1. **Aim/Purpose of this Guideline**

1.1. The aim of this guideline is to give guidance to midwives, obstetricians and other health professions upon when and when not to refer women to the DAU. This guideline will enable staff to provide appropriate management for obstetric conditions, in a timely manner, leading to improved outcomes for both the mother and her baby during the antenatal and postnatal period.

1.2. This guideline gives guidance on PRECOG referral thresholds.

1.3. This guideline gives guidance on the pathway for women with Hyperemesis Gravidarum.

2. **The Guidance**

2.1. **Criteria for Referral to the Maternity Day Assessment Unit**

The Day Assessment Unit (DAU) is open between 09.00 and 21.00. Planned admissions should be between 09.00 and 16.00. Women are not to refer themselves. All referrals must be made by a health professional following direct contact with the Ward Clerk or the Midwife working in DAU on 01872-252916. After 8pm refer women directly to Wheal Rose on 01872-252149.

DAU does not have a dedicated doctor. Women should be informed that where medical input is necessary there may be a significant delay. DAU referral may not always be the most appropriate pathway for women. Consider other appropriate professionals: Community Midwife (CMW), General Practitioner (GP), Physiotherapist or referral to the named Consultant Obstetric Clinic.

2.2. **Conditions not to be referred to DAU**

2.2.1. Abdominal pain or vaginal bleeding below 18 weeks gestation

CMW to review and refer to GP if still concerned.

2.2.2. Abnormal Fetal Heart Rate

Women with decelerations on auscultation detected in the community setting should be admitted directly to Delivery Suite.

2.2.3. Chronic Conditions

Chronic conditions, including Pelvic Girdle Pain (PGP) and chronic pain should be referred to the appropriate health professional e.g. GP or obstetric clinic if thought to be related to the pregnancy. If unable to book an appointment at the obstetric clinic email the consultant.

2.2.4. Diarrhoea and Vomiting

There are no facilities in DAU for a woman needing isolation. In the absence of severe dehydration the woman should be managed in the community, unless
diabetic on insulin. These women should be admitted to Wheal Rose 01872 25 2149 or Delivery Suite 01872 25 2361 for immediate review.

2.2.5 **Chicken pox**
Any patient unwell with Chicken pox either discuss with Service week/ or on call Consultant

2.2.5 **Term Labour Assessment** during normal community midwife working hours (9-5 seven days a week). This should be done by the Community Midwives.

2.2.5. **Ectopic Fetal Heart Beats**
When ectopic fetal heart beats are detected, the CMW must record maternal pulse and repeat auscultation and maternal pulse in 48 hours. If ectopic beats still present then refer to Fetal Medicine Centre 01872 25 2682 for on-going management.

2.2.6. **Large for Dates**
Large for dates is not an indication for scan unless polyhydramnios is suspected. If polyhydramnios is suspected a scan should be booked via MAXIMS.

2.2.7. **Obstetric Cholestasis**
Refer to Obstetric Cholestasis Guideline. Initial assessment, blood tests and diagnosis are made in the community unless the woman presents after 37 weeks in which case a referral to DAU should be made.

2.2.8. **Postnatal Woman with Baby on Neonatal Unit (NNU)**
All routine postnatal checks on fit, well women should be undertaken by the CMW even if the baby remains in the NNU. If the baby remains on NNU the CMW will contact the woman and formulate an individualised plan of care. An agreed visit schedule with the named midwife will include at least one assessment at home or postnatal clinic.

2.2.9 **Presentation Scan**
Presentation scans are not performed via DAU, they are arranged, after 36 weeks by contacting Maternity Reception.

2.2.10. **Pre Labour Rupture of Membranes at Term (TERM PROM)**
Refer to the Pre Labour Rupture of Membranes at Term (Term PROM) clinical guideline. Term PROM is to be managed within the community setting unless risk factors are identified. If meconium or bleeding is present, admit via Delivery Suite (DS).

2.2.11. **Small for Gestational Age / Fetal Growth Restriction**
Women with symphysis fundal height **below** the shaded area on the growth chart should be scanned by fetal medicine by contacting Maternity reception. Follow up, if indicated as planned by referring to woman’s named obstetric team.
2.2.12. **Spotting**
Spotting/minor post coital/old brown loss or minimal mucousy blood loss with normal fetal movements.

2.2.13. **Trauma**
All serious trauma/RTA/head injury require admission to the Emergency Department (ED) with obstetric input as required.

2.2.14 **Main Department Scans Requiring Urgent, Same Day Advice**
Ultra sonographers should seek the advice of the fetal medicine team. However, if not available to contact the Service week consultant.

2.3. **Elective Referrals accepted by DAU**

2.3.1. **Anaesthetic Review**
Women meeting anaesthetic criteria, contact the DAU to arrange an appointment. Women declining blood products, the DAU will ensure the appropriate anaesthetist is available for these appointments. If no appointment available at Anaesthetic Clinic, refer to Bill Harvey via RCHT email for confirmation of appointment.

2.3.2. **Intramuscular steroids**
As requested by a senior obstetrician.

2.3.3. **Obstetric Cholestasis presenting > 37 weeks**
As detailed in the Obstetric Cholestasis Guideline.

2.3.4. **Pre-operative Assessment**
DAU appointment, 7 days prior to Elective LSCS. This will enable the appropriate anaesthetist to review the woman's care. MRSA screening in the community is to be done at least 48 hours prior to the DAU appointment.

2.3.5. **Prolonged Pregnancy When Induction of Labour is Declined**
CTG and liquor volume scan at 40 weeks+14 days. The woman is to be reviewed by a senior obstetrician and a management plan clearly documented.

2.3.6. **Total Dose Iron Infusion for Treatment of Anaemia**
Senior obstetric authorisation for total dose iron infusion is required before the DAU appointment is made.

2.4. **Emergency Referrals accepted by DAU**

2.4.1 **Reduced Fetal Movements**
Refer to Reduced Fetal Movements Guideline.

2.4.4. **Pre-eclampsia assessment**
Adapted PRECOG thresholds for further action (Appendix 3).

2.4.5. **Acute Abdominal pain > 18 weeks gestation**
2.4.6. Significant Vaginal Bleeding > 18 weeks gestation

2.4.7. Prolonged Pre-term Spontaneous Rupture of Membranes (PPROM)
Refer to Prolonged Pre-term Spontaneous Rupture of Membranes (PPROM) clinical guideline.

2.4.8. Fall or minor Trauma involving abdomen
Review abdominal trauma as risk of placental abruption.
Review Rhesus status and consider need for Anti D.

2.4.10. Hyperemesis
Refer to the GP and aim to manage in the community setting. Refer to the Pathway for women with Hyperemesis Gravidarum (Appendix 4).

2.3.11. Postnatal
Women who have developed a post natal problem that needs urgent review e.g. hypertension, acute wound or perineal infections or post epidural headache.

2.3.13. Suspected Intrauterine Death

2.3.14. Suspected Pre-Term Labour Assessment or Term Labour Assessment out of hours.
The Triage Midwife at Penrice Birth Centre may refer a woman, who has chosen/booked to deliver at the obstetric unit, to the DAU between 17:00-20:00. After 20:00 all referrals go directly to Wheal Rose, this will enable the DAU to close promptly at 21:00.

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Audit of inappropriate referrals to DAU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>DAU Lead</td>
</tr>
<tr>
<td>Tool</td>
<td>• Were all referrals made by a health professional – no self-referrals?</td>
</tr>
<tr>
<td></td>
<td>• Were there any unplanned admissions made between 09.00 and 17.00? (except reduced fetal movements)</td>
</tr>
<tr>
<td></td>
<td>• Were all of the women referred with abdominal pain or vaginal bleeding &gt;18/40?</td>
</tr>
<tr>
<td></td>
<td>• Were any women with decelerations on auscultation in the community setting admitted to DAU?</td>
</tr>
<tr>
<td></td>
<td>• Were any term labour assessments sent to DAU between the hours of 9-5, 7 days a week?</td>
</tr>
<tr>
<td></td>
<td>• Were any women requiring cholestasis assessment at &lt;37 weeks gestation referred to DAU?</td>
</tr>
<tr>
<td></td>
<td>• Did all women receiving an iron infusion have authorization from a senior obstetrician?</td>
</tr>
<tr>
<td></td>
<td>• Were any women referred to DAU after 8p.m?</td>
</tr>
<tr>
<td>Frequency</td>
<td>1% or 10 sets of notes, whichever is the greater, of the health records of all women who have been referred to DAU.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| Reporting arrangements | - A formal report of the results will be given at the clinical audit forum.  
- During the audit process, if compliance is below 75% or other deficiencies identified, this will be highlighted at the next maternity risk management and clinical audit forum and an action plan agreed. |
| Acting on recommendations and Lead(s) | - Any deficiencies recognised will be discussed at the maternity risk and clinical audit forums and an action plan developed.  
- Action leads will be identified and a time frame for the action to be completed by.  
- The action plan will be monitored by the maternity risk management and clinical audit forum until all actions are complete. |
| Change in practice and lessons to be shared | - Required changes to practice will be identified and actioned within a time frame agreed on the action plan.  
- A lead member of the forum will be identified to take each change forward where appropriate.  
- The results of the audit will be distributed to all staff through the risk management letter. |

3. **Equality and Diversity**

3.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

3.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>DAY ASSESSMENT UNIT (DAU) MATERNITY - CLINICAL GUIDELINE FOR REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>4th December 2014</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>4th December 2014</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>4th December 2017</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Karen Stoyles
Obs and Gynae Directorate |
| Contact details: | 01872-255036 |
| Brief summary of contents | The aim of this guideline is to give guidance to midwives, obstetricians and other health professions upon when and when not to refer women to the DAU. This guideline will enable staff to provide, in a timely manner, appropriate management for obstetric conditions, leading to improved outcomes for both the mother and her baby during the antenatal and postnatal period. |
| Suggested Keywords: | DAU, cholestasis, pre-op, anaesthetic review, IOL, iron, IUGR, PPROM, rupture, membranes, reduced, movements ectopic, pre-eclampsia, bleeding, fall, trauma, diarrhoea, vomiting, PRECOG, hyperemesis, chicken, postnatal, NNU, labour, IUD, ultrasound, scan |
| Target Audience | RCHT | PCH | CFT | KCCG |
| | | ✔ | | |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | New Document |
| This document replaces (exact title of previous version): | New Document |
| Approval route (names of committees)/consultation: | Maternity Guideline Group
Obs & Gynae Directorate
Divisional Board |
| Divisional Manager confirming approval processes: | Head of Midwifery |
| Name and Post Title of additional signatories | Not required |
| Signature of Executive Director giving approval | {Original Copy Signed} |
| Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet  ✓ Intranet Only |
| Document Library Folder/Sub Folder | Clinical/Midwifery and Obstetrics |
| Links to key external standards | None |
| Related Documents: | • NICE (2010) Routine Antenatal Care Guideline CG62  
• Action on Pre-eclampsia (2004) Pre-eclampsia Community (PRECOG) Guideline |
| Training Need Identified? | No |

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
</table>
| 4th December 2014 | V1.0 | Initial Issue | Karen Stoyles  
Supervisor of Midwives  
Kerry Jenkin  
Midwife |

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description):</th>
<th>DAY ASSESSMENT UNIT (DAU) MATERNITY - CLINICAL GUIDELINE FOR REFERRAL</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Is this a new or existing Policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obs and Gynae Directorate</td>
<td>New</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elizabeth Anderson</td>
<td>01872-252879</td>
</tr>
</tbody>
</table>

1. Policy Aim*  
Who is the strategy / policy / proposal / service function aimed at?  
The aim of this guideline is to give guidance to midwives, obstetricians and other health professions upon when and when not to refer women to the DAU.

2. Policy Objectives*  
For women with obstetric complications an appropriate and timely referral to the DAU.

3. Policy – intended Outcomes*  
Improved outcomes for both the mother and her baby during the antenatal and postnatal periods. Improved patient experience.

4. *How will you measure the outcome?  
Compliance Monitoring Tool

5. Who is intended to benefit from the policy?  
All pregnant and newly delivered women.

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?  
No

b) If yes, have these *groups been consulted?  
N/A

C). Please list any groups who have been consulted about this procedure.  
N/A

7. The Impact  
Please complete the following table.

<table>
<thead>
<tr>
<th>Are there concerns that the policy could have differential impact on:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality Strands:</td>
<td>Yes</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Sex</td>
<td>(male, female, trans-gender / gender reassignment)</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
</tr>
<tr>
<td>Disability -</td>
<td>learning disability, physical disability, sensory impairment and mental health problems</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. **Yes**  **No** X

9. If you are not recommending a Full Impact assessment please explain why. **N/A**

Signature of policy developer / lead manager / director
Teresa Phillips - Community Matron
Date of completion and submission
4th December 2014

Names and signatures of members carrying out the Screening Assessment
1. Elizabeth Anderson
2.

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed: Elizabeth Anderson
Date: 4th December 2014
### Appendix 3: Adapted PRECOG referral thresholds

<table>
<thead>
<tr>
<th>New hypertension (sustained)</th>
<th>No proteinuria</th>
<th>Maternal symptoms and/or fetal signs &amp; symptoms</th>
<th>Day Assessment Unit Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-&lt;100 DBP and or 150-160</td>
<td>-</td>
<td>-</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>90-&lt;100 DBP and or SBP 150-160</td>
<td>-</td>
<td>With significant symptoms</td>
<td>Same day</td>
</tr>
<tr>
<td>160 SBP and or &gt;100 DBP</td>
<td>-</td>
<td>-</td>
<td>Same day</td>
</tr>
<tr>
<td>New proteinuria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 DBP</td>
<td>1+</td>
<td>-</td>
<td>Same day</td>
</tr>
<tr>
<td>90 DBP</td>
<td>1+</td>
<td>With significant symptoms</td>
<td>IMMEDIATE ADMISSION</td>
</tr>
<tr>
<td>110 DBP</td>
<td>1+</td>
<td>-</td>
<td>IMMEDIATE ADMISSION</td>
</tr>
<tr>
<td>170 SBP</td>
<td>1+</td>
<td>-</td>
<td>IMMEDIATE ADMISSION</td>
</tr>
<tr>
<td>-Normal BP</td>
<td>1+</td>
<td>-</td>
<td>Community check within 7 days</td>
</tr>
<tr>
<td></td>
<td>2+</td>
<td>-</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td></td>
<td>1+</td>
<td>With significant symptoms</td>
<td>Same day</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>Headaches or visual disturbances only</td>
<td>Follow local protocols. Consider reducing interval before next pre-eclampsia check.</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>Epigastric pain only</td>
<td>Same day</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>Reduced fetal movements or suspected small for gestational age fetus</td>
<td>Follow local protocols. Consider reducing interval before next pre-eclampsia check.</td>
</tr>
</tbody>
</table>

**SBP** = systolic blood pressure  
**DBP** = diastolic blood pressure

**Maternal symptoms** (after 20 weeks): headaches or visual disturbances, epigastric pain and/or vomiting  
**Fetal signs and symptoms**: reduced fetal movements, small for gestational age fetus  
**New hypertension**: a diastolic blood pressure of 90mmHg or more at or after 20 weeks in a woman with a diastolic blood pressure of less than 90mmHg before 20 weeks.  
**New proteinuria**: the presence of proteinuria as shown by 1+ or more on proteinuria dipstick testing, a protein/creatinine ratio of 30mg/mmol or more on a random sample or a urine protein excretion of 300mg or more per 24 hours

**Significant proteinuria**: urine protein excretion of 300mg or more per 24 hours

---

---

---
Pre-eclampsia: new hypertension and significant proteinurina at or after 20 weeks of pregnancy, confirmed if it resolves after pregnancy.

Appendix 4: Pathway for Women with Hyperemesis Gravidarum

Woman reports severe nausea & vomiting in pregnancy

Community diagnosis & assessment of severity of condition

Nausea & Vomiting in Pregnancy (NVP)

Advise the woman to:
- Stop taking iron tablets
- Avoid fizzy / caffeinated drinks
- Stop smoking
- Take smaller meals more frequently
- Avoid oily/spicy food
- Avoid sudden movement
- Drink liquids in between rather than with meals
- Rest and take fresh air as much as possible. Keep rooms well ventilated
- Eat dry bread/ biscuits before getting up
- Try food & drinks containing ginger
- Suck something sour e.g. slice of lemon

Hyperemesis Gravidarum (HG) (1% pregnancies)

Moderate
Vomiting > 24 hours, ++ ketones, inadequate hydration at home.

Give advice & anti-emetic in community

If symptoms not relieved then refer to DAU at next available a.m. appointment.

DAU Attendance

- Exclude differential diagnosis
- Exclude complications of HG
- Correct hypovolemia & electrolyte imbalance
- Vitamin supplementation
- Psychological support

Severe
Ketones +++, 10% weight loss, Severe clinical dehydration, tachycardia or DAU attendances x 3

Admit to Antenatal Ward

Treatment:
- IV Fluids – potassium required with subsequent IV fluids
- IV anti-emetic
- Thiamine supplement
- Nil by mouth until dehydration corrected
- Dietary advice

Investigations:
- Urinalysis
- MSU
- USS to exclude molar or multiple pregnancy if not had a scan
- Fluid balance chart
- Weigh at each attendance
- VTE

See Clinical Guidelines for Hyperemesis Gravidarum (RCHT 2012)