Burton Hospitals
NHS Foundation Trust

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Labour Ward Lead	All Obstetric Medical Staff All Anaesthetists All Midwives	Emergency Department
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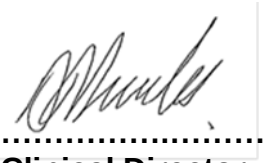
Trust: Minimum Observations Standards **Directorate:** Maternity Services Training Needs	All Obstetric Staff All Anaesthetists All Midwives Emergency Department Critical Care Unit Pharmacy department Delivery Suite Users Group All Senior Nursing/Midwifery Managers	Directorate of Women and Children's Guidelines Intranet Server
Approved by: Clinical Director for Women & Children's' Services	 **……** **Clinical Director** **Date: 24th May 2018**	

Guideline Updates and Amendments

Version	Type of Change	Date	Author
4	Routine review – no changes made	28th May 2015	Sue Harrison Labour Ward Manager
5	Minor amendment to section 4.3, bullet point 1 to identify frequency of observations for stable high risk antenatal and postnatal – as individually determined by clinical condition and plan of care	7/1/2016	Helen Hurst Matron, Maternity In-patients
6	Routine review – only changes made were in section 6.2.1: course now PROMPT rather than Emergency Skills Drills	24th May 2018	Sue Harrison Labour Ward Manager
6.1	Safety reviewed awaiting National guidelines. Safe to use until 01/01/2022. No changes made.	01/04/2021	Maternity Guidelines Group
7	To reflect updated MEWS chart	June 2023	Sarah Evans - Matron
7.1	To include escalation process following implementation of new MEWS chart	March 2024	Lauren Wilkinson - Risk Support Midwife

Burton Hospitals NHS Foundation Trust
Directorate of Surgery
Department of Obstetrics

Early Recognition of the Acutely Ill Pregnant Woman

1.0 Introduction

The recognition of severely ill women in pregnancy or during the postnatal period is a continuing challenge to care providers. The use of a modified early warning scoring system which takes into consideration the physiological changes in pregnancy and highlights developing abnormalities in the patients' condition will assist in the detection of potentially life threatening illness.

2.0 Scope

This guideline covers the following patient groups:

- All low risk antenatal women
- All high risk antenatal women
- All low and high risk women during the intrapartum period
- All low risk postnatal women
- All high risk postnatal women

The Maternity Observation Chart is to be used for all obstetric inpatient admissions in the following locations:

- All pregnant women of ***sixteen weeks gestation*** or greater; cared for on the ***maternity unit***
- All women admitted with hyperemesis at any gestation to the maternity unit
- All postnatal women
- Samuel Johnson Midwife Led Unit

All maternity patients in the critical care unit should be monitored according to ITU/HDU monitoring standards. Monitoring will be transferred to the maternity observation charts when they are transferred from HDU/ITU back to the wards.

3.0 Responsibilities

It is the responsibility of all staff providing care to a pregnant patient to undertake the required observations in accordance with the Trust Minimum Observations (2009) document. opac-retrieve-file.pl (koha-ptfs.co.uk)

3.1 Individual Responsibilities

- Staff must maintain and update their knowledge and practice and ensure that they

complete any competency based assessments of practice as defined for their role within the Minimum Observations Standard Policy.

- All NHS employees are responsible for any records which they create or use, and are also responsible for adherence to the Trusts defined Record Keeping and Records Management Policies and Procedures.
- The midwife in charge of the patients care during a shift is responsible for ensuring observations are undertaken and actions initiated as appropriate.
- When physiological observations or MEWS are delegated by registered practitioners and completed by unregistered staff (e.g. delegated to student midwife or maternity support worker), professional accountability remains with the registered professional. It is therefore essential registered practitioners review the frequency of observations, acceptable parameters and all charts.
- Individual staff using medical devices are responsible for ensuring that the device is within service date before use and to report any suspected problems to Medical Electronics.
- Each member of staff is professionally accountable for identifying items of equipment for which they require training.
- Doctors are required to review patients who trigger on the MOEWS with 2 yellow boxes or 1 red box within 30 minutes. If 2 red boxes trigger the review should be escalated for immediate review..

4.0 The Maternity Observation Chart

The maternity observation chart is a colour coded chart that sets colour parameters to identify deviation from the norm. It is based on a graded response strategy for patients identified as being at risk of clinical deterioration.

4.1 When to Use

A maternity observation chart will be commenced at the beginning of each inpatient admission and will accompany the patient throughout that episode of care

At each and every subsequent admission, a new maternity observation will be commenced

4.2 Observations to be undertaken

On admission all women will have as a minimum the following observations undertaken:

- Systolic blood pressure
- Diastolic blood pressure
- Respiration rate
- Pulse rate
- Temperature
- Urine analysis
- Respiratory rate
- Oxygen saturation %

Additional observations may include:

- Level of consciousness (AVPU)
- Pain score

The AVPU scoring tool will be used to assess the patients best neurological response (additional information regarding AVPU) and uses an assessment through which

A = Alert - Alert, conscious and able to correctly answer name, date, time and location.

V = Responds to Voice - Responds to voice. Not alert, is semi conscious but responds to a raised voice even if only groans or moans. Ensure patient is not deaf.

P = Responds to Pain - Responds to pain stimuli.

U = Unresponsive – the patient is unresponsive.

4.3 Frequency of monitoring

Frequency of monitoring is dictated by clinical status, but routinely will fall into one of the following areas:

- Stable high risk antenatal and postnatal – as individually determined by clinical condition and plan of care
- Post-op 1/2 hourly for 2 hours, hourly for 2 hours, 2 hourly for 4 hours then 4 hourly **(Note: Temp 4 hourly unless temp > 37.5)**
- Patient receiving morphine IM or PCA - hourly for first 4 hours, 2 hourly for next 8 hours, 4 hourly thereafter
- Normal labour - 4 hourly BP, Epidural during labour - hourly BP. Temp and pulse will be recorded on the partogram
- Low risk antenatal and postnatal - Once a day observation

Certain women on the maternity wards who are not in an acute phase of illness may only require once daily observations. This should be reflected in the management plan.

For women with obstetric complications e.g. severe pre-eclampsia, the frequency of monitoring will be according to clinical need and reflected in the management plan.

5.0 Referral to Clinicians

The table below identifies appropriate responses and escalation to clinicians once triggers have been activated. An early medical review should be performed to determine any changes to the patient's management plan which must be documented in the patient health records.

This documentation must include observations required, frequency of monitoring and an identification of further indicators which will trigger further interventions.

		Score				
		2	1	0	1	2
Vital Sign	Respirations Breaths/min	<=6	7-8	9-21	22-24	>=25
	SpO_2 Oxygen saturation (%)	<=92	93-94	>=95	-	-
	Temperature °C	<=35.6	35.7-36.1	36.2-37.2	37.3-37.4	>=37.5
	Pulse Beats/min	<=62	63-70	71-112	113-121	>=122
	Pulse (from 48 hours post birth) Beats/min	<=50	51-57	58-98	99-107	>=108
	Systolic blood pressure mmHg	<=93	94-100	101-135	136-144	>=145
	Diastolic blood pressure mmHg	<=56	57-61	62-88	89-96	>=97

Thresholds and triggers

- The grade of medical team member indicated as the primary contact for each level of clinical concern is a guide and may need to be adapted depending on the local skill mix within that care setting or organisation

Level of concern	Low	Low-medium	Medium	High
MEWS	0-1	2-4	5-7	8 or more
Primary escalation & response (Use SBAR framework)		Review by midwife in charge	Urgent review by midwife in charge	Immediate review by midwife in charge
		Request review by ST1/2 or equivalent	Urgent review by ST3+ or equivalent and consultant made aware of plan Consider anaesthetic review	Immediate review by ST3+ or equivalent, consultant and anaesthetic team Consider review by outreach team
Medical review timing		Within 30 minutes	Within 15 minutes	Immediate
Minimal vital signs recording until medical review/ongoing plan	Continue with current observation frequency	Reassess observations within 30 minutes & document ongoing plan	Reassess observations within 15 minutes & document ongoing plan	Continuous observations
Secondary contact		ST3+ or equivalent	Consultant or equivalent	Clinical outreach team or equivalent

- When the primary team member(s) contacted is unable to attend or fails to attend within the expected time for the level of clinical concern, escalation to the secondary contact is required
- The secondary contact would be expected to attend within the initial medical review timing, calculated from the documented time of primary escalation
- The section **pulse (from 48 hours after birth)** cut-offs should be used for all women from 48 hours after birth. The time and date from which these values should be used should be entered on the front of the chart.

An immediate medical review is required for patients who trigger a high score. This may include referral to an appropriate specialist. In urgent cases, referral can take place by telephone contact followed up by a fax if necessary.

N.B: Any patient experiencing unexplained pain severe enough to require opiate analgesia requires urgent senior assessment/review (CMACE, March 2011).

For cases of clinical emergency or cardiac arrest the nationally recognised number 2222 is used to call the appropriate emergency team and the trigger phrases “Obstetric Emergency” or “Cardiac Arrest” used as appropriate.

Involvement of the critical care team is taken in accordance with the guideline “Involvement of Critical Care Services for Obstetric Patients.”

6.0 Training

It is expected that training on recognition of the acutely ill pregnant patient and maternal resuscitation is accessed as follows. This training is now included in the Prompt training day.

6.1 Maternal Resuscitation

In accordance with the Trust Resuscitation Policy all staff are required annually to attend a basic adult resuscitation training session.

6.2 Recognition of the Acutely Ill Pregnant Patient

6.2.1 Staff new to the Trust

- All midwives newly appointed to the Trust are expected to attend a Prompt training day within the first twelve months of their employment. Following this they will attend a Prompt training day annually.

- All Obstetric Registrars/Consultants newly appointed to the Trust are expected to attend a Prompt Training day with the first twelve months of employment. Following this they will attend a Prompt training day annually.

- All Obstetric Anaesthetic Registrars/Consultants newly appointed to the Trust are expected to attend a PROMPT training day within the first twelve months of their employment. Following this they wiil attend a Prompt training day annually.

6.2.2 Established staff

Obstetricians, Anaesthetists and Midwives

Early recognition of the acutely Ill pregnant woman is now included in the Prompt training day which al established staff are expected to attend annually.

7.0 References

CEMACE (2011) Saving Mothers Lives

National Patient Safety Agency – 5th Report from the Patient Safety Observatory: Safer Care for the Acutely Ill Patient, learning from Serious Incidents

NCEPOD (2005) – National Confidential Enquiry into Patient Outcome and Death

NICE (2007) – Acutely Ill Patients in Hospital, NICE, London