Pregnancy Assessment & Maternity Assessment - Full Clinical Guideline

UHDB/PDC/08:21/P7

Contents

1. Introduction

The Maternity Assessment Unit (MAU) at Queens Hospital, Burton, and the Pregnancy Assessment Unit (PAU) at Royal Derby Hospital provide a 24-hour triage and assessment service for urgent problems in pregnancy. Patients can either self-refer to the service or be referred by health care providers such as community midwives, G.P.'s and doctors.
Women that require clinical assessment +/- intervention can attend the Maternity /Pregnancy Assessment Units as an emergency or planned appointment.

2. Abbreviations

ANC	-	Antenatal Clinic
APH	-	Ante partum Haemorrhage
CMW	-	Community Midwife
CRP	-	C Reactive Protein
CS	-	Caesarean Section
CTG	-	Cardiotocograph
ECG	-	Electrocardiograph
FBC	-	Full Blood Count
FH	-	Foetal Heart
G&S	-	Group and Save
HVS	-	High Vaginal Swab
IUGR	-	Intrauterine Growth Restriction
LAU	-	Labour Assessment Unit
MSU	-	Mid Stream Urine
NICE	-	National Institute of Clinical Excellence
PAU	-	Pregnancy Assessment Unit
PCR	-	Protein Creatinine Ratio
PDC	-	Pregnancy Day Care
PPROM	-	Preterm Prelabour Rupture of Membranes
PV	-	Per Vaginum

ROM	-	Rupture of Membranes
SROM	-	Spontaneous Rupture of Membranes
USS	-	Ultrasound Scan
UTI	-	Urinary Tract Infection

3. Documentation

Ensure all assessments and individual plans of care are documented clearly in the medical records, the maternity handheld records and if appropriate the maternity clinical system special instructions page.

PAU - Midwives are requested to use the Pregnancy Assessment Tool for all women attending as an urgent admission or alternatively use the Pro-forma for Required Management of altered foetal Movements for all women attending with perception of altered (reduced, changed or absent) foetal movements.

For both tools the front page is designed to be used for the initial assessment on arrival and to then document a plan of care for this visit (i.e. need of CTG, blood tests or other plans). An initial assessment to prioritise care will be due ideally within 15 minutes of arrival.
All care following at a later stage or directly following the initial assessment can be documented on the back and is designed to provide an overview of the visit completed by midwives. Medical staff should document their review if applicable in the handheld records as well as on the white medical notes.

In case of planned visits, documentation should be completed in the medical notes with a short summary in the handheld records prior to discharge.

MAU – The telephone log sheet (Appendix 2) continues to form part of the initial assessment and has space for contemporaneous record keeping. The Pro- forma for reduced foetal movements is also completed as appropriate. Either a ward attendance or admission is completed on Meditech V6 dependant on the outcome of the appointment. A copy of this is printed and attached to the handheld records.

4. Telephone Logs

PAU - Maternity Triage Call log in Lorenzo is completed to document every phone call to PAU and includes details of the person calling/answering, reason for calling, medical details and advice provided.
MAU - individual patient telephone log sheet is used to record phone calls to MAU and includes details of the person calling/answering, reason for calling, medical details and advice provided. Following completion these are then filed into the medical records.

5. Initial Assessment on Arrival

The initial midwifery assessment should be completed within 15 minutes of arrival for all women attending as an urgent admission (does not include women that have an appointment).

Completing this initial assessment can be a rapid process with the aim to establish clinical urgency to prioritise care. Define a plan of care for this admission based on the specific details for the reason for attending MAU/ PAU, including specific investigations to be carried out (i.e. for CTG, serology, BP profile), doctors review etc.

If clinical urgency allows (i.e. normal observations, normal movements, no active bleeding etc) the women can return to the waiting room until a midwife is available to continue care according to the care plan.

The Obstetric Triage Proforma must be completed during this initial assessment. The RAG rating should be highlighted on the triage board in the handover office.

Based on this initial RAG score - An obstetric review should be completed within the following time scales:

Red - Obstetric review within 5-15 mins from request.

Amber - Obstetric review within 30-60 mins from request depending on clinical scenario.
Green - Obstetric review within max 4 hours from the request (aim for within 2 hours).

6. Investigations, Medical Review and Discharge

Use the back of the documentation tool/V6 admission template/medical records to document all investigations carried out and communication with medical staff if applicable. Use the appropriate CTG sticker to review a CTG .

Situations where discharge can be considered without review by medical staff (this is not meant as a complete list covering all possibilities, please follow appropriate clinical guidelines):

- 1st episode of altered foetal movements in the absence of any risk factors (including any risk factors on the SGA risk assessment tool) if normal CTG and normal perception of foetal movements on admission prior to discharge
- Hypertension only when all following criteria are met:
  - Biochemistry and haematology within accepted ranges for gestation.
  - Urinalysis shows no greater than a trace of protein.
  - Blood pressure settled to normal ranges (see full guideline)
  - If plan of care already in place and woman's condition remains stable.
  - No other signs of changed well being
- Abdominal pain only when all following criteria are met:
  - Pain resolved
  - All findings within normal ranges
  - ≥ 37 weeks gestational age
  - Normal perception of foetal movements
  - No PV bleeding
- Foetal Tachycardia when all following criteria are met:
  - Normal CTG
  - No signs of infection
  - Normal perception of foetal movements
  - All findings within normal ranges
- Prelabour ruptured membranes only when all following criteria are met:
  - Low risk pregnancy ≥37 weeks gestational age
  - All findings within normal ranges
  - No signs of infection
  - Normal perception of foetal movements
- Minor trauma only when all following criteria are met:
  - All findings within normal ranges
  - Pain resolved if applicable
  - Normal perception of foetal movements
  - No PV bleeding

When ready for discharge please check and document:

- Is the next appointment with the CMW or in ANC within a suitable timeframe
- Confirm with medical staff if suitable for MLC on discharge
- Has an ultrasound scan been arranged if needed
- Has advise on altered foetal movements been re-iterated

6.1 Medical review:
This list is not exhaustive covering all possibilities and refer to the specific guidelines. Registrar/consultant should review situations such as CTG abnormality, suspected preterm labour in twin pregnancies, confirmed preterm prelabour rupture of membranes, scar pain, persistent abdominal pain, see women with recurrent reduced foetal movements.

7. Specific Care Elements and Investigations

Please see the clinical guidelines for guidance on care for women presenting with the following:

- Obstetric Cholestasis
- Hypertension
- Foetal Tachycardia or arrhythmias (foetal monitoring guideline)
- Antepartum Haemorrhage

- Genital tract
- Hyperemesis
- Preterm labour and Preterm Prelabour rupture of membranes
- Altered foetal movements (changed, reduced or absent)
- Suspected Venous Thromboembolism (VTE)
- UTI in pregnancy
- Early labour at term
- Prelabour rupture of membranes ≥37 weeks gestational age

7.1 Abdominal Pain

Women presenting with abdominal pain require assessment and observation.
The following women require immediate admission to Labour Ward **(RDH site)**:-

- Regular painful contractions (established labour/needing analgesia see Care of Women in Labour guideline
- Tender/tense uterus
- Tenderness over previous CS scar

QHB site – as above once labour has established to be transferred to Delivery Suite when bed availability or assessed by doctor for transfer with other above.

Management

All women presenting with abdominal pain who are not in labour should have a full assessment of maternal and foetal wellbeing and an obstetric review
. Additional investigations to be considered

- Ultrasound if clinically appropriate
- MSU to be sent for lab analysis according to UTI in pregnancy guideline

7.2 Minor Trauma

Assessment of foetal wellbeing may be required following a fall/minor road traffic incident/trauma to the abdomen. The woman will require an antenatal assessment including examination and documented. This can be undertaken by the midwife.
Additional investigations to be considered:

- A CTG
- If the woman's blood group is rhesus negative a Kleihauer must be taken. The woman must stay on the assessment unit until the blood bank has determined if Anti D is required or not. If Anti D is required this must be administered before the woman is discharged home.
- FBC if cause of fall appears to be secondary to a faint.

Raise awareness in checking for foetal movements

Medical review is needed for the woman if any deviation from the norm identified e.g. CTG/maternal observations otherwise can be discharged by the midwife. Appropriate follow up should be confirmed – may be suitable to attend an already arranged appointment either with their MW or in ANC, if no suitable appointment arranged this will need to be organised prior to discharge home.

7.3 Shortness of Breath or Chest Pain

Women calling with the above symptoms should be advised to attend ED

7.4 Postnatal readmission

PAU

All women presenting for postnatal review will have been referred to PAU via an obstetric registrar bleep 2206.

All postnatal readmissions will require senior medical review and are not for midwife or junior doctor discharge.

MAU

Direct to ward 11 and bleep 620

MAU/PAU - If query sepsis use Maternity Sepsis tool (Appendix C). If Sepsis 6 triggered; for urgent transfer to Labour ward/HDU and refer to 'babies readmitted with mother' clinical guideline as baby will be at increased risk.

7.5 Postnatal feed query telephone call

When a telephone feeding query is received appendix 4 – an assessment form must be completed "Maternity Telephone Log – Postnatal Infant Enquires" to ensure the wellbeing of babies by appropriate screening and management of feeding issues in new-born babies. is made and the baby if directed into the appropriate service within a prompt time frame. This needs to be considered with the Trust Policy for infant feeding.

The time frame that this assessment cover is from transfer home from hospital until the time of transfer to the Health Visitor, however individual consideration needs to be given to all telephone calls received out of this time frame.

Enable all staff, irrespective of role, to:

- Recognise when the feeding pattern/behaviour of the baby deviates from a well-baby and requires a medical review
- Support women to feed their babies effectively

PREGNANCY ASSESSMENT TOOL

Insert patient sticker or complete: Name: Date of birth: Hospital number:	Arrival in PAU: …….. Referred from: …….. Midwife: …….. Consultant: …….. Previous PAU admissions: ……..... ...…… …..……

Date	Time	Grav/Par	EDD	Gestation	BlGr/Rh	Allergies	BMI

Reason for admission:

Vaginal loss:				Pain:		
Risk factors	Pre-existing			Identified in this pregnancy		
Obstetric						
Medical						
Lifestyle (include smoking, alcohol,safeguarding)						
Blood pressure ……/……..	Pulse: …….BPM	Resp rate: ……/min	Temperature ……..°C	Saturations: …… %	Urinalysis	Oedema
SFH (i/a) ..... cm	Pres / lie:	PP to brim:	Foetal movements:	Foetal Heart rate (Pinnard or handheld Doppler): …….. BPM		

Signs of infection: ☐ NO ☐ YES Amber or Red scores on Meows: ☐ NO ☐ YES:……..

Consider SEPSIS if signs of infection, foetal tachycardia or unwell

Comments:

Plan of care: CTG indicated: ☐ NO ☐ YES Medical review indicated: ☐ NO ☐ Yes, level:

Name: ……. Designation: …… Signature: ……

Patient Name: …….. Hospital Number: ……..

Notes:

Care on discharge: MLC / CLC Next appointment: Date: …….. Location: ……..

Ultrasound scan appointment: ☐ Yes: date: …… ☐ N/A

Medical review completed: ☐ Yes, level …… ☐ Not indicated

Discharged: Date: ……... Time: ……..

MATTL

TELEPHONE LOG

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

BOOKING QHB / SJH / OTHER

DATE.....

NAME .....

TIME .....

ADDRESS .....

BOOKING .....

.....

PARITY .....

UNIT NO .....

EDD / GESTATION .....

SPECIAL FEATURES (IE medical history, obstetric history, diabetic, prev CS, SGA, liquor etc)

PRESENTING HISTORY

FETAL MOVEMENTS NORMAL / DECREASED / NONE

PREVIOUS EPSIDOES YES / NO

CONTRACTIONS FREQUENCY /10

LENGTH .....

PAIN .....

CONSTANT / INTERMITTENT

VAGINAL LOSS / DISCHARGE .....

PV BLEED NONE / SLIGHT / MODERATE / HEAVY

BLOOD GROUP .....

SROM YES / NO CLEAR / OTHER

TIME .....

SIGNS OF INFECTION .....

REASON FOR CALL

ADVICE GIVEN

TCI / DS / TRIAGE / GP / CMW / OTHER

RESPONSIVE CARE GRADE:

999 / OWN TRANSPORT

SIGNATURE .....

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2ND CALL .....

ADVICE GIVEN TCI / DS / TRIAGE / GP / CMW / OTHER

RESPONSIVE CARE GRADE: [ ]

999 / OWN TRANSPORT SIGNATURE .....

3RD CALL .....

ADVICE GIVEN TCI / DS / TRIAGE / GP / CMW / OTHER

RESPONSIVE CARE GRADE: [ ]

999 / OWN TRANSPORT SIGNATURE .....

4RD CALL .....

ADVICE GIVEN TCI / DS / TRIAGE / GP / CMW / OTHER

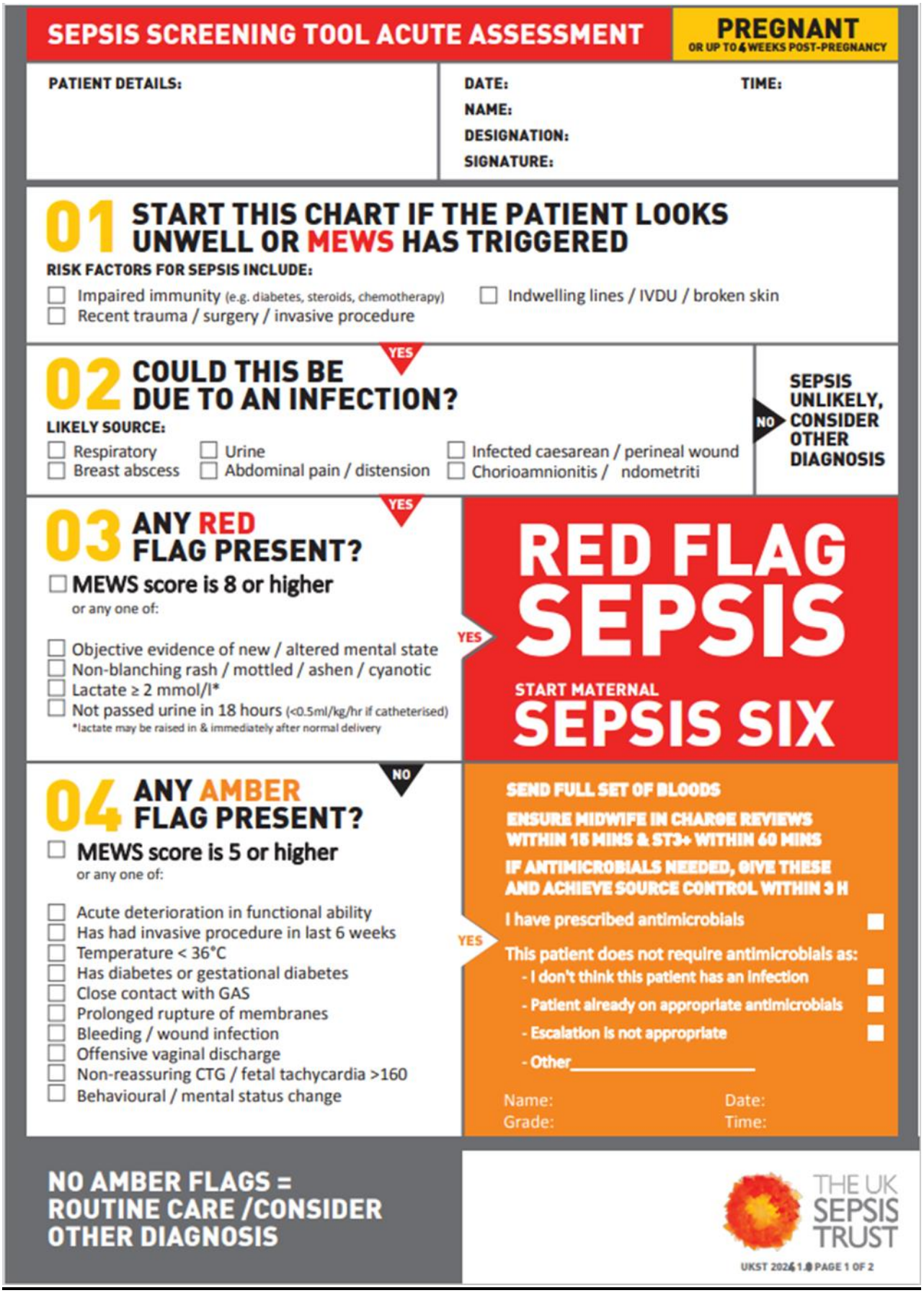
RESPONSIVE CARE GRADE: [ ]

999 / OWN TRANSPORT SIGNATURE .....

ARRIVAL TIME ..... TIME SEEN BY MIDWIFE .....

ADMISSION OBSERVATIONS TIME PERFORMED .....

BP /	RESPS	PRESENTATION .....
PULSE	SATS	FUNDAL HEIGHT .....
TEMP	URINE	SIGNATURE .....



SEPSIS SCREENING TOOL ACUTE ASSESSMENT

PREGNANT
OR UP TO 6 WEEKS POST-PREGNANCY

PATIENT DETAILS:

DATE: **TIME:**
NAME:
DESIGNATION:
SIGNATURE:

01 START THIS CHART IF THE PATIENT LOOKS UNWELL OR MEWS HAS TRIGGERED

RISK FACTORS FOR SEPSIS INCLUDE:

- ☐ Impaired immunity (e.g. diabetes, steroids, chemotherapy)
- ☐ Recent trauma / surgery / invasive procedure
- ☐ Indwelling lines / IVDU / broken skin

02 COULD THIS BE DUE TO AN INFECTION?

YES

LIKELY SOURCE:

- ☐ Respiratory
- ☐ Breast abscess
- ☐ Urine
- ☐ Abdominal pain / distension
- ☐ Infected caesarean / perineal wound
- ☐ Chorioamnionitis / ndometriti

NO → **SEPSIS UNLIKELY, CONSIDER OTHER DIAGNOSIS**

03 ANY RED FLAG PRESENT?

YES

☐ **MEWS score is 8 or higher**
or any one of:

- ☐ Objective evidence of new / altered mental state
- ☐ Non-blanching rash / mottled / ashen / cyanotic
- ☐ Lactate ≥ 2 mmol/l*
- ☐ Not passed urine in 18 hours (<0.5ml/kg/hr if catheterised)

*lactate may be raised in & immediately after normal delivery

YES → **RED FLAG SEPSIS**

START MATERNAL **SEPSIS SIX**

04 ANY AMBER FLAG PRESENT?

NO

☐ **MEWS score is 5 or higher**
or any one of:

- ☐ Acute deterioration in functional ability
- ☐ Has had invasive procedure in last 6 weeks
- ☐ Temperature < 36°C
- ☐ Has diabetes or gestational diabetes
- ☐ Close contact with GAS
- ☐ Prolonged rupture of membranes
- ☐ Bleeding / wound infection
- ☐ Offensive vaginal discharge
- ☐ Non-reassuring CTG / fetal tachycardia >160
- ☐ Behavioural / mental status change

YES →

SEND FULL SET OF BLOODS

ENSURE MIDWIFE IN CHARGE REVIEWS WITHIN 15 MINS & ST3+ WITHIN 60 MINS

IF ANTIMICROBIALS NEEDED, GIVE THESE AND ACHIEVE SOURCE CONTROL WITHIN 3 H

- I have prescribed antimicrobials ☐

This patient does not require antimicrobials as:

- I don't think this patient has an infection ☐
- Patient already on appropriate antimicrobials ☐
- Escalation is not appropriate ☐
- Other_____

Name: Date:
Grade: Time:

NO AMBER FLAGS = ROUTINE CARE /CONSIDER OTHER DIAGNOSIS

THE UK SEPSIS TRUST

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SEPSIS 6 Care Bundle

Seek urgent review by senior Obstetric Registrar (ST3) or above/ Consultant and/or Anaesthetist

Consider transfer to Maternity HDU

If woman is still antenatal consider continuous EFM if appropriate

All actions to be completed within 1 hour	*Time & initials*	*Reason not done / variance*
1. Administer Oxygen Aim to keep saturations >94%	Time: Initials:	
2. Take Blood Cultures Consider: urine, sputum, vaginal swab, throat swab, wound site swab, breast milk culture	Time: Initials:	
3. Give IV Antibiotics According to agreed maternity antimicrobial protocol	Time: Initials:	
4. Give IV Fluids If hypotensive / lactate >2mmol/l give 500mls fluid bolus. Ensure anaesthetist is involved with management of women with pre-eclampsia	Time: Initials:	
5. Check serial lactate VGB/ABG	Time: Initials:	
6. Measure fluid input and output Consider indwelling catheter. Ensure hourly fluid balance chart / HDU chart commenced	Time: Initials:	

Current antimicrobial guideline:

If admitted to maternity HDU consider input from critical outreach team

University Hospitals of Derby and Burton NHS Foundation Trust

Obstetric Triage Proforma

Name: DOB: PID: Or Insert Label	Date and time of call: Site: Date/time of arrival: Date/Time seen by Midwife:

Presenting Concerns: .....

Recommendation: Red Amber Green

MW: ..... Signature: .....

Date/Time of Dr Review:
RED ☐

Immediate (midwife review within 5 min, medical review within 5 - 15 min from request)

Please Tick Below:

☐ *No Fetal Movements
☐ Fetal bradycardia
☐ Active vaginal bleeding/massive haemmorhage
☐ Fitting / seizure
☐ Material collapse or altered level of consciousness.
☐ Cord prolapse
☐ Constant severe abdominal pain
☐ RR>30 / oxygen sat <92%
☐ Systolic BP <80mmHg/HR>/= 130b/min
☐ BP Systolic >160mmHg systolic or diastolic > X2 readings.
☐ Sepsis

Date/Time Dr Requested:

Date/Time of Dr Review:
Amber ☐

Midwife review within 15 - 30 min, doctor's review within 30 - 60min from request depending on clinical scenario.

Please tick below:

☐ Reduced fetal movements.
☐ Fetal heart rate< 110b/min or 160b/min
☐ Mild/moderate vaginal bleeding /haemorrhage (Fresh/old)
☐ Pre - existing diabetes with ketones
☐ Abnormal MEWS (1red value /2 yellow value)
☐ Pyrexia> 38degrees
☐ RR>20/min
☐ Moderate abdominal pain
☐ Previous Caesarean section with scar pain/tenderness
☐ Proteinuria >3+
☐ Moderate hypertension 140 - 160 / 90 - 110 mmHg
☐ SROM with significant meconium
☐ Suspected premature rupture of membranes.
☐ Suspected Chorioamnionitis
☐ Term SROM / labour (medical review only if concerns)
☐ Overt physical trauma or injury
☐ Postnatal signs of sepsis: sore throat, uti/ lrti infection etc.

Date/Time of Dr Review:
Green ☐

Midwife review within 30 min from admission in triage, doctor's review within max 4hrs from request (aim for within 2 hrs)

Please tick below:

☐ **Reduced fetal movements with normal CTG**
☐ **Medical Review may not be required**
☐ **Falls/Trauma (Follow Falls procedure)**
☐ **Itching**
☐ **UTI symptoms/vomiting/ diarrhoea/cough**
☐ **Mild abdominal pain**
☐ **Peripheral oedema**
☐ **Postnatal: wound infection, headache, voiding difficulty**
☐ **Any other symptom not included in red/amber list**

Date/Time Dr review requested:

Date/Time Dr reviewed:

Actions taken if delays:

MW: ..... Signature: .....

Version 1: September 2023

Documentation Control

Reference Number: UHDB/PDC/08:21/P7	**Version:** UHDB 1		**Status:** FINAL	
Version / Amendment	Version	Date	Author	Reason
	1	2003	PDC Team. Dr J Ashworth - Consultant Obstetrician	New guidance
	2	May 2011	PDC Team. Dr J Ashworth - Consultant Obstetrician	Review, merge & update of guidance
	3	Dec 2014	Suzy Thompson – Midwife Chris Doherty – Specialist MW	Merge of PDC/PAU guidelines & update
	4	Sept 2018	Suzy Thompson – Senior Midwife ANS Miss S Rajendran – Consultant Obstetrician Cindy Meijer – Risk Support Midwife	Reviewed
UHDB	1	March 2021	Suzy Thompson – Senior Midwife ANS Miss S Rajendran – Consultant Obstetrician Jo Wallace – Matron ANS	Review / merge. Includes Postnatal readmission from QHB guideline which is now archived
UHDB	1.1	April 2024	Sarah Ellement - ANS matron cross site	Addition of obstetric triage proforma RAG rating

Intended Recipients: All staff with responsibility for caring for women in PAU	
Training and Dissemination: Cascaded through lead sisters / midwives/doctors / Published on Intranet / NHS mail circulation list	
To be read in conjunction with: Referral pathway for women 13–20-week gestation (O11) / Foetal Monitoring in labour (F2) Antenatal Care guideline (A5) OC Guidelines (C6) / Severe Pre-eclampsia-Eclampsia Guideline (E1) / Reduced Foetal Movements guideline (F4)	
Consultation with:	Midwifery Staff
Business Unit sign off:	Exceptional ratification was sort for this urgent amendment 17/04/2024: Maternity Guidelines Group: Miss A Joshi 15/07/2021: Maternity Governance - Mr R Devaraj
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Key Contact:	Joanna Harrison-Engwell - Lead Midwife for Guidelines and Audit