Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Non Obstetric Emergency Care for Pregnant and Postpartum Women

This procedural document supersedes: PAT/T 37 v.4 - Non Obstetric Emergency Care for Pregnant and Postpartum Women

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Author/reviewer: (this version)	Ms Than Than Yin – Consultant Obstetrician & Gynaecologist Dr Rob Parker – Clinical Leadership Fellow with special interest in Obstetric Medicine
Date written/revised:	April 2019
Approved by:	Maternity & Gynaecology Clinical Guideline Group Emergency Department Governance Group Policy Approval and Compliance Group
Date of approval:	15 October 2019
Date issued:	22 October 2019
Next review date:	October 2022
Target audience:	All Clinical Staff – Trust Wide

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 5	22 October 2019	Fully revised document – please read in full	Than Than Yin Rob Parker
Version 4	19 December 2016	Fully revised please read in full	Elaine Merrills Than Than Yin
Version 3	July 2012	Fully revised please read in full. New style format used in accordance with CORP/COMM 1. Title changed to Non Obstetric Emergency Care for Pregnant and Postpartum Women.	Andrea Squires
Version 2	Sept 2009	References Updated	Carol Lee
Version 1	Aug 2008	This is a new document please read in full	Michelle Glave

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1 INTRODUCTION

The majority of women in the UK remain healthy during their pregnancy and post-partum period. Women whom are booked and cared for by Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) are advised to contact the Triage Midwife, Central Delivery Suite (CDS) at Doncaster Royal Infirmary (DRI), Labour Ward at Bassetlaw Hospital (BH) or their General Practitioner (GP) if they develop any problems. However, many women present to the Accident & Emergency Department (ED) or the Out of Hours GP service (OOH GP) following an accident or injury, victim to domestic abuse, a mental health issue or an acute medical problem. These women need succinct and well delivered care.

The Confidential Enquiries into Maternal Deaths make recommendations into best practice standards, including recommendations regarding the management of pregnant and post-partum women who attend the ED.

2 PURPOSE

To ensure that any pregnant or post-partum woman (up to 42 days / 6 weeks) who attends DBTH receives safe, prompt and high quality care.

To ensure clear communication occurs between DBTH staff outside of the maternity unit and obstetric/midwifery staff in the maternity unit, when pregnant women are admitted to a ward or receive unplanned care by the Trust.

To ensure pregnant and post-partum women throughout DBTH have vital signs recorded using the Modified Obstetric Early Warning Score (MOEWS). See guideline MSG 166 Early Recognition of the Severely Ill Antenatal/Postnatal Woman Using the Modified Obstetric Early Warning Score (MOEWS).

3 DUTIES AND RESPONSIBILITIES

It is the duty of all DBTH staff involved in caring for pregnant and post-partum women to be familiar with this guideline, and the procedures it outlines.

4 PREGNANT & POSTPARTUM WOMEN ATTENDING DBTH FOR EMERGENCY OR UNPLANNED CARE

1. All women of childbearing age attending for emergency or unplanned care with unexplained symptoms, that could be a result of a pregnancy related illness, must have a urinary or serum pregnancy test performed. This particularly includes all women with abdominal pain, gastrointestinal symptoms and per-vaginal bleeding.

2. All pregnant and post-partum women should have their vital signs recorded using MOEWS, in conjunction with guideline: MSG 166 Early Recognition of the Severely Ill Antenatal/Postnatal Woman Using the Modified Obstetric Early Warning Score (MOEWS). Women should have their care escalated according to this policy and how it has been adapted in their local area of work.

4.1 Women attending the Emergency Department (at DRI & Bassetlaw Sites)

1. Pregnant and post-partum women attending the ED should be triaged by the ED team.

2. Where the woman has an obstetric-specific problem, and is not requiring escalation of care (as per MOEWS), they may be referred directly as per the ED pathways for pregnant and post-partum women (See Appendix 1). However, where there is concern that the patient needs early assessment (eg. a woman with strongly suspected ectopic pregnancy), the ED should provide initial assessment and treatment of the woman's condition before referral.

3. Where the woman has an obstetric-specific problem and does require escalation of their care (as per MOEWS), they are to be assessed and treated by the ED team initially, and can then be referred to the appropriate team as per the ED pathway.

4. Where the woman has a non-obstetric problem, she is to be assessed and treated by the ED team initially and referred to the appropriate team as per the ED pathway. This is regardless of MOEWS. A woman should be admitted to the team that is most suitable to manager her predominant problem, as midwives lack nursing skills in relation to non-obstetric problems.

5. Where the woman has suspected acute venous thromboembolism (VTE), either a deep vein thrombosis (DVT) or pulmonary embolism (PE), they can be directly referred to the ambulatory care unit (ACU), provided they are clinically stable and are ambulatory and self-caring. The women who are not, will need to be referred to acute medicine as an inpatient (Acute Medical Unit (AMU) in DRI or Assessment and Treatment Centre (ATC) in Bassetlaw). If there is likely to be a delay for diagnostic imaging, pregnant women with suspected VTE should receive treatment-dose low-molecular weight heparin (LMWH) at the earliest opportunity, as per MSG 20 Management of Thromboprophylaxis & Thromboembolic Disease in Pregnancy.

6. Where a woman presents with abdominal pain with a probable non-obstetric cause (regardless of gestation), that woman should be reviewed by the Obstetric & Gynaecology (O&G) team to rule out an obstetric cause. Where this has been done, the woman should then be managed by the most appropriate specialty (commonly General Surgery).

7. Where a woman presents with pelvic pain or per vaginal bleeding, and is below 16 weeks gestation, she can be referred to the Early Pregnancy Assessment Unit

(EPAU). However she must be clinically stable, and have no suspicion of ectopic pregnancy. Where women do not fit these criteria, she should be referred to gynaecology (via SHO grade)

8. Women who have attended the Emergency Department and are fit to be discharged home from the ED should be given a copy of their discharge letter. In addition to this, a paper copy of the discharge letter must be posted to obstetric secretaries. This letter will be passed onto either the woman's named consultant as per K2 (Electronic Maternity Patient Record), or to the consultant on-call if there is no named consultant. They will action any tasks generated from the admission, as necessary. This includes referring a patient into a Consultant Led Care Clinic from Midwifery Led Care, delegating actions to midwifery staff to follow up in hospital or community, sending the information directly to the woman's obstetric consultant (if already under consultant care) or to designate the letter to be scanned into K2 (maternity records system) only.

4.2 Women attending the Minor Injuries Unit - Mexborough Montagu Hospital (MMH)

1. Pregnant and post-partum women attending Mexborough Montagu Hospital Minor Injuries Unit (MIU) should be triaged as per current protocols.

2. If the woman is deemed to have a minor injury, she should be treated as such and discharged as per currently procedure.

3. If there are symptoms in any woman of childbearing age that are consistent with pregnancy related illness, she should have a urinary pregnancy test.

4. Where a woman is pregnant or post-partum and suffering from a condition that cannot be managed by the MIU, this woman should be directed to another care provider (as per the table below).

Clinical Condition	Gestation	Direct to Care Provider
Stable & ambulatory	< 16 weeks	DRI ED or OOH GP
Stable & ambulatory	> 16 weeks and post-partum	Triage Midwife at DRI
Unstable & unwell	Any	999 ambulance - convey to DRI ED

4.3 Women attending acute wards / ambulatory care (at DRI & Bassetlaw Site)

1. Where a pregnant or post-partum woman has been directly referred to and seen on an acute ward (Acute Medical Unit, Surgical Assessment Ward, Ambulatory Care Unit, Emergency Surgical Assessment Centre, St. Ledger Wards) and a decision has been made for an admission to a non-maternity inpatient unit, the obstetric team should be contacted to inform them of the woman's admission. It is the responsibility of the non-maternity parent team to inform the following teams when and where a woman is admitted:

a. A member of the obstetric team (ST3 or higher) should be contacted when a woman of > 16 weeks or more gestation, or who is post-partum is admitted.
b. A member of the gynaecology team (SHO grade or higher) should be contacted when a woman of < 16 weeks gestation is admitted.

2. Women with gestation >16 weeks should be under shared care between the admitting speciality consultant and a named obstetric consultant (usually the obstetric consultant responsible for the woman's antenatal care or the obstetric consultant on-call). This should be listed as such on the patient administration system (PAS) – CAMIS.

3. These pregnant and post-partum women under shared care should be reviewed regularly on the non-maternity unit by the obstetric and midwifery teams. A list of these women should be kept on CDS (DRI) and Labour Ward (Bassetlaw) and it is the responsibility of the obstetric and midwifery teams to keep this up-to-date.

4. If a concern regarding maternal or fetal wellbeing arises, the parent non-maternity team should contact the obstetric team (ST3 or higher) at the earliest opportunity. It is the responsibility of the obstetric team to assess and review the woman or delegate that review to a member of the midwifery team.

4.4 Women attending Maternity Triage Services (at DRI & Bassetlaw Site) with non-obstetric presentations

1. Women who attend the Maternity Triage services at DBTH presenting with a non-obstetric presentation should be referred to the appropriate speciality to manage her care.

2. The woman should remain under shared care where referred out of the maternity unit, and should arrange monitoring of maternal and fetal wellbeing.

3. All communications should be documented in the clinical notes and/or K2.

5 WOMEN WHO SHOULD BE REVIEWED BY THE OBSTETRIC TEAM (ST3 OR HIGHER)

1. When reviewing a pregnant/post-natal woman non-obstetric staff should be vigilant that certain serious pregnancy related problems could manifest as other symptoms e.g. DVT, Pulmonary Embolism, or Eclampsia.

2. The non-obstetric team should consider requesting a review by the on-call Obstetric team (ST3 or higher) for pregnant women or post-partum women (up to 42 days) when presenting with any of the below and for any other concerns that may present. (MBRRACE-UK 2018, RCOG 2016)

- Suspected ectopic pregnancy
- Abdominal or pelvic pain
- Vaginal bleeding
- Hypertension
- Post-operative/procedure readmission
- Abnormal liver function tests
- Wherever surgery is considered
- Unexplained symptoms including: chest pain and breathlessness
- Pyrexia or any evidence of infection
- Involvement in a road traffic accident
- Fractures involving lower limbs
- Proteinuria
- Overdose or deliberate self-harm
- Epigastric pain
- Suspicion of domestic violence
- Low platelets
- Headache

3. Any pregnant woman involved in a road traffic accident, however minor, must have an assessment of fetal well-being by a midwife and/or an obstetrician.

4. If at any time, birth appears imminent, dial 2222, state obstetric emergency and give your location.

5. All communication should be documented in the general notes/patients electronic record (K2).

6 INFORMING AND ESCALATING CARE TO THE OBSTETRIC CONSULTANT

1. Any acutely unwell pregnant women should have her care escalated to the obstetric consultant on-call. It is the responsibility of the non-obstetric team to contact the obstetric team (ST3 or higher) regarding acutely unwell pregnant and post-partum women, and it is the duty of the obstetric team to escalate their care to the obstetric consultant.

2. Should the woman require admission to the Department of Critical Care (DRI) or the Intensive Care Unit (Bassetlaw) the Obstetric Consultant on call must be notified immediately. This is the responsibility of the obstetric team (ST3 or higher)

3. The woman's name and ward should be documented on the outlier list on CDS/Labour Ward indicating the next time a review is necessary.

4. All communication should be documented in the general notes and/or on K2 as appropriate.

7 DISCHARGE OF PREGNANT AND POSTPARTUM WOMEN

1. Women who have been discharged from a non-obstetric inpatient unit as an inpatient, should be done so in conjunction with the midwifery and obstetric teams where appropriate.

2. The obstetric team are responsible for updating the outliers list on CDS/LW and any entries on the electronic patient record system.

3. The non-obstetric team are responsible for sending a copy of the discharge summary to the obstetric secretaries via internal post. This will be distributed to the appropriate consultant's admin tray and the summary to be uploaded on to the electronic patient record (K2).

8 POTENTIAL DOMESTIC VIOLENCE & MENTAL HEALTH PROBLEMS

1. The Maternity Department must be informed where any injury or attendance leads to the suspicion of domestic violence. It is the responsibility of the Labour Ward Coordinator who is made aware of this attendance to ensure that the Community Midwife and Safeguarding Midwife is aware of the attendance and outcome.

2. If a pregnant or newly delivered woman is referred to any psychiatric services, the Maternity Bleep holder/Labour Ward Coordinator should be informed.

9 MATERNAL DEATHS OCCURING OUSTIDE OF MATERNITY UNIT

1. A maternal death is defined as a woman dying during pregnancy, or within 1 year of birth, termination of pregnancy or miscarriage (CMACE 2011).

2. The Head of Midwifery should be informed within working hours, at other times the Maternity Bleep Holder/Labour Ward Coordinator must be informed. This should occur as soon as possible following the death. It is a Trust and statutory requirement to report all Maternal Deaths up to 1 year following birth, irrespective of the reason for death.

10 PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.

- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest .

- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

11 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Compliance with the document will be monitored via the Clinical Guidelines Group and the Women & Children's Governance Group. This will be done by the Governance Midwife who will review all DATIX submissions for pregnant women outside of the maternity unit, and will check compliance to this guideline. This document is to be reviewed by the Clinical Guideline Group within 3 years of its published date.

12 DEFINITIONS

1. CDS – Central Delivery Suite (DRI)
2. ED – Emergency Department
3. K2 – Electronic Maternity Patient Record
4. LW – Labour Ward (Bassetlaw)
5. SHO grade – grade of doctor including, Foundation Year 2 (FY2 doctor), General Practice Trainees (GP VTS) and Junior obstetrics and gynaecology grade doctors (ST1-2)
6. ST3 or higher – Grade of doctor considered at "registrar level"

13 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 2)

14 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

MSG 20 – Management of Thromboprophylaxis & Thromboembolic Disease in Pregnancy
MSG 166 – Early Recognition of the Severely Ill Antenatal/Postnatal Woman Using the Modified Obstetric Early Warning Score
CORP/EMP 4 – Fair Treatment For All Policy
CORP/EMP 27 – Equality Analysis Policy
PAT/PA 19 – Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)

15 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016).

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/uk-data-protection-legislation-eu-general-data-protection-regulation-gdpr/

16 REFERENCES

CMACE (2011) Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer—2006–08; The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. CMACE

MBRRACE-UK (2018): Saving Lives, Improving Mothers' Care; Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16: Oxford

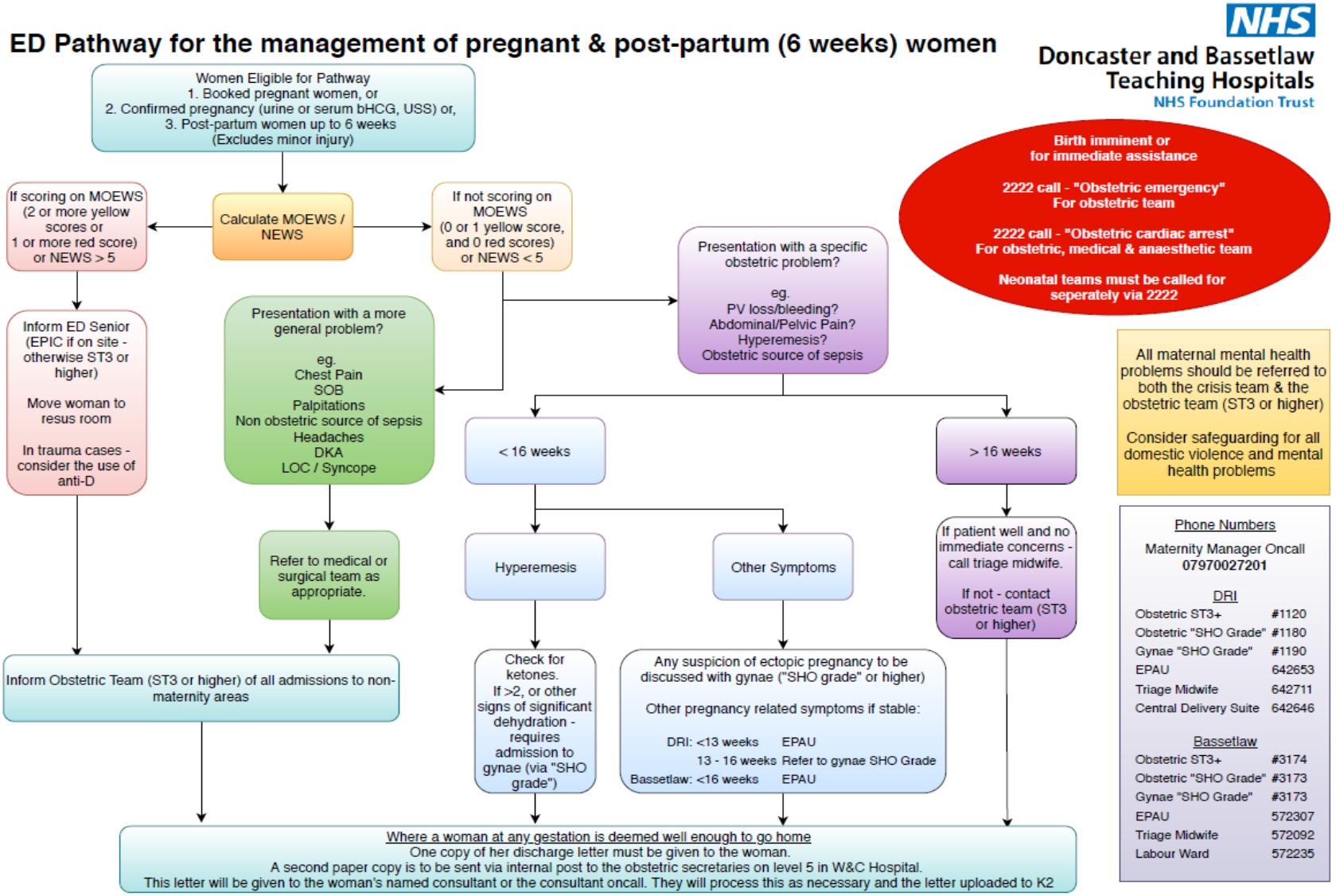
RCOG (2016): Providing Quality Care for Women; A framework for Maternity Standards; London

Data Protection Act 2018

General Data Protection Regulation (GDPR) 2016

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

APPENDIX 1 – ED PATHWAY FOR PREGNANT AND POSTPARTUM WOMEN



APPENDIX 2 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Non Obstetric Emergency Care for Pregnant and Postpartum Women PAT/T37 v.5	Children & Families'	Emma Merkuschev	Existing	15/10/2019

1) Who is responsible for this policy? Name of Division/Directorate: Mr E Emovon

2) Describe the purpose of the service / function / policy / project/ strategy? Pregnant women

3) Are there any associated objectives? Legislation, targets national expectation, standards: No

4) What factors contribute or detract from achieving intended outcomes? – None

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? None known

7) Are any of the following groups adversely affected by the policy? None known

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: **October 2022**

Checked by: **Dr Robert Parker** **Date:** **15/10/2019**