Ambulance Crews: a good practice guide

Developed by the Miscarriage Association.

"I was on my own at home. I couldn't walk, I was on the floor so I had to call an ambulance."

From a medical perspective, miscarriage[1] is a common and generally minor complication of pregnancy, but for women and their partners it can be distressing, frightening and lonely. If they have called an ambulance they may be bleeding heavily, in pain and very frightened for their baby and perhaps for themselves.

Any risk to the woman's health – and to her life in the case of haemorrhage or a suspected ectopic pregnancy – will always be your prime concern. But your overall approach can make a positive difference to her experience at a very difficult time.

We spoke to women and ambulance crews about what helps and what makes things harder.

Women told us that they wanted compassion, understanding and acknowledgement of the emotional impact of miscarriage as well as good physical care.

Ambulance staff told us that they needed more information about pregnancy loss: causes, symptoms and how it is treated or managed. We highlight some key points below, and have added links to where you can find more detailed information.

The context

If a woman has called an ambulance because of pregnancy problems, it is likely to be because she is experiencing unexpected severe pain and heavy bleeding and has no other way of accessing emergency care. She may have collapsed or had a fainting episode/s. She may be in the process of labour or she might have delivered rapidly and unexpectedly.

[1] This good practice guide focuses mostly on first trimester miscarriage. But the principles noted here apply equally to women with second trimester loss, ectopic pregnancy or molar pregnancy, alongside the issues specific to those losses.

This training resource focuses on pregnancies which are less than 24 weeks' gestation and specifically pregnancy loss or suspected/likely pregnancy loss. Delivery or possible delivery of a live baby before 24 weeks is outside our scope, as is termination of pregnancy for any reason, though many of the same principles will apply.

Pre-24 week pregnancy loss may be:

Miscarriage

- First trimester (4 -12/13 weeks gestation)
- Second trimester (14 – 23 weeks + 6 days)

Ectopic pregnancy

Molar pregnancy – usually diagnosed only after a miscarriage

In miscarriage

- Pain and/or bleeding may have started completely unexpectedly and increased rapidly; or she might have had some signs and symptoms earlier.
- She may already have been diagnosed with a 'missed', 'silent' or incomplete miscarriage and be waiting for medical or surgical management of the process.
- She may have opted for expectant/natural management of her miscarriage (letting nature take its course) but the pain and bleeding are far more than she expected.
- She may have miscarried unexpectedly, rapidly and relatively painlessly in the second trimester.
- Even in the first trimester, pain can be very similar to the contractions of labour.

In ectopic pregnancy

- Acute abdominal pain, often to one side, is the primary symptom, but there may also be shoulder-tip pain. Bleeding is usually minimal.
- Symptoms may be confused with appendicitis, especially if the woman does not know if she is pregnant.
- Acute abdominal pain that resolves may indicate tubal rupture and internal bleeding.
- The only symptoms may be collapse and pallor.

> ***If a woman of child-bearing age presents with acute abdominal pain, ectopic pregnancy should always be considered, even if she does not know she is pregnant.***

Consider how she might be feeling – be sensitive and compassionate

- She may be highly anxious, hoping that something can be done to save her pregnancy. She may feel as though her baby is dying while she is in the ambulance.
- If she is bleeding heavily, in considerable pain and/or in and out of consciousness, she may also be very frightened for herself.
- In both cases, she may need reassurance that you will do your best to get her to hospital as soon as you can - but.
- Don't give her false hope or reassurance, as Tony does in the film ('*You're going to be just fine.'*). He means to comfort but it is neither appropriate nor helpful.
- She may be embarrassed if she is bleeding heavily and visibly. Reassuring her and taking practical steps to maintain her dignity and respect can help.
- She may be very distressed if the loss has already happened or happens during the journey. Even if you mean to reduce her distress, don't try to cheer her up or say anything that might downplay her feelings. Showing empathy and kindness will be much more valuable.
- If she has miscarried at home or does so in the ambulance, treat the tissue, remains or baby sensitively and place them in a suitable container, which might be
    - a container in the maternity pack
    - a leak-proof cuddle-pocket or similar (West Midlands Ambulance Service have examples) and
    - ask the woman if she would like to hold her baby (or the pregnancy tissue) in the container.

"It's a lot different bleeding because you've had an accident, and bleeding because you are losing your baby."

Think about your language

- Most (though not all) women want you to refer to the pregnancy as a baby, and to the miscarriage as the loss of their baby. If you're not sure what language to use, ask her what she'd prefer.
- Terms like 'spontaneous abortion' or 'products of conception' are upsetting to most women.
- Try not to minimise the loss. Referring to it as a 'just a heavy period', 'back luck' or saying 'you're young, you can try again' can actually increase distress.
- Try to avoid using medical terminology and/or explain things in lay language.

Deal sensitively with pregnancy tissue and remains

During the process of miscarriage, women may pass blood clots, pregnancy tissue or a recognisable fetus or baby. This may happen at home (or wherever she is) before you arrive or during the journey to hospital. For many, what happens to these remains is very important. Even if they appear just to be blood and tissue, they are all that remains of their baby. Try to deal with them sensitively.

- If you see pregnancy tissue or a recognisable fetus in the house, including in the toilet, ask if she would like these collected. Do not automatically dispose of it or flush it away.
- Treat the tissue, remains or baby sensitively and place them in a suitable container, which might be
    - a container from the maternity pack
    - a leak-proof cuddle-pocket or similar (West Midlands Ambulance Service have examples) and
    - ask the woman if she would like to hold her baby (or the pregnancy tissue) in the container.
- Ensure the remains are labelled and go with the woman into hospital.

"If I had lost anything in the house or en route, I would like it compassionately taken to hospital with us."

Give clear information about what is happening now…

Be prepared to respond to questions. Here are some example questions and answers.

Is my baby OK?

- *'I'm afraid we won't know until we get you seen at the hospital/until you have a scan.'*
- *'I'm afraid it doesn't look that way.'*

Can you stop the bleeding?

- *'I'm afraid we can't, but we'll look after you as well as we can.'*

Is there supposed to be this much pain? Is this normal?

- *'Unfortunately this kind of pain does often happen during the process of miscarriage. It can be like a mini labour…'*

If you can't give clear answers, think about who might be able to, in the hospital or elsewhere. If appropriate, pass on details of the Miscarriage Association as a source of support. (We can provide you with a supply of contact cards.)

… and about next steps

- Tell her that you'll be transferring her to the Emergency Department/A&E unless you have a direct link to another department, such as an early pregnancy or emergency gynae unit or maternity department .
- Explain that once there, she may have to wait some time to be seen.
- Reassure her that you will make sure that she is covered up during transfer and when you leave her, so she is not embarrassed by obvious vaginal bleeding.

Got more time?

These additional resources might be helpful:

Additional information for ambulance crews – more detailed information about miscarriage, ectopic and molar pregnancy.

Our other good practice guides:

- Accident & emergency
- General practice
- Scanning in pregnancy
- Talking about management of miscarriage
- Talking about the sensitive disposal of pregnancy remains

Our e-learning films:

- The ambulance call-out
- In A&E
- The GP surgery
- At the booking-in scan
- Talking about the management of miscarriage
- Talking about the sensitive disposal of pregnancy remains

You'll find further references here.

Consider your needs too

Working in the ambulance service can he hugely rewarding but there's no denying that it can also be stressful, especially when you are treating people with life-threatening illness or injuries.

The extra factor in dealing with miscarriage patients is that you have an additional invisible patient, one whose life you are very unlikely to be able to save or prolong. But that may not be the woman's perspective. Her levels of anxiety and distress may be very high and you might encounter some difficult emotions not only from her but also from anyone accompanying her.

We hope some of the following suggestions will help – for miscarriage patients and perhaps others too.

Identify the difficulties

> **"Not being able to answer their questions is very difficult and makes me feel like I'm inadequate in my job, when in fact I've just not had adequate training."**

These may include:

- particular reactions that you find difficult to deal with:
- desperation for you to 'do something', solve the problem
- tears
- anger and blame – especially if directed at you
- particular situations that are difficult or distressing:
- a patient or loss that you identify with due to your own experience
- your own views and values on the significance of some cases, especially compared with other patients you see
- the context:
- limits to the care you can provide
- limits to the information you can provide: about her condition and about next steps
- lack of follow-up – never knowing the outcome of your care

Identify your sources of support…

Your most likely source of support will be your peers:

- in your hospital/Trust
- individually, informally
- in staff meetings, training sessions and/or clinical supervision
- peers from other hospitals
- individually, informally
- at conferences and wider training events

You might also consider:

- your partner, if you have one, or a trusted friend
- joining one of the monthly 'Professional Pause' sessions[2] hosted by the Miscarriage Association and the Ectopic Pregnancy Trust
- talking to us at the Miscarriage Association in strict confidence

… and make use of them

It's one thing to know where you can find support. It's another thing to do something about it. It's worth considering that your peers may have similar concerns and might also benefit from talking about these issues together.

[2] These sessions offer a safe online discussion and learning space to share experiences and reflect on challenging situations in order to support your practice, while also considering your needs. Contact helen@miscarriageassociation.org.uk for details.

And finally

Miscarriage is never easy – for the woman or couple involved or for the staff who are tasked with looking after them. You may not get it right for everyone, but patients will always remember your care, kindness and compassion.

> **"The paramedics were wonderful. They called my husband, asked if there was anyone else I needed contacting … and they gave me some gas and air, which I needed."**

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