Brighton and Sussex University Hospitals NHS Trust

Emergency Maternity Admissions

Maternity Protocol: MP022

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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 pregnant women or people who birth

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 Introduction

1.1 This guideline is based on the recommendations of the Confidential Enquiry into Maternal and Child Health 'Why Mothers Die' (2004) and the Saving Mothers Lives (2007). There are specific recommendations for the management of pregnant and postnatal women attending the accident and emergency department.

1.2 Its aim is to support Obstetricians, midwives and careers outside the maternity unit in the delivery of safe and effective care to pregnant women and those in the postnatal period (up to 6 weeks post-delivery) that require medical attention.

1.3 Pregnant and postnatal women may present to one of the following;

1.3.1 Accident and emergency department

1.3.2 1.3.2 Non –obstetric wards (other wards in the hospital)

1.3.3 1.3.3 Urgent Care Centre (out of hours GP)

2 Women Presenting to the Accident & Emergency Department

2.1 All pregnant and postnatal women attending A&E should be seen promptly by an ED doctor, and graded as high risk by the assessment nurse. Those with anything other than very minor physical injuries should be seen in conjunction with a senior obstetrician (Registrar level and above)

2.2 The management of pregnant or postnatal women who are acutely ill/collapsed for non-obstetric reasons should include early liaison with:

2.2.1 Emergency services (Ambulance services)

2.2.2 Accident and emergency

2.2.3 Intensive Care Unit / high Dependency Unit (Anaesthetics)

2.2.4 Maternity services

2.3 Pregnancy testing must be offered to all women of child-bearing age with potentially pregnancy related condition. This should be offered following initial review by an A&E clinician.

2.4 All pregnant women or women who have given birth within the previous 28days attending the emergency department should be seen by an experienced doctor from the obstetrics/gynaecology team or a midwife (further details on which conditions are seen by which doctor or midwife and where is stated below)

2.5 Care of women with non-obstetric problem/s who require admission should be discussed and planned with the obstetric team

3 Women Presenting with an Obstetric Problem

3.1 All women or people who birth presenting to ED with an obstetric problem at less than 14 weeks gestation should initially be assessed by the A&E doctor and if stable they should be booked into the next available EPU appointment. If requires 'same day' specialist gynaecology review the ED doctor must contact the on call Gynaecology Registrar. Women presenting at RSCH must be transferred to the Gynaecology Assessment Unit if clinically stable.

3.2 All women or people who birth presenting with an obstetric problem >24 weeks gestation to ED should be urgently reviewed by the A&E doctor and referred to the obstetric registrar. Following assessment by registrar if an assessment/admission is required from the midwifery team contact relevant department as per clinically indicated

3.2.1 MAU/Triage

3.2.2 Labour ward

3.2.3 Antenatal Ward

4 Women Presenting with a Post-Natal Problem

4.1 Women presenting with a problem who are still under the care of the midwife (usually 10 days post-delivery) should attend DAU/Triage.

4.2 Women presenting with a problem who are not under the care of the midwife (usually after 10 days post-delivery) should attend GAU (RSCH) and A&E (PRH).

5 Ectopic Pregnancy

5.1 All women of childbearing age that present with unexplained abdominal pain must have ectopic pregnancy excluded (urine pregnancy test).

5.1.1 All ED staff should be aware of the dangers of ectopic pregnancy and have an awareness of the atypical clinical presentations (up to 25% may present without a history of per vaginal bleeding).

5.1.2 Guidelines for the management of ectopic should be included in all induction programs for all A&E and Obstetric staff.

6 Women Presenting with a Non-Obstetric Problem

6.1 Women that present to the accident and emergency department with injuries or non-obstetric problems should be stabilised by the ED team.

6.2 Once stabilised the ED doctor must immediately contact the midwifery and obstetric team to ensure the case is discussed and care planned with the obstetric team:

- this is to include frequency of auscultation/ctg monitoring
- consideration of USS dependant on presentation
- consideration of differential diagnosis

6.3 The ED doctor assessing the patient must call labour ward and inform the Labour Ward co-ordinator. An overview of the women and cases should be discussed. These women should be reviewed daily by the obstetric team whilst in hospital irrespective of where they are admitted.

6.4 The Labour Ward Co-ordinator should undertake a phone assessment of the situation and arrange a midwifery and/or obstetric review dependent on the urgency of the situation. All pregnant women attending need a fetal wellbeing assessment by the obstetric team on admission to ED

6.5 Pregnant women with the following, otherwise unexplained signs and symptoms *must* be reviewed by obstetrics and/or gynaecological team as soon as possible

- Abdominal pain
- Severe headache
- Hypertension
- Proteinuria
- Breathlessness
- Pyrexia
- Chest pain

6.6 If the Revised Trauma score of a patient is less that 12 following an RTA, a clinical decision should be made by the ED consultant as to when to involve the obstetricians.

6.7 Pregnant women with non-obstetric problems who require hospital admission should be discussed and planned with the local obstetric team on admission (see section 9 below)

7 Perimortem Caesarean Section

7.1 On identification of an obstetric cardiac arrest of a pregnant woman:

7.1.1 **2222** is made to switch board.

7.1.2 A request is made for:

1) **'Obstetric & Neonatal Emergency'**
And
2) **'Cardiac arrest'**

These are to be made simultaneously

7.2 Perimortem caesarean section is part of the resuscitation procedure in any woman who arrests in the second half of pregnancy. The outcome is universally poor after 5 minutes.

7.3 If there is no initial response to advanced life support in the left tilted/wedged position within *5 minutes* (i.e return of spontaneous cardiac output), a perimortem caesarean section should be undertaken immediately preferably by the obstetric consultant on-call.

8 Ambulance Service Involvement

8.1 Ambulance personnel should be aware of conditions in which direct referral to the labour ward is indicated.

8.2 Direct transport to labour ward
Indicated in all women presenting after 24 weeks gestation complaining of the following:

8.2.1 Severe headache, nausea, vomiting or epigastric pain.

8.2.2 Blood pressure over 140/90 mmHg

8.2.3 Vaginal bleeding with or without rupture of membranes

8.2.4 Suspected labour

8.3 Direct transport to ED

8.3.1 Pregnant and postnatal women following falls or subject to an abdominal insult

8.3.2 RTA victims Pregnant and postnatal women with obvious trauma and fractures

8.3.3 Pregnant and postnatal women that have taken an overdose of any substance (this should communicated and escalated to mental health midwife and substance use midwife)

8.3.4 Any other circumstances where the woman's life or wellbeing is obviously threatened

8.3.5 Any circumstance where the stability of the woman would be compromised by further distance travelled.

9 Admission to Other Hospital Department

9.1 The care of the pregnant and postnatal women with a medical condition requiring treatment and hospitalisation should be discussed and planned in conjunction with the Obstetric team through the on call Obstetric Registrar

9.2 Where a pregnant and postnatal woman is admitted to a general ward the obstetric team should be informed by the admitting clinician through the on call Obstetric Registrar

9.3 System for ensuring that the on call obstetric consultant is aware of all sick pregnant women in the hospital who have a non-obstetric problem or a problem related to their pregnancy:

9.3.1 The details of all sick pregnant women admitted to other departments must be discussed with the on call Registrar, who is then responsible for informing and discussing the case with the Consultant Obstetrician.

9.3.2 If any sick pregnant women in other hospital wards develop an obstetric problem the lead clinician for that department should contact the on call obstetric registrar via the bleep and ask for an urgent review. The on call registrar must inform the on call obstetric consultant of any reviews and, dependant of the clinical scenario, discuss the case with the obstetric consultant either immediately or at the next daily ward round.

9.3.3 The details of pregnant women admitted to other departments in the hospital must be written on the labour ward handover board as outliers by the clinician who is first told of the admission. The labour ward co-ordinator should be informed and the pregnant woman and her case discussed during the consultant ward round each day.

9.3.1 All pregnant women with non-obstetric cases or who have a problem related to their pregnancy and are admitted on non-maternity wards will be reviewed daily by the consultant obstetric team as part of the daily ward rounds. Midwifery care will also be provided based on an individualised plan of care once the consultant has reviewed the patient. These patients will be added on to the antenatal white board as outliers and should give details of the patients ward location.

9.3.2 The labour ward co-ordinator is responsible for ensuring all information is up to date on the maternity whiteboard, allocating midwifery care if required and ensuring the patient is reviewed at consultant ward round daily.

10 Monitoring Compliance

Please refer to the Monitoring and Auditing document for details on monitoring compliance for this protocol.

11 References

Confidential Enquiry into Maternal and Child Health 'Saving Mothers Lives (2007)

Confidential Enquiry into Maternal and Child Health 'Why Mothers Die' (2004)

NHSLSA CNST 2008

Department of Health Northwick Park Hospital. Investigation into Maternal Deaths at Northwick Park (2006)

12 Appendix A –Obstetric an Gynaecology contacts

RSCH	Ext
Obstetric SHO	Bleep 8610
Gynae SHO	Bleep 8611
Obstetrics SPR	Bleep 8612
Gynae SPR	Bleep 8618
Please Note: SHO & SPR on call cover both Obstetrics and Gynaecology after 20:30 hours Obstetric and Gynaecological Consultants can be reached via switch board	
The Labour Ward	**Ext 64373 or 64374**
Can be contacted at all times for advice regarding all pregnant women and their babies	
The Day Assessment Unit	**Ext 64392 or 67622**
Can be contacted from 09:00 to 17:00 hours Mondays to Fridays	
Labour Triage	**Ext 64793**
For patients suspected to be in early labour	
Early Pregnancy Assessment Unit (EPU)	**Ext 64402**
Mondays to Fridays 08:00 – 16:00 (for early pregnancy review/assessment up to 18 weeks gestation)	
Gynaecological ward/Gynaecology Assessment Unit (GAU)	**Ext 64022 or 64013**
Can be used to book patients into the EPAU out of the hours stated above	

PRH	Ext
Obstetric SHO	Bleep 6035
Gynae SHO	Bleep 6037
Obstetrics SPR	Bleep 6036
Gynae SPR	Bleep 6223
Please Note: SHO & SPR on call cover both Obstetrics and Gynaecology after 20:30 hours Obstetric and Gynaecological Consultants can be reached via switch board	
Central Delivery Suite (CDS)	**Ext 68485**
Can be contacted at all times for advice regarding all pregnant women and their babies	
The Day Assessment Unit	**Ext 65486**
Can be contacted 08:30 to 18:00 Mondays to Fridays	
Labour Triage	**Ext 68412**
For patients suspected to be in early labour	
Early Pregnancy Assessment Unit (EPU)	**Ext 65685**
Closed on Tuesday and Thursday	
Gynaecological ward	**Ext 65685**
Can be used to book patients into the EPAU out of the hours stated above	

13 Appendix B - Emergency Admission of Pregnant women flowchart