Women's and Children's Division
Trust Guideline

This guideline will impact on Maternity / Emergency dept / other clinical areas in the Trust

MANAGEMENT OF PREGNANT (over 20 weeks gestation at RDH and over 16 weeks gestation at QHB) AND POSTNATAL WOMEN (up to 6 weeks postnatal) WHO PRESENT FOR CARE OUTSIDE THE MATERNITY SERVICE

Contents

1. Introduction

An unwell pregnant or postnatal woman or birthing person 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 to:

- Emergency Departments (ED)
- Other wards and assessment areas within the Trust such as MSDEC, SAU

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.

Pregnant women have physiological changes that enable them to compensate well, but they may deteriorate rapidly. The safety of the mother/birthing person is paramount, but they will also require an assessment of fetal wellbeing.

2. Purpose and Outcomes

To ensure that any pregnant or postpartum woman (up to 42 days) who attends UHDB receives safe, prompt and high-quality care.

The Confidential Enquires into Maternal Deaths make 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
RTC - Road Traffic Collision
SAU - Surgical Assessment Unit
MSDEC - Medical Same Day Emergency Care

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.

5. Points of Contact

RDH site	
Obstetric Registrar	Bleep 8100 - 9AM to 9PM weekdays or 9AM to 5PM weekends
	Bleep 2206 outside of the above hours
Labour ward coordinator	85140
Labour ward red phone	85268
QHB site	
Obstetric Registrar	Bleep 621
Labour ward coordinator	Bleep 310
Labour ward red phone	01283 593173
Both sites	
Obstetric emergency/ Major obstetric haemorrhage	2222 - state type of obstetric emergency and location
Obstetric consultant on call	Contact via switchboard

6. Women Presenting Outside the Maternity Services

1. Emergency Department (ED) triage nurses should ensure that pregnant and postnatal women are recognised as potentially high risk. Triage training will include facets of the altered physiology of pregnant and postnatal women.

2. All ED clinicians must have regular training that includes the identification and management of:

    - The sick pregnant woman.
    - The sick postpartum woman.
    - Ectopic pregnancy

    This will be included as a Vlog on the existing nursing study days.

3. Pregnant and postnatal women with the following signs and symptoms must be reviewed by the obstetric and gynaecology registrar on-call, this face-to-face review must be completed within 1 hour of review request as per Trust IPS policy:

    - Heavy vaginal bleeding
    - Abdominal pain
    - Severe headache
    - Visual disturbances
    - Hypertension
    - Proteinuria

- Pyrexia
- Seizures

If the obstetric team are unable to attend ED to review the patient within 1 hour, the patient must be transferred to the maternity unit (place agreed by obstetric team at time) for review within 1 hour. If there is any doubt about whether the patient is safe to be transferred prior to her obstetric review, she must remain in ED until this has occurred.

4. All pregnant women attending ED who do not meet the below exclusion criteria should be informed to the Labour ward co-ordinator on attendance to ED. The labour ward co-ordinator will make an assessment of the timeliness of which fetal and maternal well-being needs to be assessed. If fetal monitoring is required, then a member of the obstetric/maternity team should attend ED to perform.

   Exclusion criteria:
   - Minor breaks/ fractures to extremities
   - Lacerations (excluding abdominal)
   - Minor burns
   - Sprains, strains, muscular skeletal/ joint problems

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

6. 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 quick, easy and sensitive.

7. When a pregnant woman presents with abdominal pain with a likely non-obstetric cause, they should be reviewed by the Obs and Gynae team and fetal well-being assessed. Once an obstetric cause has been excluded, they should be referred to the most appropriate specialty, commonly general surgery.

8. 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

9. Following each ED attendance, the named GP will receive an electronically generated letter.

10. Pregnant and postnatal women attending the emergency department (ED) with anything other than very minor physical injuries (such as twisted ankle, fractured finger) should be discussed with an obstetrician. Routine enquiry should be undertaken to exclude safeguarding concerns.

11. All pregnant women involved in Road Traffic Collisions (RTC) or physical assaults, however minor, should have an antenatal assessment of fetal well-being. A member of the obstetric/maternity/gynaecology team should attend ED to perform. See Appendix A for contact details.

12. If the condition of the woman is critical following an RTC or other injury, immediate assistance should be requested of the obstetric team. Phone 2222 and state that this is an obstetric emergency.

13. Success of CPR and maternal survival increases if the uterus is emptied for women >20 weeks gestation. Where cardiac arrest occurs and cardiac output is not restored a perimortem section should be considered and performed at 5 minutes of resuscitation effort.

If not possible to perform at 5 minutes, then it should be considered at the earliest opportunity beyond this time.

14. The Obs and Gynae Registrar on-call should be informed of all pregnant and postnatal women admitted within the hospital at the time of decision made to admit. They are then responsible for adding these patients details to the labour ward handover board as an outlier.

15. All pregnant women admitted within the hospital should be included in the LW handover. If not in attendance, the obstetric consultant on call must be informed and involved in the care planning. These women should have an agreed plan for frequency and seniority of review and frequency/type of fetal monitoring.

16. Women with a medical condition requiring inpatient treatment should be discussed and planned in conjunction with the obstetric team. The location will depend on her gestation, how unwell she is and where her medical needs will be met. Any confusion regarding this should have a discussion between the obstetric consultant and the consultant for the other specialty involved.

7. Pregnant women who should be referred directly to Labour Ward

The on-call Obs and Gynae registrar should be informed of all women presenting after 20 weeks gestation at RDH and 16 weeks gestation at QHB with:

- Severe headache, nausea, vomiting, epigastric pain or feeling generally unwell.
- A blood pressure of over 140/90 mmHg, with or without proteinuria.
- PV bleeding and/or ruptured membranes. (Please collect all blood-soaked materials in a plastic bag for this to be weighed by the maternity team).

The labour ward co-ordinator should be informed of any pregnant women or birthing person thought to be in labour

8. 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
- Pregnant/postnatal women with chest pain and/or breathlessness
- Any other non-obstetric circumstances where the woman's life or wellbeing is potentially threatened.

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

9. Monitoring Compliance and Effectiveness

- Audit patients attending ED have been informed to the labour ward for fetal assessment and the obstetric registrar as appropriate.
- Audit to see if patients have been correctly escalated and seen by the Obstetric team

10. References

MBRRACE-UK (2022) Saving Lives, Improving Mothers' Care; Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity (2018-2020) Oxford

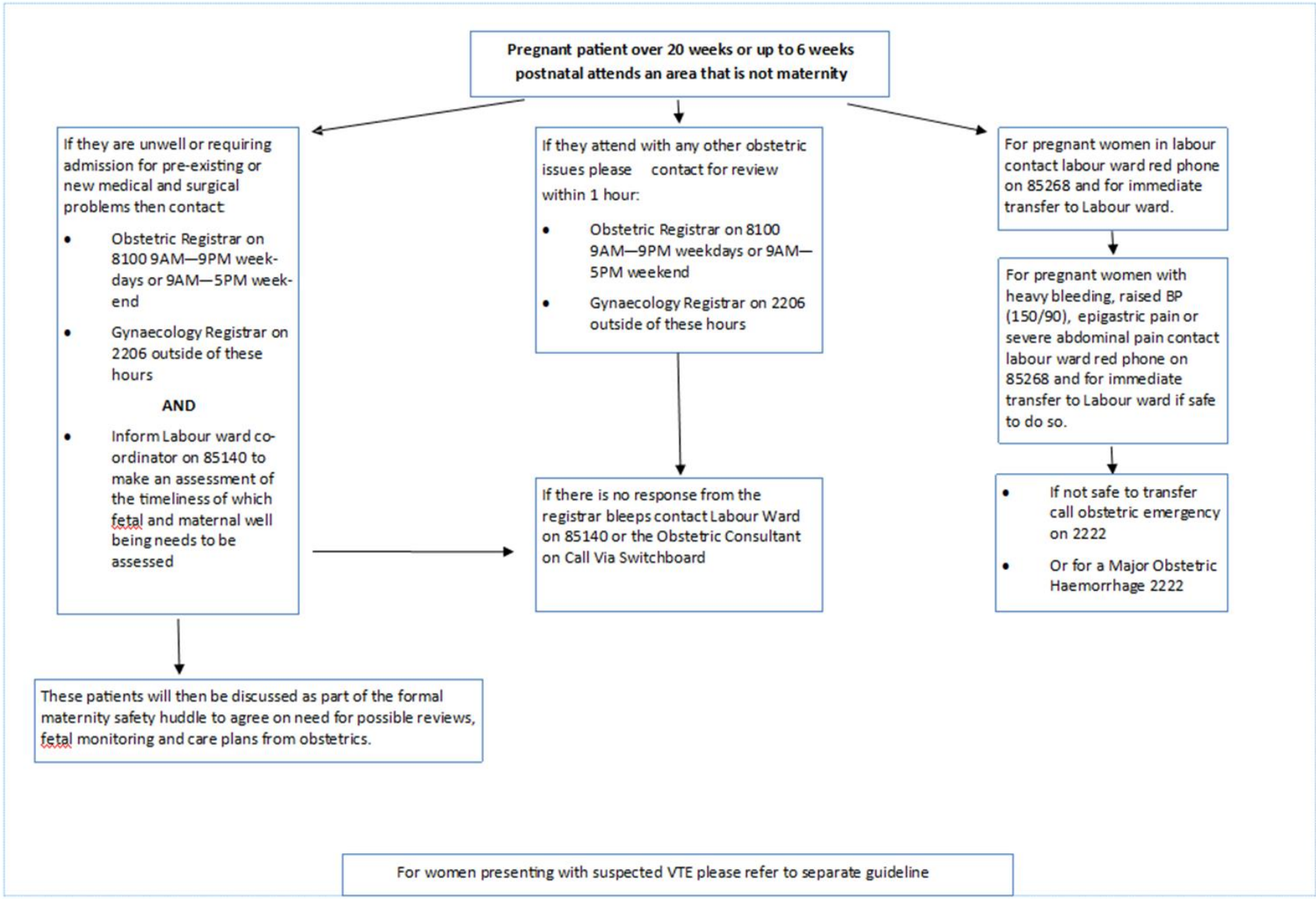
RCOG (2016): Providing Quality Care for Women; A framework for Maternity Standards; London

Appendix A

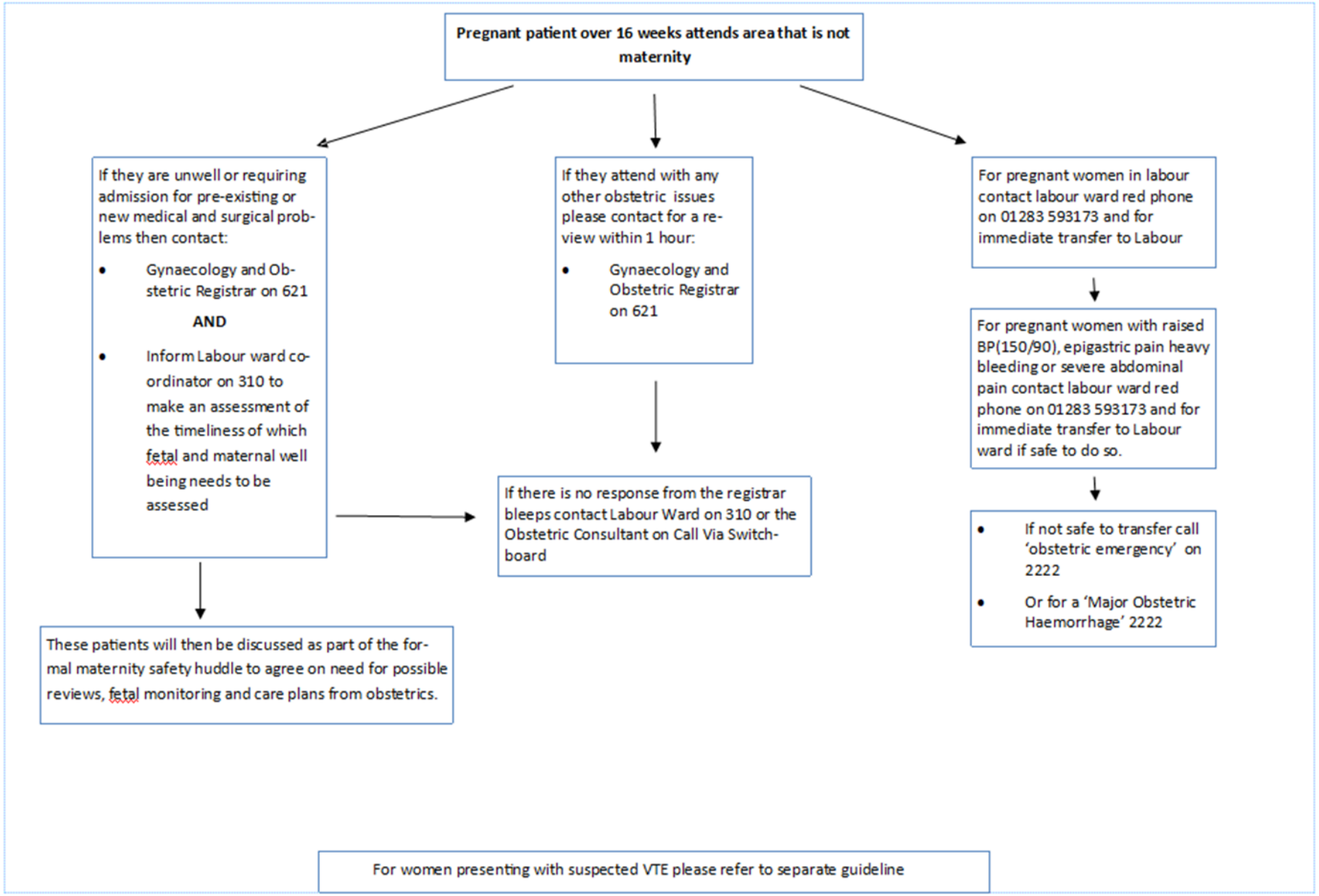
Contact	Number	Time of availability
Labour ward RDH	Internal 85140	24/7
Labour ward QHB	Bleep 310	24/7
Labour ward red phone RDH	Internal 85268	24/7
Labour ward red phone QHB	01283 593173	24/7
Pregnancy assessment unit RDH	01332 785 796	24/7
Maternity assessment unit QHB	01283 593 038	24/7
Obstetric registrar RDH	Bleep 8100 Bleep 2206	9AM - 9PM weekdays or 9AM - 5PM weekends Outside of these hours
Obstetric registrar QHB	Bleep 621	24/7
Major Obstetric Haemorrhage/ Obstetric emergency call - both sites	2222	24/7

Appendix B

Process for review of patients at RDH



Process for review of patients at QHB


Pregnant patient over 16 weeks attends area that is not maternity
If they are unwell or requiring admission for pre-existing or new medical and surgical problems then contact:
Gynaecology and Obstetric Registrar on 621
AND
Inform Labour ward co-ordinator on 310 to make an assessment of the timeliness of which fetal and maternal well being needs to be assessed
If they attend with any other obstetric issues please contact for a review within 1 hour:
Gynaecology and Obstetric Registrar on 621
For pregnant women in labour contact labour ward red phone on 01283 593173 and for immediate transfer to Labour
For pregnant women with raised BP(150/90), epigastric pain heavy bleeding or severe abdominal pain contact labour ward red phone on 01283 593173 and for immediate transfer to Labour ward if safe to do so.
If not safe to transfer call 'obstetric emergency' on 2222
Or for a 'Major Obstetric Haemorrhage' 2222
If there is no response from the registrar bleeps contact Labour Ward on 310 or the Obstetric Consultant on Call Via Switchboard
These patients will then be discussed as part of the formal maternity safety huddle to agree on need for possible reviews, fetal monitoring and care plans from obstetrics.
For women presenting with suspected VTE please refer to separate guideline

Documentation Control

Reference Number: Obstetric/Trust/ 02:24/ O10	**Version: 4**		**Status: FINAL**	
Version / Amendment	Version	Date	Author	Reason
	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
	4	August 2023	Dr J Rowley Cons Obstetrician Dr S Midgley ED Consultant	Review
Intended Recipients: All staff caring for pregnant and postnatal women that present at the Derby Hospitals NHS Foundation Trust				
Training and Dissemination: Cascaded through lead midwives/doctors / lead nurses; Published on Intranet NHS mail circulation.				
To be read in conjunction with: Guidelines for the initial diagnosis and management of suspected ectopic pregnancy in the ED (E4)				
Consultation with:	• Emergency Department, • Aimee Adams - Risk Midwife, • Joanna Harrison-Engwell - Lead midwife for Guidelines, audit and Quality, • Simon Mehigan - NHSE • Natasha Stringer - Head of Midwifery • Trust Guideline Group			
Business Unit Sign off:	02/01/2024: Maternity Guidelines Group: Miss A Joshi – Chair 10/01/2024: Maternity Governance Group - Mr R Deveraj			
Notification Overview sent to TIER 3 Divisional Quality Governance Operations & Performance: 16/01/2024				
Implementation date:	11/03/2024			
Review Date:	February 2027			
Key Contact:	Joanna Harrison-Engwell			