Derby Hospitals NHS
NHS Foundation Trust

Integrated care division

Trust Guideline

This guideline will impact on Maternity/Gynaecology & GUM business unit / Emergency dept / other clinical areas in the Trust

MANAGEMENT OF PREGNANT AND POSTNATAL WOMEN WHO PRESENT FOR CARE OUTSIDE THE MATERNITY SERVICE

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	1	Sept 2009	A. Meadows Risk Coordinator: Dr S Hewitt ED Consultant: Mrs K Dent Cons Obstetrician	CNST requirement
	2	Nov 2011	Mrs K Dent Cons Obstetrician: Dr E Burgess ED Consultant	To include gynae referrals
	3	Nov 2014	Mrs K Dent Cons Obstetrician: Dr E Burgess ED Consultant	Review
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In consultation with: Emergency Department, Gynae Development, Trust Guideline Group				
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Lead Signature	Chair of Maternity Development Committee: Dr J Ashworth		Date: 02/12/14 Sig: J. Ashworth	
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Approving Signature (2)	Head of Midwifery/Gynae & GUM: Mrs J Haslam		Date: 14/11/14 Sig: J. Haslam	
Approving signature (3)	ED Consultant: Elizabeth Burgess		Date: 03/12/14 Sig: E. Burgess	

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Contents

1. Introduction

A pregnant or postnatal woman should be seen by an obstetrician or midwife. This professional will be aware of the complications of pregnancy and the postnatal period. Pregnant and postnatal women may also present:

- At Emergency Departments (ED)
- Admitted onto other wards and assessment areas within the Trust
- Walk in centres
- Sure Start & Childrens Centres
- General Practitioner surgeries

Staff in these areas will need the support of the Maternity Services and this guideline should serve to raise awareness of the Maternity Services and the support they provide.

2. Purpose and Outcomes

The Confidential Enquiry into Maternal and Child Health 'Why Mothers Die' 2000-2002 (2004) and "Saving Mothers Lives" 2003-2005 (2007) made recommendations regarding the management of pregnant and postnatal women in ED. This guideline is based on those recommendations.

3. Abbreviations

ANC - Antenatal Clinic
ßHCG - Beta Human Chorionic Gonadatrophin

CMW - Community Midwife
ED - Emergency Department
MAU - Medical Assessment Unit
PAU - Pregnancy Assessment Unit
RTC - Road Traffic Collision
SAU - Surgical Assessment Unit

4. Information

The Maternity Services for Derby Hospitals NHS Foundation Trust provide care for women and their babies from booking until 42 days post delivery (obstetric care) and approx 28 days post-delivery (midwifery care)

5. Points of Contact

- The on-call Registrar or consultant can be contacted via switchboard
- The Labour Ward can be contacted at any time (Tel: 01332785141) for advice regarding all pregnant and postnatal women and their babies.
- Midwifery advice can be sought on 01332 785796 (24hours) Pregnancy Assessment Unit
- Staff in the Antenatal Clinic can provide advice 08:30 until 16:30 Monday to Friday (Tel: 01332 785671)
- Pregnant women, gestation less than 20 weeks, can be referred to Gynaecology by bleeping the on call Registrar or by their General Practitioner.

6. Women Presenting Outside the Maternity Services

In addition to the Why Mothers Die (2005) recommendations, the Saving Mothers Lives (2007) document has specific recommendations for the management of pregnant and postnatal women attending Emergency departments (p230). These are:

1. All Emergency Department (ED) clinicians must, at the start of their post and at regular intervals thereafter, have regular training delivered by Women and Childrens Directorate staff. This training will include the identification and management of:

    - The sick pregnant woman.
    - The sick postpartum woman.
    - Ectopic pregnancy (see 6.4 below)
    - Pregnant women with the following signs and symptoms, and any other otherwise unexplained signs, must be reviewed by an experienced doctor from the obstetric team:

        - Severe vaginal bleeding
        - Abdominal pain
        - Severe headache
        - Visual disturbances
        - Hypertension
        - Proteinuria
        - Breathlessness
        - Pyrexia
        - Chest pain
        - Convulsions

2. Pregnancy testing should be routine for all women of child-bearing age with a potentially pregnancy-related condition.

3. All women of childbearing age who present with any abdominal pain should have ectopic pregnancy excluded as part of their diagnostic work up. (Dipstick testing for ßHcG is now quick, easy and sensitive).
4. All ED staff should be aware of the dangers of ectopic pregnancy and have an awareness of the atypical clinical presentation of the condition, especially the way in which it may mimic gastrointestinal disease. The location and understanding of the Guideline for Management of Ectopic Pregnancy should be included in all induction programs for all ED and Obstetric Staff.
5. The management of women who are acutely ill/collapsed for non-obstetric reasons should include early liaison with (as appropriate):

    - Obstetrics and Maternity Services
    - Intensive Care Unit and/or High Dependency Departments
    - East Midlands Ambulance Service
    - MAU & SAU as required

6. Following each ED attendance the named GP will receive an electronically generated letter. The GP will communicate with the primary care team as required (e.g., community midwife, Health Visitor).
7. Triage nurses should ensure that pregnant and postnatal women are recognised as potentially high risk.
8. Pregnant and postnatal women attending the emergency department (ED) should be seen as soon as possible by a doctor, and those with anything other than very minor physical injuries should be seen in conjunction with an obstetrician or midwife. Consideration must also be given to possible domestic abuse.
9. All pregnant women involved in Road Traffic Collisions (RTC), however minor, should have an antenatal assessment of fetal well being by a senior midwife or an Obstetrician. This can be arranged by contacting the duty Obstetric Registrar via switchboard or the Labour Ward co-ordinator. This assessment will take place in PAU or Labour Ward, as appropriate. Triage nurses should ensure that pregnant and postnatal women are triaged appropriately. Triage training will include facets of the altered physiology of pregnant and postnatal women.
10. If the condition of the woman is critical following a RTC or other injury immediate assistance should be requested of the Obstetric team.
11. Ideally, peri-mortem Caesarean section should be carried out within 5 minutes of maternal cardiac arrest to facilitate resuscitation. In addition, the baby must be delivered within 5 minutes of the procedure being started to facilitate resuscitation.
12. The Obstetric Registrar on-call or Labour Ward Co-ordinator should be informed via switchboard of all sick pregnant and postnatal women admitted within the hospital. The Obstetric Registrar is responsible for informing the duty consultant.
13. Women with a medical condition requiring treatment and hospitalisation should be discussed and planned in conjunction with the local Obstetric team. The name of the woman will be recorded on the white board on the labour ward to aid continuity of review.
14. The on-call Obstetric Consultant to be updated at regular handovers on labour ward of any sick pregnant women in the hospital with an obstetric problem e.g. ITU

7. Ambulance Service Involvement

- Prompt attention by the most appropriate professional team can lead to improved outcomes.
- Ambulance personnel should be aware of the conditions in which direct referral to the Labour Ward is most appropriate.

8. Pregnant women who should be referred directly to the Labour Ward

The on-call Registrar or Labour Ward Co-ordinator should be informed of all women presenting after 20 weeks gestation complaining of:

- Severe headache, nausea, vomiting or epigastric pain, or generally feeling unwell.
- Pregnant women with a blood pressure of over 140/90 mmHg with or without proteinuria
- Pregnant women over 20 weeks who are bleeding PV and/or whose membranes have ruptured.
- Pregnant women in labour - any gestation greater than 20 weeks.

9. Pregnant women who should be referred directly to the GAU/Ward 209

Women who experience bleeding and or pain in early pregnancy are very anxious and need reassurance that all is well with their pregnancy. This can often only be achieved by ultrasound scanning if the pregnancy is less than 15weeks gestation, after this stage listening for a fetal heartbeat is as effective.

The GAU is open 7 days a week 9am to 4.30pm with scans available Monday to Friday and a limited scan service for urgent cases on Saturday. There is an appointment service which is essentially nurse led for scanning (Medical staff are available to see urgent cases and these must be referred to the on call SHO or Registrar)

P.V. Bleeding

If a woman complains of bleeding PV which is less than a normal period, and has no pain, she should be reassured that this is not always significant, but the nurse should ring the Gynae assessment unit for advice and if appropriate they will arrange a scan for her. (Scans are not offered if the pregnancy is less than 8 weeks gestation as these are often inconclusive and therefore may defer an appointment until that stage) After 4.30pm the unit is closed and the diary for appointments is kept on ward 209.

If the woman's pregnancy is greater than 12 weeks gestation it is important to know her blood group as she may need an injection of anti D within 72hours of the bleed if she is rhesus negative.
If the pregnancy is over 15weeks and the bleeding is not heavy she should be reassured by listening to the fetal heartbeat. If this cannot be performed in the ED then it should be arranged for the woman to see a community midwife if she is well enough to go home. Otherwise she should attend GAU for assessment and to listen for the fetal heartbeat. However a scan appointment may not be available immediately if the fetal heartbeat cannot be heard with Sonicaid. The blood group needs to be known.

Heavy P.V. Bleeding

If a woman has heavier bleeding than a period with clots then she must be transferred to a gynae ward for urgent admission. Bloods must be taken including a Full Blood Count and Group and Save serum.

Pain

If a woman is complaining of lower abdominal pain particularly one sided (with or without PV bleeding) and her pregnancy is less than 9 weeks gestation then an ectopic pregnancy must be considered and the woman must be referred to gynae for further assessment, (if she is stable an appointment can be given). The transfer must be discussed with the on call SHO.

Tests to be undertaken include:

- Group and Save serum,
- FBC and
- ßhcg (red topped bottle)
- Pregnancy Test on urine if there is a doubt of pregnancy.

If the woman is in severe lower abdominal pain ,has a positive pregnancy test and feels faint or has signs of shock then the Gynae Registrar must be consulted urgently (Guidelines for the Initial Diagnosis and Management of Suspected Ectopic Pregnancy in the Accident & Emergency Department (E4)).

See appendix A & B

10. Pregnant Women who should be referred directly to the Emergency Department

- RTA victims who have sustained potential or actual injuries
- Pregnant/Postnatal women who have sustained traumatic injuries
- Pregnant/Postnatal women who have taken an overdose of any substance.
- Any other circumstances where the woman's life or wellbeing is potentially threatened.
- Any circumstance where the stability of the woman would be compromised by further distance travelled.

These guidelines cannot anticipate all possible circumstances and exist only to provide general guidance on clinical management to clinicians.

Guidance from the Disability Discrimination Act will be implicit in all Maternity Women and Children's Guidelines

11. Monitoring Compliance and Effectiveness

Monitoring requirement	Health records of pregnant women admitted to ED and other medical wards.
Monitoring method	Retrospective case note review
Report prepared by	Named individual undertaking audit
Monitoring report sent to:	Maternity Risk Group
Frequency of report	As per agreed audit forward programme

12. References:

Confidential Enquiry into Maternal and Child health 'Saving Mothers Lives 2003-2005 (2007)

Confidential Enquiry into Maternal and Child Health 'Why Mothers Die' 2000-2002 Ed 2004

NHS Litigation Authority CNST Standards 2008

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

ED Management of PV Bleed in Early Pregnancy

(<15 weeks)

Observations
IV access
FBC, G & S, (Serum βHCG if not confirmed intrauterine pregnancy)
Consider anti-D if Rhesus negative and >12 weeks pregnancy

Light bleeding/spotting. Mild/no abdominal pain.

No previous USS or USS confirms intra-uterine pregnancy

Possible Miscarriage

Light Bleeding/spotting. Unilateral abdominal pain.

No previous USS

Possible Ectopic
(**Refer to Trust guidelines**)

Heavy bleeding with clots/products. Cramp-like abdominal pain. No previous USS or USS confirms intra-uterine pregnancy

Likely Miscarriage

Full Assessment of Patient

Haemodynamically stable. No signs of peritonism

If possible miscarriage, phone GAU for further advice 9am-4pm (ext: 86525) or Gynae Nurse-in Charge out of hours (phone 07879115877) to arrange a GAU appointment. Ask the patient to phone GAU the following day to confirm appointment time

For all other cases, contact Gynae SpR on-call (bleep 2206) to discuss case. Then contact GAU 9am-4pm or ward 209 out of hours via Gynae Nurse-in-Charge to transfer patient to the ward. The patient is not to wait in the ED for gynae review unless haemodynamically compromised

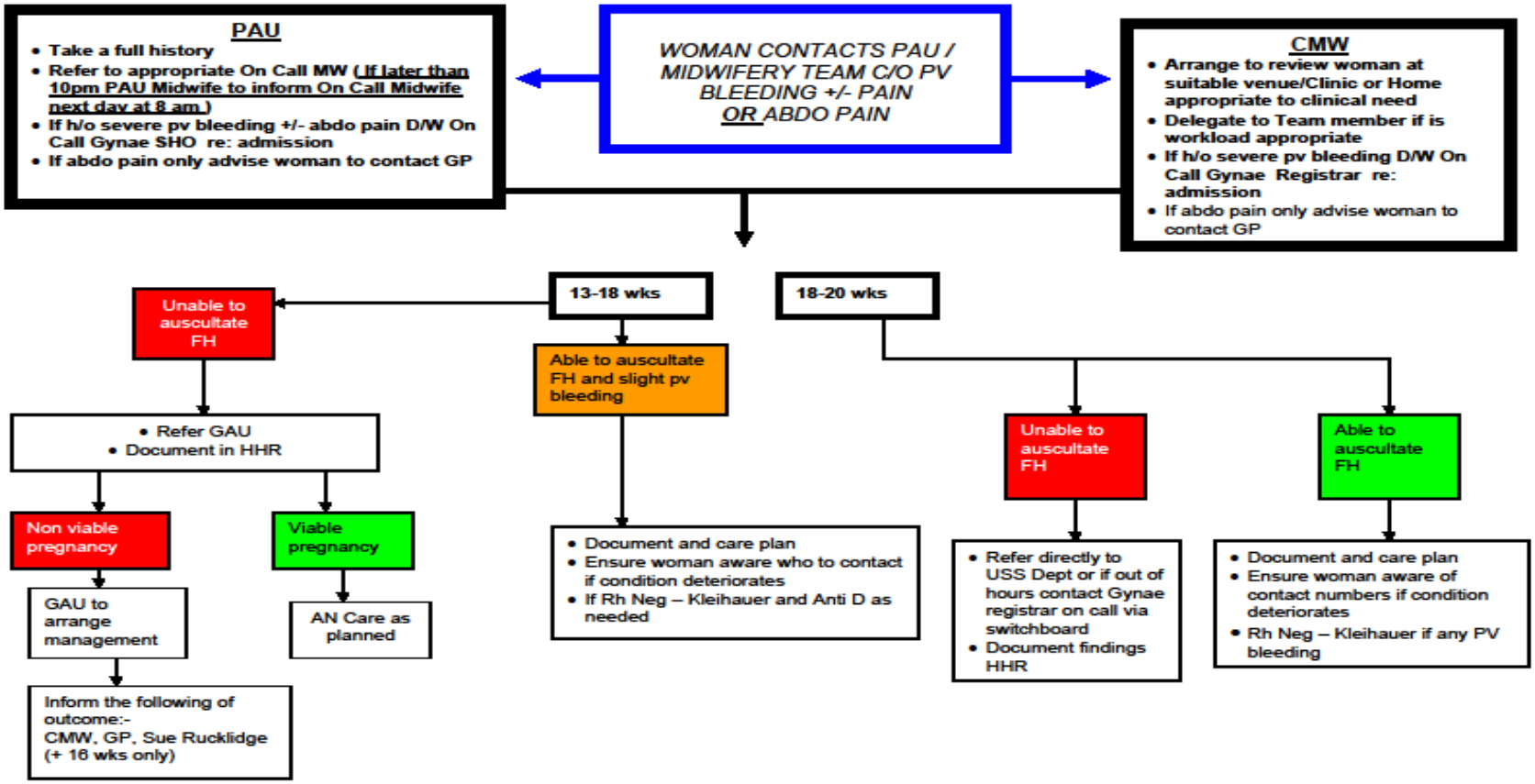
Haemodynamically compromised or signs of peritonism

Summon senior ED help. Large-bore IV access x2 X-match 4U IV fluids.

Resuscitate in Resus. Contact Gynae SpR on call (bleep 2206) and Gynae Nurse in Charge

If no response from Gynae SpR in 20 minutes (or significant expected delay), phone Labour Ward to locate them (ext: 85141). If this fails, inform Gynae Nurse-in-Charge again and and contact Gynae consultant on-call to discuss case.

Referral Pathway for women between 13-20 wks pregnant



Gynae/Maternity/04:2011