Calderdale and Huddersfield
NHS Foundation Trust

Maternity Services Clinical Guideline

DOCUMENT TITLE	**Guideline for ensuring appropriate management of maternity patients presenting to the Emergency Department (ED) and/or admitted to hospital** **Section 1:** Management of pregnant women presenting to ED **Section 2:** Process for ensuring awareness of all maternity patients admitted to hospital
DOCUMENT VERSION	4
SUPPORTING REFERENCES	See reference section page 10
TARGET AUDIENCE	Obstetricians, Midwives, Nurses, ED Doctors and Junior O and G Doctors
DISTRIBUTION	Trust Intranet
AUTHOR(S)	Kathy Kershaw – Clinical Governance Midwife
RATIFIED BY	Families and Specialist Services Directorate
DOCUMENT REPLACES	Version 3
DATE ACCEPTED	June 2018
AUTHORISED BY	Children, Women and Families Division
NEXT REVIEW DATE	June 2021
AMENDMENTS	Women who attend ED with reduced fetal movements should be referred to maternity services

Has this guideline been EQUIP'd? If so, please provide the unique EQUIP reference number below:

EQUIP-2018-063

For guidance click on this link: http://intranet.cht.nhs.uk/non-clinical-information/equality-and-diversity/equip-yourself/

This guideline has been registered with the trust.

Caution is advised when using guidelines after the review date.

IMPORTANT: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

Table of Contents

Section 1

Management of pregnant women presenting to the Emergency Department

Background

In sequential confidential enquiries and national investigations into maternal deaths, inappropriate triage in Emergency Department (ED), delayed treatment, failure to recognise severely unwell pregnant women and delayed involvement of obstetric personnel are cited as factoring significantly in some adverse maternal outcomes. Locally, infrequent, but still regular cases of the same problems are recognised as contributing to sub-optimal management. Early recognition of critical illness, prompt involvement of senior clinical staff and multi-disciplinary team working remain the key factors in providing high quality care (MBRRACE 2017).

Conversely, pregnant women presenting with minor injury or illness not associated with pregnancy may suffer delays in referral to appropriate care due to waits for non-urgent obstetric input, thus compromising care. Similarly, a pervasive perception that pregnant women must be cared for in ante-natal setting results in in-patient admission to clinical areas not accustomed to dealing with her presenting complaint, leading to sub-optimal care.

Aims

This section provides advice on the appropriate management of pregnant women who present to ED with pregnancy and non-pregnancy related problems.

It aims to assist staff to categorise pregnant women presenting to ED into categories, dependent on injury/disease and advise on appropriate management. In each case the involvement of the obstetric and midwifery staff for review or referral and their expected role is outlined.

This guideline does not deal with early pregnancy problems such as miscarriage and suspected ectopic pregnancy. Please refer to the approved trust guideline on early pregnancy problems.

Category 1 patients

Severe life threatening injury or condition including (peri) respiratory or cardiac arrest.

Action in ED

- Manage as per ALS/ATLS/MOET guidance **(Don't forget uterine displacement manually).**
- Obstetric/Gynae Registrar to be fast bleeped and to attend resus as soon as possible (Appendix 1). If they are not contactable or unable to immediately attend, contact the on-call obstetric consultant.
- Senior midwife to accompany SpR.
- Prepare resus area for emergency caesarean section (see appendix 2).

- Call the obstetric consultant on call if not already done.
- Contact the neonatal unit if delivery is imminent. **(But do not delay delivery awaiting neonatal team's arrival)**

Obstetrician's Role

- Attend ED as soon as possible.
- Ascertain the need for urgent or perimortem caesarean section.
- Ascertain the need for and progress of maternal resuscitation.
- If indicated perform perimortem caesarean section.
- If urgent delivery is indicated, plan the appropriate timing and place of delivery and liaise with appropriate departments (e.g. anaesthetics, theatres, ITU)
- Liaise with the ED staff to ascertain the cause of collapse and its subsequent management.
- Liaise with the on-call consultant.
- Handover the status and need for ongoing review of these women at shift changes

Senior Midwife's/LDRP Co-ordinator Role

- Contact consultant on-call if not already done.
- Call neonatal team if not already done.
- Allocate senior midwife to attend ED to assist in assessment, perimortem caesarean section and/or neonatal resuscitation
- Enact escalation policy if necessary.
- Liaise with staff in ED to keep track of events
- Liaise with theatre team as indicated.
- Handover the status and need for ongoing medical review/midwifery care of these women at shift changes. Record details in the file on LDRP “Maternity In-Patients on Non-Obstetric Wards” if the woman is admitted to a non-obstetric ward.

Interim Management

- If the patient does not survive, all lines to be left in situ and incisions left open.
- Coroner to be informed of a maternal death. reporting to be completed following the Maternal Death Guideline available on the trust Intranet.
- If the patient is resuscitated, ongoing obstetric input will be required
- Full range of investigations to search for a potential cause of the collapse should be completed if not already done and if the cause remains unknown.
- Multidisciplinary working with relevant specialties is crucial in organising appropriate further management.

Category 2 patients

Serious injury such as RTA or assault with abdominal trauma, or a serious medical emergency such as MI or severe sepsis, and obviously shocked

Action in ED

- Manage as per ALS/ATLS/MOET guidance **((Don't forget uterine displacement manually)**
- Obstetric/Gynae Registrar to be fast bleeped and to attend resus as soon as possible (Appendix 1). If not contactable or unable to attend immediately, contact the on-call obstetric consultant
- Senior midwife to accompany Registrar/consultant
- Prepare resus area for emergency caesarean section (see appendix 2)
- Call the obstetric consultant on call if not already done.
- Contact the neonatal team and unit if delivery is imminent. **(But do not delay delivery awaiting neonatal team's arrival)**
- Complete triage of patient and assess fetal gestation and viability. This is not primarily to assess fetal well-being but to influence maternal management.
- Management will depend upon specific injury or illness and the need and possible timing for delivery will vary. Maternal resuscitation and stabilisation should take precedence and delivery should be considered as a means to improve maternal resuscitation or treatment. Delivery should, wherever possible, be timed following optimisation of maternal condition, in the correct setting (e.g. theatre) with the appropriate personnel.

Obstetrician's Role

- Attend ED as soon as possible.
- Ascertain maternal status and assess fetal gestation and viability
- Ascertain the need for urgent or perimortem caesarean section.
- Ascertain the need for and progress of maternal resuscitation.
- If indicated perform perimortem caesarean section.
- If non-immediate delivery is indicated, plan the appropriate timing and place of delivery and liaise with appropriate departments (e.g. anaesthetics, theatres, ITU)
- Liaise with ED staff and other specialties to ascertain the extent of the injury or cause of the illness, and plan further management
- Liaise with the on-call consultant.
- Handover the status and need for ongoing review of these women at shift changes

Senior Midwife's/LDRP Co-ordinator Role

- Contact consultant on-call if not already done.
- Call neonatal team if indicated and not already done.
- Allocate senior midwife to attend ED and assist in assessment, perimortem caesarean section and/or neonatal resuscitation
- Enact escalation policy if necessary.

- Liaise with theatre team as indicated.
- Handover the status and need for ongoing medical review/midwifery care of the woman at shift changes. Record details in the file “Maternity In-Patients in Non-Obstetric Wards” on LDRP if the woman is admitted to a non-obstetric ward.

Interim Management

- Dependent on the precise nature of the injury and management will depend upon the review and advice of relevant specialties.
- Full range of investigations to search for a potential cause of the collapse should be completed if not already done and if the cause remains unknown. Multidisciplinary working with relevant specialties is crucial in organising appropriate further management.
- Maternal condition may involve compromise of one or more body system; therefore, after initial resuscitation and possible delivery seeking advice of HDU/ITU staff and arranging ongoing care is vital.

Category 3

Serious injury such as RTA or assault with abdominal trauma, or a serious medical emergency such as MI or severe sepsis, and is apparently stable

Action in ED

- Manage as per ALS/ATLS/MOET guidance **((Don't forget uterine displacement manually)**
- Obstetric/Gynae Registrar to be bleeped and to attend ED within 10 minutes (Appendix 1). If they are not contactable or unable to attend, contact the on-call obstetric consultant.
- Midwife to accompany the attending obstetrician.
- Assist in completing the triage of the patient. Assess fetal gestation and viability.
- Full range of investigations to search for a potential cause of the woman’s condition should be completed if not already done so and if the cause remains unknown. Multidisciplinary working with relevant specialties is crucial in organising appropriate further management.

Obstetrician's Role

- Attend ED as soon as possible.
- Ascertain the need for and progress of maternal resuscitation.
- Assist with completion of the patient assessment including auscultation of the FH.
- Advise on additional aspects of resuscitation and further investigation.
- If non immediate delivery is indicated, plan the appropriate timing and place of delivery and liaise with appropriate departments (e.g. anaesthetics, theatres, ITU)
- Liaise with the ED staff and other involved specialties to ascertain extent of the injury or cause of the illness, and ongoing management. Aim to treat primary presenting problem.

- If admission is required women should be admitted to the clinical area most able to provide the appropriate management. **Admission to LDRP/Ward 9 should only be considered if pressing obstetric/social/capacity concerns necessitate it**.
- The on call obstetric team must ensure appropriate review of these women wherever located and handover care to new team at safety briefings.
- Liaise with the on-call consultant.

Senior Midwife's/LDRP Co-ordinator Role

- Contact consultant on-call if not already done.
- Allocate experienced midwife to attend ED if judged necessary by obstetrician.
- Enact escalation policy if necessary.
- Record details in the file on LDRP "Maternity In-Patients on Non-Obstetric Wards" if the woman is admitted to a non-obstetric ward.
- Ensure provision of midwifery staff to fulfil any monitoring or ante/post-natal care needs in other clinical areas as required. This must be handed over at each shift change.

For women in the above 3 categories presenting at ED in Huddersfield:

During working hours – call the Registrar on call in Huddersfield and ring Antenatal Clinic to see if consultant is available
Between 5pm and 8.30am – ring on call consultant.

Category 4 patients

Major medical illness potentially requiring admission, e.g. severe asthma/suspected PE.

Action in ED

- Manage as per normal protocols for that condition.
- Obstetric/Midwifery input may be required, therefore contact the Maternity Unit.
- Dependent on the clinical situation, SpR/SHO to review and/or inform the consultant of admission.
- Daily review/status check of the patient in relevant clinical areas.

Obstetrician's Role

- Liaise with ED staff regarding concerns and review patient in ED or relevant clinical area or delegate to SHO.
- If admission is required women should be admitted to clinical areas most able to provide the appropriate management. **Admission to LDRP/Ward 9 should only be considered if pressing obstetric/social/capacity concerns necessitate it**. ‘
- The on call obstetric team must ensure appropriate review of these women when admitted, wherever located and handover care to new team at safety briefings.
- Liaise with the on-call consultant where required.
- Inform the LDRP co-ordinator of admission so this can be recorded in the file on LDRP "Maternity In-Patients on Non-Obstetric Wards"

Senior Midwife's/LDRP Co-ordinator Role

- Ensure midwifery care is provided where necessary
- Update the file "Maternity In-Patients on Non-Obstetric Wards" daily.

Category 5 patients

Minor injury or medical illness not necessarily requiring admission, e.g. minor fracture or mild asthma attack.

Action in ED

- Manage as per normal protocols and treat as appropriate.
- If there are no fetal or obstetric concerns, discharge as appropriate.
- All pregnant women attending with reduced ED with reduced fetal movements should be referred to either the Maternity Assessment Centre (MAC) or Antenatal Day Unit (ANDU) as soon as possible.
- If there is a history of reduced fetal movements, bleeding per vagina, headache, raised blood pressure or history of a knock to the abdomen or abdominal pain or concerns or anxiety; then an antenatal review would be indicated by an obstetric/gynae doctor or midwife.
- It **may** be appropriate for the women to be reviewed in ED or Maternity Assessment Centre (MAC) after discussion with a midwife, the obstetric registrar or SHO on call. If the woman is to be reviewed in MAC or other maternity areas she should be escorted to the area.
- NB: have a low threshold for suspected thromboembolic disease and possibly escalate to category 4.

Obstetrician's Role

- Liaise with ED staff regarding concerns providing advice and possibly review, either in ED or ANDU/MAC prior to planned discharge.
- Review all women complaining of abdominal pain, bleeding per vagina, reduced fetal movements and raised blood pressure. (Where appropriate these women may be sent to ANDU/MAC for review following discharge from ED)
- If the woman is to be reviewed in MAC/ ANDU or other maternity areas she should be escorted to the area.
- If the woman is admitted to hospital, inform the LDRP co-ordinator so this can be recorded in the file on LDRP "Maternity In-Patients on Non-Obstetric Wards"

Senior Midwife's/LDRP Co-ordinator Role

If the woman is admitted:

1. If the woman is to be referred to MAC or other maternity areas the Senior midwife/ LDRP Co-ordinator should ensure that the woman is escorted to the area and not left to find her own way there.
2. Ensure midwifery care is provided where necessary
3. Update the file "Maternity In-Patients on Non-Obstetric Wards" daily.

Category 4 & 5 women presenting in Huddersfield

During working hours – call the on call registrar in Huddersfield or midwife in Huddersfield Birth Centre or Antenatal Clinic
Between 5pm and 8.30am and out of hours contact LDRP at CRH.
If women are referred to the Antenatal Day Unit (ANDU) at the Cedar Wood in Huddersfield they should be escorted to the area.

Category 6 patients

Stable women with an obstetric problem with no other issues, e.g. labour, PV bleeding, abdominal pain, reduced fetal movements, raised blood pressure or headache.

Action in ED

- All pregnant women attending with reduced ED with reduced fetal movements should be referred to either the Maternity Assessment Centre (MAC) or Antenatal Day Unit (ANDU) as soon as possible.
- Contact the maternity unit via the midwifery co-ordinator on LDRP.
- Transfer to ANDU/MAC/LDRP as advised by above.
- If the woman is to be reviewed in ANDU/ MAC/ LDRP she should be escorted to the area.

(If these women have presented to ED in Huddersfield, during working hours the on call registrar can assess if the patient can be managed in ANDU at HRI depending on gestation and severity of symptoms). Out of hours contact MAC or LDRP at CRH.

Category 7 patients

Attempted suicide or psychiatric problem

Action in ED

- If the midwife or the woman has significant concerns, the woman should normally be referred for further assessment to the relevant mental health service:
  Single Point of Access Calderdale 01422 222888

- Psychiatric services to be contacted following the Guideline for. The Care of Pregnant Women Suffering Maternal Mental Health Problems available on the Intranet.
- Associated injuries/illness to be treated appropriately as per previous categories.
- If there is a history of reduced fetal movements, bleeding per vagina, headache, raised blood pressure or history of abdominal trauma or abdominal pain, call the obstetric Registrar on call for advice and possible review.
- The on call team should inform the patient's consultant or assign a consultant as per unit policy.
- Contact the LDRP co-ordinator to inform community midwifery team and Eden team.

- Antenatal follow-up (with community midwife or consultant as appropriate) appointment to be arranged within 10 days of discharge from hospital or psychiatric care.

Category 8

Domestic violence (suggested or confirmed)

Action in ED

- Treat any injuries sustained as discussed depending on the category.
- If there are any obstetric concerns, a history of reduced fetal movements, bleeding per vagina, headache, raised blood pressure or history of a trauma to the abdomen or abdominal pain; or concerns raised by the woman then please contact the maternity unit via LDRP for advice and possible review.
- Child protection protocols should be enacted, even if this is her first pregnancy.
- Contact the LDRP co-ordinator to ensure community midwifery follow-up
- Provide support and information, explaining that violent assault by a partner represents a real potential threat to her life in the future, the willingness of police to protect her and the availability of domestic violence support organisations
- Please refer to the Trust Midwifery Domestic Abuse Guideline available on the Intranet.

Section 2

Process for ensuring awareness of all maternity patients admitted to hospital

Background

The Confidential Enquiry into Maternal and Child Health (CEMACH) produced in 2004 suggests that care provided to women may be hampered by a lack of cross disciplinary working including not only between GP's and midwifery and obstetric services but also between consultants in different specialities and between staff in ED and the maternity service.

Local Issues

The Calderdale and Huddersfield NHS Foundation Trust operate two acute hospitals on separate sites.

On the Calderdale Royal Hospital (CRH) site, ED services are provided along with inpatient maternity services and high risk obstetric services, acute medicine and elective surgery.

On the Huddersfield Royal Infirmary (HRI) site, ED services are provided along with outpatient obstetric services (Antenatal Clinics and Antenatal Day Unit) and a free standing Birth Centre, acute surgery and medicine.

Guidance

The on call obstetric team should be made aware of all maternity women admitted anywhere in hospital, whether the admission is for an obstetric cause or not.

1. Process for Assessing Women on the Obstetric Unit:

1. The hot week or weekend on-call consultant will conduct a ward round on LDRP (Labour, Delivery, Recovery, and Postnatal) and Ward 9 (ante-natal ward) at least once a day to ensure that all pregnant women have been appropriately reviewed and those who are seriously unwell fully assessed.

2. Medical staff of appropriate seniority will visit Ward 1D daily to ensure post natal women with complications are reviewed and treated and discharges facilitated.

3. On the CRH site it is expected that women seen in the ED Department with problems **related to their pregnancy** will be seen either in ED by a member of the obstetric or gynaecology team, or will be transferred to the Antenatal Day Unit, Antenatal Ward, MAC or LDRP for assessment. (See section 1 of this guideline). If the woman transferred she should be escorted to the area and not left to find her own way there.

4. On the HRI site it is expected that the flow charts in place (see Birth Centre Protocols and CWF Obstetric and Gynaecology Pathways for Accident and Emergency Department) will ensure that those women who present with obstetric problems will be transferred to the appropriate service.

2. Process for ensuring all maternity in-patients in other clinical areas receive appropriate obstetric/midwifery input

It is the responsibility of the LDRP co-ordinator at CRH and midwife at HFBC, to ensure the on-call consultant is aware of all maternity patients on non-obstetric wards and that the women receive appropriate midwifery/obstetric care. This also works in conjunction with the existing Trustwide Patient Flow system.

All maternity in-patients elsewhere in the hospital will be briefly discussed at the LDRP Safety Briefing and documented on the safety briefing checklist form to ensure the team is fully aware of input required.

Failure to observe the above:

An incident form should be filled in whenever an obstetrician or midwife becomes aware of a woman who has been an inpatient in hospital but who was not notified to the obstetric team. A review of each case will then be undertaken by the Maternity Patient Safety Group to ensure that the lessons learnt can be fed back to the medical team responsible.

Monitoring

Refer to the Maternity Services Clinical Audit program

References

Saving Lives, Improving Mothers Care Report (2017), Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-2015. Oxford.

Training

The training requirement for all grades of staff is detailed in the Obstetric Mandatory Training Policy available on the Trust Intranet.

Trust Equalities Statement

This guideline has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

Document checklist

(Please note that this will be used for monitoring purposes and will be completed following completion of all stages of the above)

	Yes	No	N/A	Comments
Version number (footer)	✓			
Date fully ratified (footer)	✓			
Date for review of document	✓			**June 2021**
Reviewer identified	✓			**Kathy Kershaw**
Author (individual or team)	✓			
List of interested groups completed (including ratification dates)	✓			
Page numbered	✓			
Consistent font style – Trust format	✓			
Referenced to national guidance / expert opinion	✓			
Strength of evidence stated	✓			
Equality impact assessed	✓			
Arrangements for training detailed	✓			
List of changes and dates changed	✓			
Monitoring / audit process	✓			
Process for review of monitoring / audit results	✓			
Process for monitoring of resulting action plans	✓			
Guideline available on Trust intranet	✓			

Appendix 1

Contact Numbers & Details

- Obstetric registrar – bleep via switchboard. In emergency dial 300 and ask for obstetric crash call for registrar
- Consultant on-call: DECT phone or Mobile via switch board.
- LDRP: (01422 22)4420 or via switchboard
- Neonatal SpR on-call - bleep via switchboard. In an emergency dial 300 and ask for neonatal crash call for registrar and Tier 1 doctor(SHO)
- Adult resuscitation team: 2222

Appendix 2

Equipment Required For Perimortem Caesarean Section*
*This equipment should be available in the resus area of ED

- Videne
- Disposable scalpel