University Hospitals of Derby and Burton NHS Foundation Trust

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Divisional Guideline	Clinical	23/08 /2023 Approved at divisional level by RD, SW and NS 23/08/23
Written	**Last Reviewed**	**Next Review**
February 2015	Aug 2023	June 2026
Responsibility:	**Essential Reading for:**	**Information for:**
Department of Obstetrics	All Obstetricians All Obstetric Anaesthetists All Midwives	-
Linked Guidelines/Policies:	**Consulted:**	**Stored:**
WC/OG/81Th: Maternity Theatre Recovery Guideline WC/OG/38A Critical Care of the Obstetric Patient WC/OP/08Ob – Management of Women Requiring Postnatal Readmission	Obstetricians Obstetric Anaesthetists Midwifery team ITU/HDU	1) KOHA

Version	Type of Change	Date	Author
1	New Document	Feb 2015	Vicky Simpson Midwife Practitioner
2	Amendments to clarify parameters of service	July 2016	Cath Askey Clinical Risk Midwife
3	Minor amendment to include Appendix 2	May 2017	Sue Harrison Senior Sister, Labour Ward
4	Review and Minor amendment	Jan 2019	Louise Baxendale Lead Obstetric Anaesthetist
5	Reviewed	June 2020	M. Thangavelu – O&G Consultant L. Baxendale Lead Obstetric Anaesthetist
6	Reviewed	June 2023	Sarah Evans - Matron
7	Amended to remove level 2 care on Labour ward	Aug 2023	Raymond Devaraj - CD, Mohammed Elriedy - Consultant anaesthetist, Joanna Harrison-Engwell - Lead midwife for guidelines and audit

Burton Hospitals NHS Foundation Trust
Directorate of Women and Children's Services
Department of Obstetrics

Enhanced Care on Labour Ward

9.0 Introduction

Enhanced care provision on labour ward is not based around a specified location; the facilities to provide enhanced care are transferable room to room via the use of the enhanced care lockable trolley. This is stored in the maternity recovery area.

The level of enhanced care required is dependent on the number of organs requiring support and the type of support needed. These levels as determined by the Intensive Care Society's 'Level of Care' document are:

Level 0	Patients whose needs can be met through normal ward care in an acute
Level 1	Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team. The patient's condition will be assessed using the MEOWS chart / HDU chart.
Level 2	Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.
Level 3	Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

2.0 Service Parameters

Labour Ward enhanced care is primarily for women requiring additional level 1 clinical support around the time of birth, namely:

- Antenatal women requiring stabilisation prior to delivery or transfer
- Intrapartum women for stabilisation prior to delivery
- Women in the immediate postpartum period requiring stabilisation prior to transfer to the postnatal wards
- Postpartum care for women who have yet to be discharged from hospital care following birth

Labour Ward enhanced care ***is not for***:

- Postnatal women readmitted to hospital from community care – please refer to clinical guideline UHDB/PDC/08:21/P7 Pregnancy Assessment & Maternity Assessment - Full Clinical Guideline
- Step down care from the hospital main HDU/Critical Care Ward
- Any woman requiring Level 2 or level 3 support

Postnatal readmissions are not a continuation of the birth episode; these women should be admitted under the service consultant/consultant on-call as appropriate. Admission should be to gynaecology, other medical/surgical ward as appropriate or to main HDU. Please refer to operational policy UHDB/PDC/08:21/P7 Pregnancy Assessment & Maternity Assessment - Full Clinical Guideline

The service is not to provide step down transitional care for women discharged from main HDU prior to admission to another ward. Women deemed fit for discharge from main HDU will need to be assessed as level 0 care with needs that can be met in a normal ward environment.

3.0 Clinical Criteria for Enhanced Care on Labour Ward

The following list identifies clinical conditions that are likely to require labour ward enhanced care; however, cases should be considered on an individual basis and this list is not exhaustive. The care provided to women will be level 1 only. Under no circumstances will women requiring level 2 or level 3 care be admitted to labour ward for enhanced care.

- Postpartum haemorrhage (not requiring any additional interventions stated in Appendix 1)
- Pre-eclampsia (provided there is no evidence of organ failure requiring support)
- Sepsis (not requiring any additional interventions stated in Appendix 1)

- Sliding scale for control of diabetes (excluding patients in DKA or any other sign of organ deterioration)

5.0 Consideration for transfer to HDU/ITU

Early consideration should be given to requesting intensive care advice on the management of women with difficult clinical problems. The consultant obstetrician and anaesthetist will need to liaise with the ITU/HDU consultant to discuss the suitability of transferring care of the women to ITU/HDU.

6.0 Responsibilities

The woman should receive one to one care by a named midwife for each shift. The decisions in the woman's care should be made by the obstetric consultant and the obstetric anaesthetist consultant. The woman should be reviewed by both teams twice a day at 09.00 and 16.00, and then at 22.00 by the consultant obstetrician and anaesthetic registrar, or more frequently if her condition deteriorates.

In the ideal case the woman should be reviewed by both consultants; however, if this isn't possible she should be reviewed by the senior obstetric registrar and obstetric anaesthetist on duty who will then discuss all aspects of her care with the consultant at the earliest opportunity. It is essential that the involvement of multidisciplinary team is utilised to ensure high level quality care. It may be necessary to work closely with the ODPss, Outreach nurses, ITU, haematology and blood bank.

7.0 Equipment

The facilities to provide enhanced care on delivery suite will be transferable to room to room by the use of the enhanced care trolley (blue) which will have the monitor and all other equipment locked away. This will be stored alongside the resuscitation trolley on labour ward. The additional equipment required to provide enhanced care:

- Continuous oxygen supply
- Continuous suction supply
- Adult resuscitation equipment & airway box
- Portable 12 lead ECG (Shared with other departments)
- Blood warmer
- Infusion devices
- Oxygen saturation monitoring
- Blood glucose machine
- Blood gas analyser
- Eclampsia box
- Major haemorrhage trolley

- Non-invasive blood pressure monitoring
- Relevant guidelines
- TED/Flowtron boots

8.0 Documentation

When the woman is admitted to labour ward for obstetric enhanced care the 'Maternity Enhanced Care Observation Chart' should be commenced. Hourly observations should be completed unless otherwise stated by consultant obstetrician or anaesthetist. Care should also be documented on the woman's note on the HISS system and the care plan should also be completed each shift.

9.0 Discharge

Step down from enhanced care on labour ward to the maternity wards should be a joint decision between the obstetric and anaesthetic consultant, involving other members of the multi-disciplinary team as appropriate. Consideration must be given to staffing levels, skill-mix and workload on the ward. The woman should be:

- Haemodynamically stable and requiring no intravenous access
- Medication must exclude IV fluids (many patients goes to ward with a need to continue IV antibiotics for further 24 hours, hence guideline group to consider to remove this item)
- Hourly observations are no longer required
- No active bleeding present
- No supplementary oxygen required
- The patient is mobilising

On transfer from Labour Ward enhanced care to maternity wards a summary of the woman's initial diagnosis, current condition, investigation discharge results and observations, should be documented in the postnatal health record, with a management plan for ongoing care. The maternity early warning observation chart (MEWS) should be recommenced. While in the postnatal ward, these patients should have a daily medical review. On the day of discharge, they should be reviewed by a registrar or consultant. A clear discharge summary should be made so that the community midwife/GP are fully updated about the hospital episode involving enhanced care.

10.0 References

Levels of Adult Critical Care second Edition, Consensus Statement, 2021, Intensive Care Society.

Examples of Maternity Care Required at ICS Levels of Support for Critical Care

The table below will help to decide which women will require further specialist care on the intensive care unit, as the highlighted care will not be provided on the delivery suite.

Level of Care	Maternity Example (this list is not exhaustive)
Level 0 – Normal ward care	- Care of low risk women
Level 1 – Additional monitoring or intervention, or step down from higher level of care.	- Risk of haemorrhage - Oxytocin infusion - Postpartum haemorrhage (not requiring any additional interventions and not amounting to signs of single organ failure requiring support ie: vasopressors) - Pre-eclampsia (provided there is no evidence of single organ failure requiring support) - Sepsis (not amounting to signs of single organ failure that requires support) - Sliding scale for control of diabetes (excluding patients in DKA or any other sign of organ deterioration)
Level 2 – Single organ support ***This care will not be provided via enhanced care on Labour Ward***	Respiratory Support (BRS) - Escalated oxygen via face-mask to maintain oxygen saturation Invasive respiratory support Cardiovascular Support (BCVS) - Arterial line used for pressure monitoring or sampling - CVP line used for fluid management and CVP monitoring to guide therapy Advanced Cardiovascular Support (ACVS) - Escalated use of intravenous, anti-arrhythmic /antihypertensive/vasoactive drugs - Need to measure and treat cardiac output Neurological Support - Magnesium infusion to control seizures (not prophylaxis) - Intracranial pressure monitoring Hepatic Support - Management of acute fulminant hepatic failure, e.g. from HELLP syndrome
Level 3 – Advanced respiratory support alone or support of two or more organ systems above. This care will not be provided via enhanced care on Labour Ward	Advanced Respiratory Support - Invasive mechanical ventilation Support of two or more organ systems - Renal support ad BRS - BRS/BCVS and an additional organ which needs to be supported (a BRS and BCVS occurring simultaneously during the episode count as a single organ support)

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Enhanced Maternity Care Admission

Location:

☐ PN day:

☐ AN gestation: weeks days

Name:

DOB:

HN:

Date:

Consultant Obstetrician:

Consultant Anaesthetist:

Date/time of delivery :

G P BMI:

Mode of delivery:

Admission to Enhance maternity care—details: Date: Time:

Reason for admission:

☐ PPH Amount: ml Cause:

Uterotonics:

☐ PET PCR: Reflexes:

Treatment:

☐ Sepsis Source:

Antibiotics:

Sepsis 6 ☐ lactate ☐ Oxygen ☐ ABX ☐ Blood cx ☐ urine ☐ IVF

☐ Other Details:

MEWS Observations:

A Airway concerns Y / N

B RR: O_2 Sats:

C HR: BP:

D Temp:

AVPU

Lines/access:

Urine output:

Uterine Tamponade Balloon / Drain / Vaginal pack:

Admission notes:

VTE score:

Bleeding risk: N / Y:

$MgSO_4$ start:

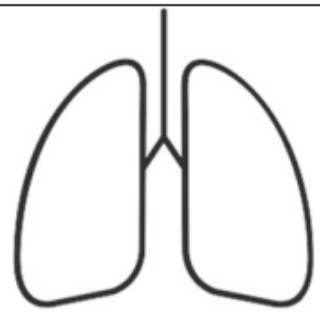
stop:

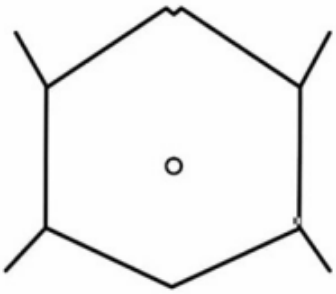
Units received / units given:	RBC:	FFP:	Cryo:	Platelets:

Allergies:

PMHx / Surgical HX:

Review:





Bowels:

PV loss:

Lines:

Reflexes:

Management plan:

Reviewed by:

Obstetrics:	Name:	Grade:	Signature
Anaesthetist:	Name:	Grade:	Signature

Enhanced Maternity Care Review

☐ **PN day:**

☐ **AN gestation:**

weeks days

Date / time:

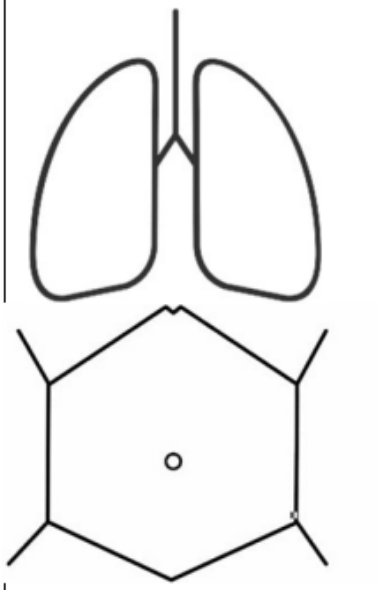
Location:

Consultant Obstetrician:

Consultant Anaesthetist:

Current issues:

Review:



PV loss:

Lines:

Reflexes:

Observations:

MEWS

A Airway concerns Y / N

B RR: O_2 Sats:

C HR: BP:

D Temp:

AVPU

Lines/access:

Fluid restriction: Y / N

Fluid input (24 hours)

ml/hr Target: ml/hr

Overall fluid balance (+/-)

Name: DOB: Hospital No:

	Today	Prev.		Today	Prev.
Hb			ALT		
WCC			Creat		
Neut			eGFR		
Plts			Coag		
Lactate			BA		
CRP			PCR		

Other results:

Imaging:

Microbiology:

Culture results:

Antibiotics:

Indication:

Start date:

Review date:

Plan:

Bloods: Next due:

VTE score: Bleeding risk: Y / N Enoxaparin: Y / N Next due:

Transfer to PN ward? Time of decision:

NSAIDs Y / N

Frequency of observations: ☐ 30 minutes ☐ Hourly ☐ 2-hourly ☐ 4-hourly ☐ Other:

Reviewed by:

Name: Grade: Signature:

Locally printed for trial—V2 August 2021