilisation within 6 hours. LMWH prophylaxis for at-risk women. TED stockings as appropriate.

Mental Health Screening

Edinburgh Postnatal Depression Scale (EPDS) at 10–14 days and 6 weeks. Refer score ≥10 for review.

Neonatal Safety – Immediate Care at Birth

Systematic assessment and stabilisation of the newborn in the first hours of life

APGAR Score Assessment

Criterion	0	1	2
Appearance	Blue/pale	Blue extremities	Pink all over
Pulse	Absent	< 100 bpm	> 100 bpm
Grimace	No response	Grimace	Cry/cough
Activity	Limp	Some flexion	Active motion
Respiration	Absent	Weak/irregular	Strong cry

Score: 7–10 = Normal | 4–6 = Moderate concern | 0–3 = Immediate resuscitation required

Thermoregulation

Dry immediately, skin-to-skin contact, warm room (25°C+), delay bath 24 hours.

Cord Care

Clamp at 1–3 min (delayed clamping). Clean, dry cord care. Check for 2 arteries, 1 vein.

Vitamin K & Eye Care

Vitamin K 1 mg IM within 4 hours. Erythromycin eye drops in endemic areas.

Early Breastfeeding

Initiate within 1 hour of birth. Support latch. Assess feeding every 3–4 hours.

Neonatal Resuscitation

Structured response to the compromised newborn – NRP/ILCOR guidelines

KEY REMINDERS

- Golden Minute: Complete initial steps and assess within 60 seconds
- Call for help immediately if HR < 100 bpm
- Ensure bag-mask seal and adequate chest rise
- 2-thumb technique for chest compressions (3:1 ratio)
- SpO_2 targets: 1 min = 60%, 5 min = 85%, 10 min = 95%
- Warm environment throughout resuscitation
- Document time of events meticulously

Birth
Term? Tone? Breathing?

Initial Steps
Warm, dry, stimulate
Position airway, suction if needed

Evaluate
Breathing? HR > 100 bpm?

PPV / SpO_2 Monitoring
Positive Pressure Ventilation
HR < 60: CPR + intubation

Medications
Epinephrine 0.01–0.03 mg/kg IV
Volume expansion if needed

Infection Prevention & Control

Standard and transmission-based precautions in midwifery settings

IPC Best Practices

- Use surgical hand scrub before invasive procedures
- PPE: gloves, apron, eye protection for all deliveries
- Aseptic Non-Touch Technique (ANTT) for catheterisation, IV access
- Neonatal cord and eye care: prevent omphalitis and conjunctivitis
- Screen for GBS, HIV, Hepatitis B at booking; act on results
- Environmental cleaning between patients; safe sharps disposal

Medication Safety in Midwifery

Preventing medication errors in antenatal, intrapartum, and postnatal care

The 10 Rights of Medication Administration

Right Patient	**Right Drug**	**Right Dose**	**Right Route**	**Right Time**
Right Documentation	**Right Reason**	**Right Response**	**Right Education**	**Right to Refuse**

⚠ High-Alert Drugs

Oxytocin, Magnesium Sulfate, Methotrexate, Insulin – require double checking by two midwives.

⚠ $MgSO_4$ Protocol

Antidote (calcium gluconate) must be at bedside. Monitor patellar reflexes and respiratory rate hourly.

⚠ Oxytocin Safety

Never administer as IV bolus. Infusion must be on a syringe driver with maternal/fetal monitoring.

⚠ Opioid Safety

Document all controlled drugs. Naloxone available for neonatal respiratory depression.

Postpartum Hemorrhage – Prevention & Management

PPH is the leading cause of maternal mortality; early recognition saves lives

PPH = Blood loss ≥ 500ml after vaginal birth or ≥ 1000ml after C-section | Minor: 500–1000ml | Major: >1000ml | Massive: >2000ml

TONE

Uterine atony (70%)
Bimanual massage
Oxytocin, Ergometrine
Misoprostol

TISSUE

Retained placenta
Manual removal
Curettage if needed

TRAUMA

Lacerations/tears
Surgical repair
Vaginal/uterine packing

THROMBIN

Coagulopathy
FFP, Platelets
Cryoprecipitate
Tranexamic acid

CALL FOR HELP

Obstetric emergency call. Senior midwife + obstetrician + anaesthetist + theatre team.

IV ACCESS & FLUIDS

2 large-bore IV cannulae. Blood samples: FBC, clotting, G&S. Hartmann's / O-negative blood.

MEASURE & DOCUMENT

Calibrated drapes. Time blood loss volume. Observations every 5 min. SBAR communication.

ESCALATE CARE

Surgical options: B-Lynch suture, uterine artery ligation, hysterectomy as last resort.

Pre-eclampsia & Eclampsia Management

Hypertensive disorders affect 5–8% of pregnancies; require prompt intervention

Recognition

- BP ≥140/90 mmHg on 2 occasions
- Proteinuria ≥300 mg/24h
- Severe features: BP ≥160/110
- Headache, visual disturbance
- Epigastric pain, vomiting
- Oedema (rapidly developing)
- HELLP syndrome warning signs

Assessment

- Hourly BP monitoring
- Urinalysis every 4 hours
- Blood: FBC, LFT, U&E, clotting
- Fluid balance: strict I&O
- Fetal wellbeing: CTG, USS
- Symptom review every shift
- Level of consciousness

Management

- Antihypertensives: Labetalol / Nifedipine
- $MgSO_4$ for seizure prophylaxis
- Eclampsia: ABC, $MgSO_4$, recovery
- Fluid restriction: 80–100 ml/hr
- Timing of delivery depends on severity
- Postpartum: BP monitoring 48 hrs
- Inform patient of recurrence risk

Eclampsia: Place in recovery position • Call emergency team • $MgSO_4$ 4g IV over 5–10 min • Airway management • Deliver after stabilisation

Safe Transfer & Referral

Structured communication and care continuity during emergency and elective transfer

SBAR Communication Tool for Referral

S — Situation
Patient name, age, gestation
Presenting problem
Current clinical concern

B — Background
Obstetric & medical history
Medications & allergies
Antenatal care summary

A — Assessment
Current vital signs
Fetal wellbeing (CTG/FHR)
Your clinical impression

R — Recommendation
Action required
Level of urgency
Expected time of arrival

Transfer Checklist

- [ ] Informed consent obtained
- [ ] Receiving unit contacted & accepts
- [ ] Transfer record completed
- [ ] Partogram / notes copied
- [ ] Medications packed + given
- [ ] IV access patent and secured
- [ ] Qualified escort accompanies
- [ ] Appropriate transport arranged
- [ ] Family/partner informed
- [ ] Handover at receiving unit

Documentation & Communication

Accurate, timely documentation is a legal and clinical safety requirement

Contemporaneous

Record events as they happen. Time-stamp all entries. Never back-fill notes hours later.

Accurate & Factual

Document what was observed, not what was assumed. Avoid jargon or abbreviations.

Legible & Signed

Sign every entry with full name, designation, and date. Countersign verbal orders.

Confidential

Access records on a need-to-know basis only.

Complete Handover

Use structured handover: SBAR. Include all outstanding tasks and risks.

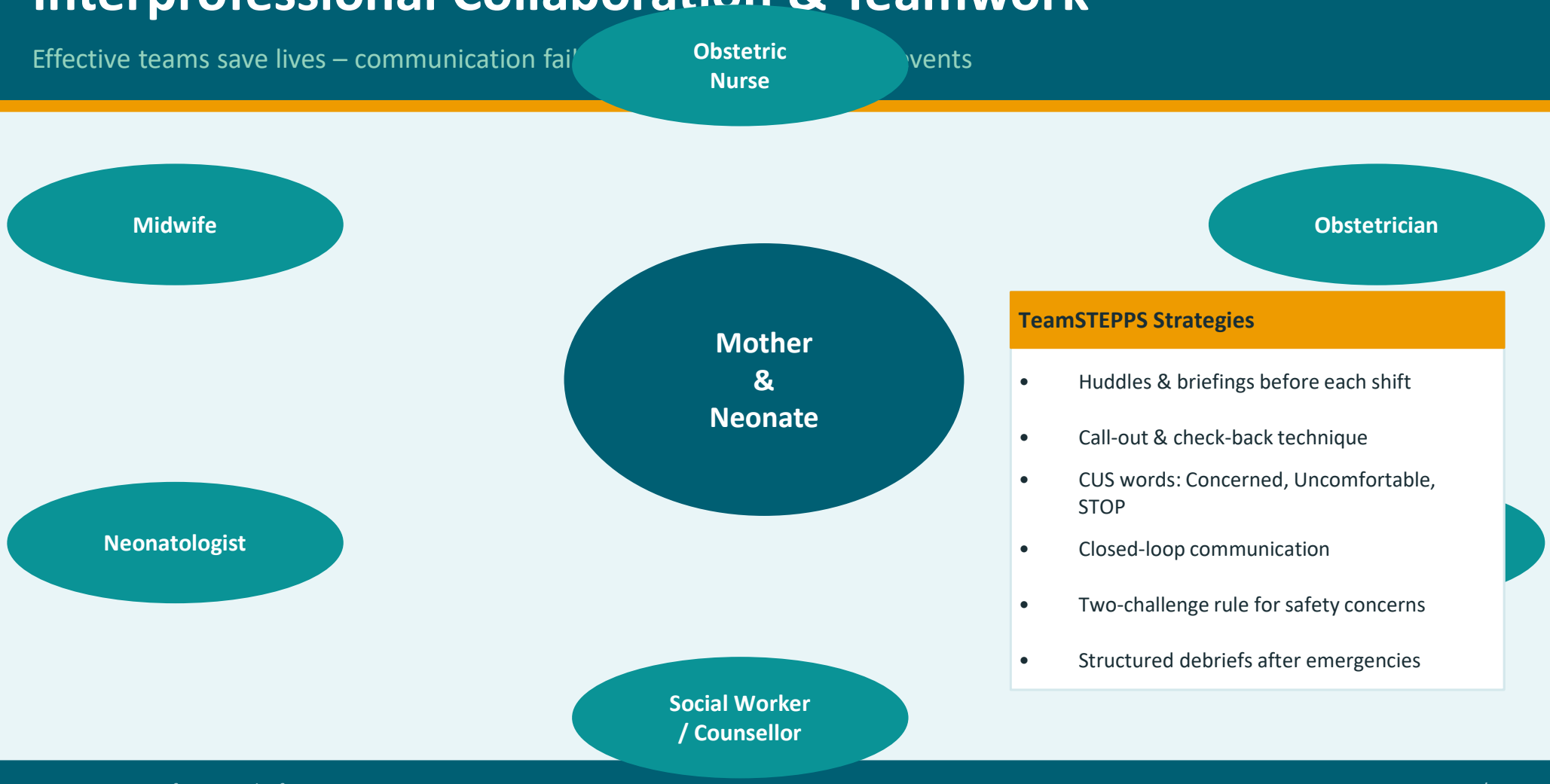
Incident Reporting

Report near-misses and adverse events via local risk management system within 24 hrs.

"If it wasn't documented, it wasn't done." — Nursing & Midwifery Council Principle

Interprofessional Collaboration & Teamwork

Effective teams save lives – communication fai[l]vents



TeamSTEPPS Strategies

- Huddles & briefings before each shift
- Call-out & check-back technique
- CUS words: Concerned, Uncomfortable, STOP
- Closed-loop communication
- Two-challenge rule for safety concerns
- Structured debriefs after emergencies

Patient Education & Informed Consent

Empowering mothers through knowledge is central to safe, woman-centred care

4 Elements of Valid Informed Consent

Disclosure

All material risks, benefits, and alternatives must be explained in plain language.

Capacity

Assess mental capacity at each encounter. Document capacity assessment.

Voluntariness

Consent must be free from coercion. Respect refusal of treatment.

Specificity

Consent is procedure-specific. Verbal consent documented; written for invasive procedures.

Key Education Topics

- Signs of labour & when to attend hospital
- Danger signs: reduced fetal movement, bleeding
- Breastfeeding initiation and positioning
- Cord care and jaundice recognition
- Postpartum contraception options
- Mental health: baby blues vs depression
- Immunisation schedule for mother & baby
- Safe sleep: back to sleep, clear cot
- When to re-attend: warning signs postnatal

Use teach-back method to confirm understanding. Provide written information in patient's language.

Emergency Preparedness in Midwifery

Readiness drills and protocols for obstetric emergencies

RED Major PPH

Massive transfusion protocol
Call emergency team
Cellsaver if available
Surgical intervention

BLUE Maternal Collapse

ALS algorithm
Call crash team
Perimortem C-section at 4 min if no ROSC
Lateral tilt if >20 weeks

GREEN Cord Prolapse

Knee-chest position
Manual elevation of presenting part
Emergency C-section
Bladder filling if delay

AMBER Shoulder Dystocia

Call for help – note time
McRoberts manoeuvre
Suprapubic pressure
Rubin II, Woods screw
All-fours / Gaskin

PURPLE Eclampsia

Position, ABC
$MgSO_4$ 4g IV bolus
AntiHTN if BP ≥160
Delivery plan after stabilisation

TEAL Neonatal Compromise

Summon neonatal team
NRP protocol
Document APGAR
Transfer to NICU if indicated

Perinatal Mental Health Safety

Mental illness is the leading indirect cause of maternal death in high-income countries

Baby Blues Onset: Days 2–5 Prevalence: 50–80%	Tearfulness, mood swings, mild anxiety; self-limiting	Reassurance, rest, support; resolves by day 10
Postnatal Depression Onset: 2–8 weeks Prevalence: 10–15%	Low mood, tearfulness, poor bonding, loss of interest, anxiety	EPDS screening; CBT, antidepressants, peer support
Postnatal Psychosis Onset: 24–72 hours Prevalence: 1–2 / 1000	Confusion, hallucinations, delusions, rapid mood changes	Psychiatric emergency – inpatient admission
Perinatal Anxiety Onset: Anytime Prevalence: 15–20%	Excessive worry, panic attacks, tokophobia, OCD	CBT, mindfulness; pharmacotherapy if severe

Refer any concerns to perinatal mental health team. All mothers to be screened using EPDS at booking, 28 weeks, and 6 weeks postnatal.

Quality Improvement & Safety Monitoring

Continuous improvement systems to sustain high standards of midwifery care

PDSA Quality Improvement Cycle

P — Problem

Identify the problem. Set measurable objectives. Predict outcomes. Assign team roles.

D — Driven

Implement the change on a small scale. Collect data. Document unexpected observations.

I — Iterative

Analyse results vs predictions. Identify what worked and what didn't.

A — Adaptation

Adopt, adapt, or abandon the change. Scale up successful interventions.

Key Safety KPIs to Monitor

PPH Rate	> 500ml: target <10%
C-Section Rate	WHO target: 10–15%
APGAR < 7 at 5 min	Benchmark < 2%
Maternal Mortality	Per 100,000 live births
Neonatal Mortality	Per 1,000 live births
Infection Rate	SSI: < 2% post C-section
Medication Errors	Track & trend monthly
Patient Satisfaction	Minimum 85% positive
Incident Reports	All near-misses reviewed

Key Takeaways & Conclusion

01 Patient safety is non-negotiable – every birth, every mother, every neonate deserves safe, evidence-based care.

02 Risk stratification early and often prevents the majority of adverse maternal and neonatal outcomes.

03 Structured protocols (SBAR, APGAR, 10 Rights, PDSA) reduce variation and errors across settings.

04 Teamwork, clear communication, and psychological safety are as important as clinical skills.

05 Every incident – including near-misses – is a learning opportunity to improve systems and culture.

06 Continuous professional development, simulation drills, and reflective practice underpin safe midwifery.

"The care of the mother and baby is not just a duty — it is the highest calling of our profession."

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