Brighton and Sussex University Hospitals NHS Trust

Maternal & In Utero Transfers

Maternity Protocol: MP023

Date agreed: April 2020

Guideline Reviewer:	Sonya Brear and Sarah Ward
Manager responsible:	Amanda Clifton
Version:	3.0
Approval Committee:	Women's Safety and Quality Committee
Date agreed:	August 2020
Review date:	August 2023
Cross reference:	**MP022** Emergency Maternity Admissions **MP031** Pre-Term Labour **MP056** High Dependency Care **MP058** Escalation Protocol

Contents

Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol

Scope

This protocol applies to:

- All members of staff dealing with women being transferred during the antenatal, intrapartum and postpartum periods.
- Women being transferred from home to hospital, from site to site and from this Trust to another Trust.

Responsibilities

Midwives & Obstetricians:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

Management:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff

1 Maternal Transfer by Ambulance

1.1 It is essential that formal local multidisciplinary arrangements are in place to ensure the safe transfer of women in the antenatal, intrapartum and postnatal periods.

1.2 An effective working relationship between the multi-disciplinary team and a clear organisational structure for midwives and medical staff with explicit and transparent lines of communication is crucial to ensure optimum care for women and babies. For a consistent approach to communication and documentation of care when transferring a mother by ambulance a locally agreed tool SBAR

- Situation
- Background
- Assessment
- Recommendation

2 In Utero / Maternal Transfer

2.1 Indications

2.1.1 All women with symptoms and/or signs of pre-term labour and one or more of the following: positive fetal fibronectin with levels>50 (MP031 Pre-Term Labour), history of preterm delivery or PPROM should be transferred to a tertiary unit. Transfer following PPROM should be considered if there is evidence of uterine activity or clinical chorioamnionitis (British Association of Perinatal Medicine, 2008).

2.1.2 Women at preterm gestation admitted for medical reasons or obstetric reasons where there is minimal risk of pre-term delivery i.e no uterine activity, no cervical changes do not necessarily need to be transferred in utero, following discussion with SCBU at PRH

2.1.3 A thorough clinical assessment of every woman in threatened pre-term labour or deemed to be at risk of delivering pre term should be performed as per MP031 Pre-Term Labour by the Obstetric SpR and discussed with the Obstetric Consultant prior to decision for transfer in utero.

2.1.4 Loading Dose of Magnesium Sulphate (MgSO4) should be considered prior to transfer if the woman is at risk of preterm delivery (<30/40)

2.1.5 Continuous Monitoring should be performed until the time of transfer.

2.1.6 The neonatal team should be informed of all admissions.

2.1.7 All women admitted to PRH at <34 weeks gestation should have a thorough clinical assessment by the Obstetric SpR and be discussed with the Obstetric Consultant.

3 Transfer Site to Site

3.1 In the first instance all women should be transferred between sites.

3.2 In the case of maternal transfer because of a need for neonatal services, RSCH have a responsibility to take women from PRH even if TMBU is closed if transfer to an alternative site with an available NNU cot cannot be facilitated imminently. Full communication between sites is vital in the management planning for these women.

3.3 RSCH can refuse to take women from PRH only if the maternity unit is full and accepting the transfer would lead to care being compromised. NB in this scenario a midwife may be able to change sites to provide care - Refer to MP058 Escalation Protocol**.**

3.4 The decision to transfer should be made as follows (see Appendix C):

3.4.1 Need to transfer recognised and documented in maternal notes

3.4.2 LW co-ordinator and obstetric team Obstetric Registrar/Consultant discuss and agree on transfer

3.4.3 Obstetric Registrar/Consultant contacts the other sites Obstetric Registrar/Consultant and discusses and agrees to transfer (informing the LW co-ordinator at receiving site)

3.4.4 Obstetric Registrar/Consultant or LW co-ordinator contacts the receiving units neonatal unit and discusses and agrees to transfer

3.4.5 All discussion and names of persons agreeing to transfer should be documented in the maternal notes.

3.5 Once a decision has been made that transfer is required i.e. less than 34 weeks pregnant with delivery probable or medically indicated by either maternal or fetal condition:

3.5.1 Midwife providing care for the woman should ensure:

3.5.1.1 There is agreement to transfer the woman with Consultants/Registrars at each site

3.5.1.2 Labour ward coordinators at each site know and agree to the transfer

3.5.1.3 Neonatal unit contacted and transfer accepted

3.5.1.4 Maternal consent gained and documented in notes

3.5.1.5 SBAR transfer form filled out and placed in the notes

3.5.1.6 LWC complete in utero transfer paperwork (appendix c)

3.5.2 Obstetrician providing care

3.5.2.1 Write a clear plan of action/letter in maternal note

3.5.2.2 Discussed case with other unit and accepted transfer

3.6 When transferring by ambulance all cases will be classed as an emergency unless otherwise indicated

3.7 The Midwife providing care or the labour ward co-ordinator should arrange for an ambulance by phoning ambulance control:

Ambulance } From PRH telephone *8001
Control } From RSCH telephone *8711

3.7.1 Ambulance by blue light transfer by paramedic, categorisation
Cat 1 – 7 Minutes
Cat 2 – 18 Minutes
Cat 3 – 120 Minutes

3.7.2 The booking reference shown be documented in the notes

3.7.3 The Midwife providing care should accompany the women in the ambulance (bringing appropriate equipment for eventualities during transfer)

3.7.4 On arrival at the other unit the Midwife providing care should give a full hand over to the receiving midwife (LWC and Reg if possible) using SBAR format.

3.8 Staff documentation requirements when undertaking an in-utero transfer:

Staff group	Documentation responsibilities
Midwife providing care	In the maternal notes: • Need and reason for transfer • Consent from woman • Agreement from receiving site • SBAR sheet and SBAR sticker • Time ambulance called • Arrival & departure at transferring site, & arrival of ambulance at receiving site • Datix Form if transfer out of the trust
LW coordinator	• Completion of in utero transfer folder paperwork
Obstetric Registrar	In the maternal notes:

/Consultant	• Discussion and agreement to transfer from receiving site Obstetric Registrar/Consultant, LW coordinator and NNU (where appropriate) • Clear plan of action/letter
Ambulance crew	• Completion of transfer paperwork a copy of which should be attached to the maternal notes

4 Transfer Off site

4.1 For a transfer to another Trust for access to neonatal services the Obstetric Registrar should use the bed bureau if looking for a cot

4.2 Agreement for the transfer should be sought from both the accepting labour ward and NNU (as appropriate) this process should be performed by the Labour ward coordinator and Registrar. The plan and names of professionals agreeing to the transfer should be documented in the maternal notes.

4.3 Plan of care documented and in notes

4.4 The maternity notes should accompany the woman on the transfer and a photocopy of any relevant information in the brown notes.

5 Home Birth Transfer (Women Having a Planned Labour and Birth at Home)

5.1 See MP060 Homebirth protocol

6 Agreed process for contacting the ambulance service in emergencies or when transfer is required and subsequent management

6.1 The Midwife Providing Care Should:

6.1.1 Dial 999 and state you are a midwife with a maternity emergency requiring paramedic support

6.1.2 Always ask for a paramedic ambulance crew and state the emergency. Give any specific information on previous history etc as required

6.1.3 Give details of the emergency as this will determine the Ambulance response time (as above)

6.1.4 Inform the woman of the need to be transferred and gain her consent.

6.1.5 Call Delivery Suite. Speak to the coordinator. Give details of the impending transfer and request second on call midwife to give additional support as appropriate.

6.1.6 For babies undergoing active resuscitation call neonatal unit and inform them about an impending transfer of neonate requiring resuscitation and ask for the team to meet the ambulance in A&E

6.1.7 For babies requiring review but NOT active resuscitation, inform the NNU about an impending transfer and ask for the neonatal team to be on standby to review the newborn on arrival

6.1.8 Instigate any immediate emergency or urgent treatment. (Refer to the relevant emergency guidelines for APH, PPH, retained placenta, breech delivery, shoulder dystocia, maternal collapse, newborn life support etc).

6.1.9 Document events in the notes as contemporaneously as possible

6.1.10 On arrival of the paramedics, ask for any assistance needed to stabilise condition for transfer e.g. IV cannulation

6.1.11 Accompany mother/baby in ambulance and continue to observe and care for mother or baby. If both mother and baby require transfer into hospital, ideally two ambulances would be sent.

6.1.12 In the event of maternal or neonatal collapse ensure ambulance staff have requested obstetric/neonatal staff to be standing by in A&E

6.1.13 Give a full report to staff accepting care in the hospital, if possible the midwife responsible for transfer, should continue to give the care.

6.1.14 Ensure documentation of the notes is complete and a SBAR is completed.

6.1.15 Complete a Datix for all home births transferred into the hospital.

6.2 Staff documentation requirements (from community into hospital during intrapartum period):

Staff group	Documentation responsibilities
Midwife providing care	In the maternal notes: • Need and reason for transfer • Consent from woman • Informed Labour ward coordinator • SBAR form completed • Time ambulance called • Arrival & departure at transferring site, & arrival of ambulance at receiving site • Datix form
LW coordinator	Documentation of information received and advice given during in the telephone log book on labour ward, including timings.
Ambulance crew	Completion of transfer paperwork a copy of which should be attached to the maternal notes
A&E staff (if appropriate)	Document in hospital notes any care given and referrals made to obstetric/midwifery and neonatal staff

7 Transfer to ITU/HDU

7.1 Please refer to Maternity Protocol: MP056: High Dependency Care

7.2 The decision to transfer a woman to HDU or ITU is made jointly by an Obstetric Consultant and Anaesthetic Consultant (in liaison with ITU/HDU). The names of persons involved, discussions, decisions made and plan of care should be clearly documented in the maternal notes

7.3 Both teams should liaise with ITU/HDU and plan care that is appropriate to the individual patient. This should be documented in the maternal notes.

7.4 There must be full verbal and documented handover of care to HDU/ITU staff from the Obstetric, Midwifery and Anaesthetic Teams using the SBAR systematic tool and transfer form.

8 Transferring Women in the Postnatal Period

8.1 Well women:

8.1.1 If a woman is fit for discharge they should be discharged from one unit and advised to make their own transport arrangements as required. This should be documented in the maternal notes by the midwife providing care

8.1.2 Unwell women following homebirth immediately post delivery

8.1.3 Midwife providing care should follow the procedure outlined above (emergency transfer)

8.2 Unwell women at home during postnatal period up to 28 days postnatally

8.2.1 Women that become unwell in the postnatal period should be advised to call an ambulance and be transferred delivery suite for review. Advice given over the phone should be documented in the telephone call log on the ward by the person taking the call.

8.2.2 See Maternity Protocol MP022: Emergency Maternity Admissions

8.3 Unwell women transferring between sites

8.3.1 If a women is not fit for discharge and needs to be transferred between sites in the post natal period this should be by ambulance and accompanied by a midwife.

8.3.2 Staff documentation requirements (woman and her newborn in postnatal period):

Staff group	Documentation responsibilities
Midwife providing care (if present at time transfer required)	In the maternal notes: • Need and reason for transfer • Consent from woman • Informed Labour ward coordinator • SBAR form completed • Time ambulance called • Arrival & departure at transferring site, & arrival of ambulance at receiving site • DATIX form
LW coordinator/midwife receiving telephone call	Documentation of information received and advice given during in the telephone log book on labour ward, including timings.
Ambulance crew	Completion of transfer paperwork a copy of which should be attached to the maternal notes
A&E staff (if appropriate)	Document in hospital notes any care given and referrals made to obstetric/midwifery and neonatal staff

9 References

Ottewill M, Urben J, Elson D .Safe handover: Safe care. Midwives RCM December 2007 Volume 10 No 11

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press. Available at: www.rcog.org.uk

Fenton A, Peebles D, Ahluwalia J: **Management of acute in-utero transfers: a framework for practice** for British Association of Perinatal Medicine, 25th June 2008

10 Appendix A - Situations which potentially require an emergency transfer:

First stage of labour

- Delay or lack of progress in the first stage of labour
- Meconium stained liquor
- Haemorrhage
- Cord presentation and /or cord prolapse
- Suspected fetal compromise
- Malpresentation or breech presentation
- Maternal collapse
- Mother requesting an epidural
- Eclampsia / pre-eclampsia
- Maternal request

Second stage of labour

- Delay in progress in the second stage of labour
- Contractions diminished
- Cord presentation / cord prolapse
- Haemorrhage
- Shoulder dystocia
- Suspected fetal compromise
- Eclampsia / pre-eclampsia
- Maternal collapse
- Malpresentation/breech presentation

Third stage of labour

- Retained placenta
- Postpartum haemorrhage
- Maternal collapse
- Eclampsia / pre-eclampsia

Postnatal

- Postpartum haemorrhage
- Third or fourth degree tear or suturing that requires additional skills/equipment/analgesia unable to be provided in the home
- Mother or baby requiring resuscitation

Appendix B: SBAR Escalation/transfer:

SBAR report to escalate to clinician about a clinical situation

S

I am calling about ..... On .....

The problem I am calling about is:

On assessment the observation are: Resps: Sats: BP: / P: T:
Meows / Eobs Score:

I am concerned about:
Blood Pressure because it is:
- Systolic > 160
- Dystolic >100
- Systolic <90

Pulse because it is:
- Over 120bpm
- Less than 40bpm

Respirations because they are:
- Less than 10
- Over 30
- Oxygen requirements are _____

Temperature because it is _____°C

Urine output because it is:
- Less than 100mls over the last 4 hours
- Significant proteinuria _____

Haemorrhage:
- Antepartum
- Postpartum

Fetal Wellbeing:
- Non reassuring trace
- Abnormal trace

Serum Lactate because it is _____mmol/l
Blood results because:_____
_____
Blood Sugar_____gl

B

The women or Person who births is:
Primparous Multiparous Grand Multiparous
Gestation_____ wks Singleton/Multiple Pregnancy
Previous LSCS or uterine surgery

Fetal assessment:
SFH____cms Presentation:_____ Fifths palpable:_____ FH rate: _____bpm
CTG: Normal Non-Reassuring Abnormal

Antenatal History:_____

Labour: Spontaneous Induced
IUGR Pre-eclampsia <FM Diabetes: GDM/GIDM/DM APH Oxytocin Augmentation
VE at _____ Findings: _____CM's, Presenting part at_____ , Position_____
SROM: Date _____ Time: _____ PV Loss: Meconium, Fresh red, clear or Intact
Third stage: complete or retained placenta

Postnatal: is _____ days postnatal following a _____ delivery the EBL was _____
Fundus is: Normal Atonic High
Uterus is: Non-tender / tender
Abdominal/perineal wound is oozing / Offensive

Current treatment is:_____

A

I think the problem is:_____

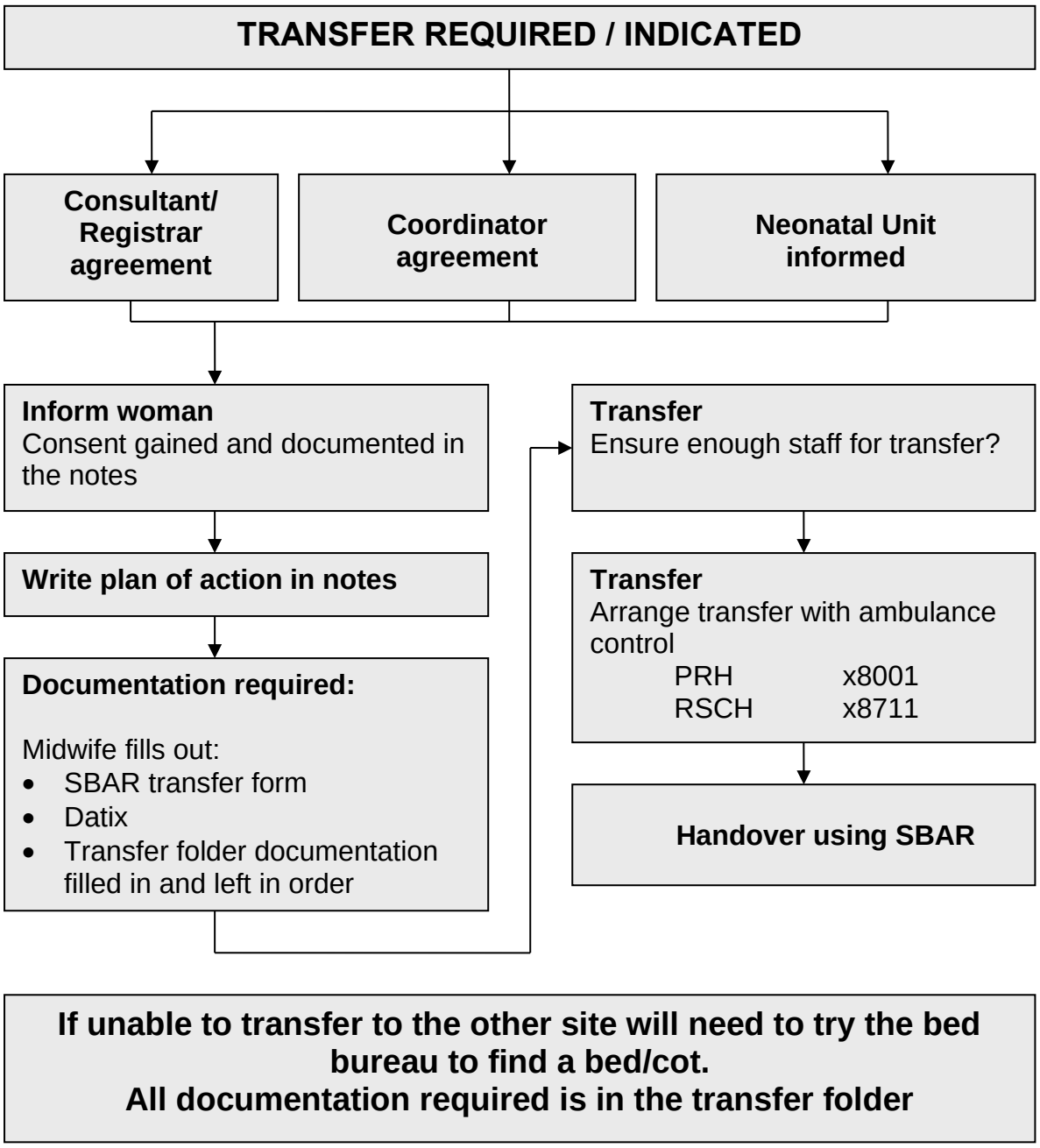
I am not sure what the problem is.

R

Request: Please can you come and review immediately ☐
I think delivery needs to be expedited ☐
I think a transfer to delivery suite / HDU is required ☐
I would like your advice please ☐
Reported to: _____Bleep Number/Extension Number_____
Response: _____
_____

Person Completing (name)_____ Date_____ Time_____

11 Appendix C - Flowchart for Managing Transfers



If unable to transfer to the other site will need to try the bed bureau to find a bed/cot.
All documentation required is in the transfer folder