Summary:
MATERNAL COLLAPSE IN PREGNANCY AND PUERPERIUM

1. COLLAPSED WOMAN
2. SHOUT FOR HELP AND ASSESS
3. OPEN AIRWAY (HEAD TILT/CHIN LIFT OR JAW THRUST)
4. SIGNS OF LIFE? LOOK, LISTEN AND FEEL FOR 10 SECONDS
5. NO
   - CALL MATERNAL AND NEONATAL RESUSCITATION TEAM 2222 (OR CALL 999 OUTSIDE OF HOSPITAL)
   - KEEP WOMAN SUPINE WITH LEFT UTERINE DISPLACEMENT
   - 30 COMPRESSIONS RATE: 100-120/MINUTE DEPTH: 5-6CM
   - 2 BREATHS CONTINUE CPR 30:2 (COMPRESSIONS TO BREATHS)
   - APPLY PADS/MONITOR ATTEMPT DEFEBRILLATION IF APPROPRIATE
   - ADVANCED LIFE SUPPORT WHEN ANAESTHETIST/RESUSCITATION TEAM ARRIVE
6. YES
   - PLACE WOMAN IN LEFT LATERAL OR RECOVERY POSITION
   - ASSESS ABCDE
     - RECOGNISE AND TREAT OXYGEN, MONITORING, IV ACCESS
   - CALL FOR HELP OR CALL MATERNAL RESUSCITATION TEAM IF APPROPRIATE

+ A AIRWAY
  B BREATHING
  C CIRCULATION
  D DISABILITY
  E EXPOSURE
1. **Aim/Purpose of this Guideline**

1.1. This document guides obstetricians, obstetric anaesthetists, midwives, nurses and maternity support workers (MSW) on the recognition and management of maternal collapse in both the acute and community settings.

1.2. This version supersedes any previous versions of this document.

1.3. **This guideline to be read in consideration with the following guidelines**

   - VTE risk assessment in pregnancy, labour and post-partum period
   - Eclampsia and severe pre-eclampsia
   - Vaginal birth after caesarean section (VBAC)
   - Epidurals analgesia in Labour
   - Caesarean Section
   - Obstetric Haemorrhage
   - Severely ill obstetric woman-the management and early recognition of
   - MEOWS
   - SEPSIS with BUFALO

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**Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

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1.4. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

2. **The Guidance**

2.1. **Incidence**

This is a rare event that presents variably as a combination of apnoea, cyanosis and hypotension possibly followed by convulsions and/or cardiac arrest.

The incidence of maternal collapse lies between 0.14 and 6/1000 (14 and 600/100 000) births. As it is rare, with potentially devastating consequences, it is essential that caregivers are skilled in initial effective resuscitation techniques and are able to
investigate and diagnose the cause of the collapse to allow appropriate, directed continuing management. It should be noted that vasovagal attacks and the post-ictal state following an epileptic seizure are the most common causes of ‘maternal collapse’ and are not covered by this guideline.

2.2. Identification
A Maternity Early Obstetric Warning Scoring system (MEOWS) should be used for all women; this includes antenatal, intrapartum and postpartum observations. This is to allow early recognition of the woman who is deteriorating and becoming critically ill. In some cases maternal collapse occurs with no prior warning, although there may be existing risk factors that make this more likely. Antenatal care for women with significant medical conditions at risk of maternal collapse should include multidisciplinary team input with a pregnancy and delivery management plan in place.

2.3. Causes
The common reversible causes of collapse in any woman can be remembered using the well known ‘aide memoire’ employed by the Resuscitation Council (UK) of the 4 T’s and the 4 H’s.

- Thromboembolism (include Amniotic fluid embolism/Anaphylactoid Syndrome of pregnancy)
- Toxicity (remember spinal and local anaesthetics; magnesium)
- Tension pneumothorax
- Tamponade (cardiac)
- Hypovolaemia,
- Hypoxia
- Hypo/hyperkalaemia and other electrolyte disturbances
- Hypothermia
- Eclampsia, intracranial haemorrhage and sepsis

Although consideration should be given to the cause of the collapse throughout the resuscitation process, this should never delay the initiation or continuation of resuscitation. The immediate resuscitative management of all conditions is the same for any woman who collapses before, during, or after labour.

Hypovolaemia due to bleeding is the most common cause of a maternal collapse, but shock can occur secondary to a high spinal block.

2.4. Identification
In the event of a collapsed woman - Immediate Emergency Resuscitative Management:

2.4.1. Call for help via emergency bell

2.4.2. Call 2222 Request ‘Maternal Emergency Response Team for maternal collapse’. State location. If neonatal team are required call 2222 and request Team

2.4.3. Commence Basic Life support (A.B.C.). In trauma consider c-spine injury.
2.4.4. Give oxygen via facial mask at 15 L/Min with reservoir mask and ensure you fill the reservoir bag.

2.4.5. Manual uterine displacement with slight head down (pregnant women only).

2.4.6. Obtain venous access (2 large bore cannulae), consider CVP line

2.4.7. Initiate fluid resuscitation to correct shock

2.4.8. Institute Advanced Life Support (intubation / ventilation / inotropes) for:
- persistent hypoxia
- hypotension or
- reduced level of consciousness

2.4.9. Start modified early obstetric warning system chart (MEOWS)

2.5. Initiate Investigations to Establish a Diagnosis:
- Review maternal medical history to identify possible cause
- MEOWS observations
- Obtain venous blood samples for tests appropriate to the clinical situation including blood glucose.
- Arterial blood gases
- ECG

N.B Inform the Obstetric and Anaesthetic Consultants on call at an early stage. For ANY maternal collapse Obstetric Consultant must attend in person

2.6. Maternal cardiac arrest
To achieve a perimortem caesarean section within 5 minutes it is essential the obstetric registrar is included in the cardiac arrest call team. Stating 'maternal cardiac arrest' will ensure the obstetrician is included in the emergency call.

2.7. Perimortem section
As soon as it is clear that resuscitation efforts have been deemed unsuccessful delivery should be undertaken to assist maternal resuscitation if the woman is over 20 weeks' gestation.

This should be achieved within 3 minutes to achieve the best outcome for the woman. Preparations for birth are therefore required the moment that a cardiac arrest is declared.

The perimortem section should be performed where resuscitation is taking place and not delayed by moving the woman. Perimortem section is not performed for the benefit of the baby but it may survive and so a paediatrician should be called at viable gestations. CPR should be continued throughout the procedure.
If resuscitation is successful, the abdomen should be packed and the mother moved to an operating theatre for closure.

### 2.8. Maternal Collapse in the community setting

#### 2.8.1. During intrapartum care a MEOWS chart is used as per the intrapartum guideline

#### 2.8.2. In the event of the MEOWS triggering ≥ 5 or 3 in one parameter, the woman must be transferred into the acute unit. In the community oxygen saturations will not be recorded.

#### 2.8.3. In the event of maternal collapse request paramedic ambulance via 999 emergency call and initiate immediate basic life support according to the Resuscitation Council (UK) guidelines ensuring that the uterus is displaced manually (if adequate personnel are available) rather than by lateral tilt so that venous return can be maintained.

#### 2.8.4. In a full resuscitation situation, communication should be made directly with the delivery suite coordinator who will liaise with the on call neonatal team and NNU to agree the most appropriate place for admission/ambulance destination. This could be direct to Delivery Suite or NNU for on-going resuscitation/stabilisation. If two midwives are present the midwife undertaking the resuscitation should escort the baby with the ambulance crew and document events on arrival. If only one midwife present and the woman requires care by the midwife, the resuscitation of the baby should be handed over to the paramedic team (NEW 2021).

### 2.9. Local arrangements for Ambulance Transfer

- The midwife should phone 999 or give instructions for someone else to phone 999 for an ambulance; request a Paramedic and state ‘Emergency’ maternity transfer. Please refer to SWASFT maternal ambulance transfer (Appendix 3)
- This is a category 1 call
- Ask for confirmation that the call has been made and the estimated time of arrival (ETA) taking a reference number
- If calling from the Isles of Scilly, the midwife should phone 999 and request transfer by the Search and Rescue Helicopter (The Isles of Scilly GP should also be informed)
- The Isles of Scilly Midwife or GP will transfer the patient to the mainland and stay with the patient until she has handed over the care to a member of staff on Delivery Suite.
- Continue to follow the Maternal transfer by ambulance clinical guidance. (Appendix 3).

### 2.10. Specific conditions to consider in differential diagnosis

#### 2.10.1. Toxicity
2.10.1.1. Magnesium toxicity- antidote is 10mls of 10% calcium gluconate given by slow IV injection

2.10.1.2. Local anaesthetic toxicity (Bupivicaine). Consider use of Intralipid 20% 1.5ml/kg over 1min (100ml for 70kg woman) followed by an IV infusion of 15mls/kg/hr (400ml over 20mins). The bolus injection can be repeated twice at 5 minute intervals. See AAGBI guideline ². Advanced life support and CPR should be continued throughout administration of intralipid until an adequate circulation is restored. All cases of lipid rescue should be reported to the Lipid rescue site (www.lipidrescue.org).

2.11. Amniotic Fluid Embolism
This is a rare obstetric event with high rates of maternal morbidity and mortality.

2.11.1. Risk Factors
- Multiparity or very fast labour
- Abruption
- Intrauterine fetal demise.
- Oxytocin hyper stimulation or prostaglandin induction of labour.

2.11.2. Clinical Presentation
- Respiratory distress, wheeze, hypoxia with cyanosis, may have a cough and frothy sputum
- Restlessness, distress, panic, nausea and vomiting
- Feeling cold, light headedness, a feeling of pins and needles in the fingers
- Seizures in up to 30% of patients
- Unexpected cardiovascular collapse
- Rapid progression to DIC predominantly manifested by uterine haemorrhage, coma and death

2.11.3. Specific Tests
- Fetal squames, fat, mucin or keratin: Send a clotted sample to Histology and ask for cytokeratin staining on clot to be performed.

2.11.4. Remedial actions
- DIC: Administer fresh frozen plasma and platelets as indicated by ROTEM, coagulation and liaise with haematology.
- Supportive care with MDT input
- Liaise with ICU consultant and outreach team

2.12. Cardiovascular Events
2.12.1. There should be a low threshold for further investigating pregnant or recently delivered women with:
- severe chest pain
• chest pain that radiates to the neck, jaw, back or epigastrum
• chest pain associated with other features such as agitation, vomiting or breathlessness, tachycardia, tachypnoea or orthopnea.

NB: The presence of a wheeze may not necessarily indicate asthma and may be a feature of heart failure and management of suspected cardiovascular events will be directed by a cardiology specialist.

2.13. Uterine Inversion
Uterine inversion is uncommon and may result from mismanagement of the third stage occurring when traction on the cord is attempted before uterine contraction and placental separation are established.

2.13.1. Presentation
• Severe lower abdominal pain
• Cardiovascular collapse
• Haemorrhage
• Shock - the degree of shock is usually out of proportion to the amount of blood lost and may be associated with a low pulse rate and hypotension.
2.14. Uterine Rupture

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This most commonly occurs in women with a uterine scar from previous LSCS or following uterine surgery such as myomectomy. Most uterine ruptures will occur during labour, but can be associated with instrumental delivery or manual removal of placenta. Rarely may it present with antenatal collapse.

2.14.1. Presenting symptoms and signs:
- Fetal heart rate abnormalities, typically starting with a fetal tachycardia, reduced variability followed by deep late decelerations
- Maternal tachycardia and hypotension
- Inco-ordinate uterine activity or slow progress in labour
- PV bleeding
- Haematuria
- Presenting part rising out of the pelvis
- Severe abdominal pain (may be masked somewhat by epidural anaesthesia)

2.14.2. Actions
- Seek Senior Obstetric and Anaesthetic opinion (Registrars and on-call Consultants)
- Stop Oxytocin infusion (if running)

2.14.3. Management
- MEOWS monitoring and resuscitation
- Request Obstetric haemorrhage pack
- Proceed to caesarean section (or laparotomy) after adequate resuscitation
- Deliver baby by extending rupture if necessary
- Repair uterus if possible and ensure bladder is not damaged
- Follow protocol for massive obstetric haemorrhage (Obstetric Haemorrhage)
- Antibiotics
- Consider ICU opinion depending on maternal status (to be discussed between Obstetric Consultant and Obstetric Consultant Anaesthetist)

2.15. Documentation
Accurate documentation is essential. All staff involved in the provision of care should provide written:-
- Documentation of actions undertaken within the maternity notes
- Documentation of the staff in attendance and the time they arrived
- Documentation of involvement of clinicians outside the maternity service

2.16. Incident reporting
Any incident of maternal collapse, whatever the outcome, will be reviewed through the Patient Safety Meeting. All maternal deaths should be reported to MBRRACE and perinatal deaths to PMRT.

2.17. Compliance monitoring
Attendance at the PROMPT training will be monitored monthly and an action plan developed and monitored if any deficiencies are identified.

2.18. Roles and responsibilities

2.18.1. Maternity Support Worker (MSW)
- Supporting the team within the remit of their job description.
- To support the wider MDT, birthing person and the birthing partner.

2.18.2. Midwife
- Commence BLS if required. Arrange category 1 ambulance transfer in community setting.
- To assess additional parameters of MEOWS and calculate the total score or undertake full MEOWS observations and score.
- To escalate within the required timeframes following the MEOWS triggers table.
- To ensure the escalation is followed appropriately and escalate further (to Outreach/ICU teams) if unable to obtain senior review and/or clear care plan within the 30 min timescale or if woman is deteriorating rapidly.

2.18.3. Obstetric team
- To respond to the escalation as per MEOWS triggers table.
- Doctors called to review patients with a MEOWS trigger should ensure that there is a clear patient review and time limited management plan in the medical notes and discussed with the midwife caring for the patient.
- If the physiological parameters are accepted by the medical staff as appropriate/normal/acceptable for that individual patient then this should be clearly indicated in the midwifery and medical notes.
- If women deteriorate and become severely ill to coordinate involvement from the multidisciplinary team if required (Anesthetic Team, Outreach etc.)
- Regular Consultant involvement is needed in care of women who deteriorate and become severely ill.

2.18.4. Anaesthetic team
- All severely ill women should be reviewed by multidisciplinary team involving the Anesthetists.
- For the Consultant Anaesthetist to liaise with the ITU/HDU team if transfer is necessary.
• To document care plans in maternal notes with the planned review times.

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Audit of adherence to guideline</th>
</tr>
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<tr>
<td>Lead</td>
<td>Audit midwife and Maternity Forum.</td>
</tr>
<tr>
<td>Tool</td>
<td>Audit midwife and Documentation Audit</td>
</tr>
<tr>
<td>Frequency</td>
<td>1% of notes during three year period or more frequent if need identified in Patient Safety management</td>
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<tr>
<td>Reporting arrangements</td>
<td>Report back to maternity forum</td>
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<td>Acting on recommendations and Lead(s)</td>
<td>Action plan will be developed and leads appointment, monitoring of action plan at the forum</td>
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<td>Change in practice and lessons to be shared</td>
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4. Equality and Diversity

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

4.2. 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>Maternal Collapse In Pregnancy And Puerperium, Clinical Guideline 3.0</th>
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<tbody>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Maternal Collapse In Pregnancy And Puerperium, Clinical Guideline 2.0</td>
</tr>
<tr>
<td>Date Issued/Approved:</td>
<td>March 2021</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>April 2021</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>April 2024</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Rob Holmes – Obstetric Consultant</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252270</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Guideline for the care of maternal collapse in pregnancy.</td>
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<tr>
<td>Suggested Keywords:</td>
<td>Maternal, collapse,</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Midwifery Guidelines Group Obs &amp; Gynae Directorate Care Group Board</td>
</tr>
<tr>
<td>General Manager confirming approval processes</td>
<td>Mary Baulch</td>
</tr>
<tr>
<td>Name of Governance Lead confirming approval by specialty and care group management meetings</td>
<td>Caroline Amukusana</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>CNST 2.8 &amp; 2.9</td>
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<tr>
<td>Related Documents:</td>
<td>• Resuscitation Council (UK).Resuscitation Guidelines 2010</td>
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UKOSS 2017

PROMPT 2017

Training Need Identified?
Refer to Training Needs Analysis

Publication Location (refer to Policy on Policies – Approvals and Ratification):
Internet & Intranet ✓ Intranet Only

Document Library Folder/Sub Folder
Clinical / Midwifery and Obstetrics

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>
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<td>12th January 2017</td>
<td>1.0</td>
<td>See additions (new 2017) in text</td>
<td>Rob Holmes Consultant Obs and Gynae</td>
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<tr>
<td>5th September 2017</td>
<td>1.1</td>
<td>Addition of collapse in the community setting. Ambulance transfer agreement</td>
<td>Trudie Roberts Maternity Matron Community</td>
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<tr>
<td>14th March 2018</td>
<td>2.0</td>
<td>Updated with CQC recommendations, see new 2018 in body of text</td>
<td>Maternity Guidelines group and Helen Odell, Safety and quality Improvement lead.</td>
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<tr>
<td>March 2021</td>
<td>3.0</td>
<td>Full version update</td>
<td>Sophie Haynes Obstetric Consultant</td>
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This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

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## Appendix 2. Initial Equality Impact Assessment

### Section 1: Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Maternal Collapse in Pregnancy and Puerperium Clinical Guideline V3.0</th>
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<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td>Obs &amp; Gynae Directorate</td>
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<tr>
<td><strong>New or existing document:</strong></td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td>Rob Holmes</td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>01872 252270</td>
</tr>
</tbody>
</table>

1. **Policy Aim**
   - Who is the strategy / policy / proposal / service function aimed at?
   - To provide guidance to obstetricians and midwives on the management of maternal collapse in pregnancy.

2. **Policy Objectives**
   - To ensure evidence based advice and management of a pregnant woman declining blood products.

3. **Policy – intended Outcomes**
   - Safe outcome for women and baby

4. **How will you measure the outcome?**
   - Compliance monitoring

5. **Who is intended to benefit from the policy?**
   - Women and new-born

6a). **Who did you consult with**
   - Workforce |
   - Patients |
   - Local groups |
   - External organisations |
   - Other
   - X

   **Please record specific names of groups**
   - Clinical Guidelines Group
   - Obstetric and Gynaecology Directorate

b). **Please identify the groups who have been consulted about this procedure.**
   - Guideline approved

c). **What was the outcome of the consultation?**
   - Guideline approved

7. **The Impact**
   Please complete the following table. If you are unsure/don't know if there is a negative
Are there concerns that the policy could have a positive / negative impact on:

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<td>Age</td>
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<td>Sex (male, female, non-binary, asexual atc.)</td>
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<td>Disability -</td>
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<tr>
<td>Learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions.</td>
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<td>Religion / other beliefs</td>
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<td>Marriage and Civil partnership</td>
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<td>Pregnancy and maternity</td>
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<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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<td></td>
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</tbody>
</table>

If all characteristics are ticked 'no', and this is not a major working service change, you can end the assessment here as long as you have a robust rationale in place.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Rob Holmes

If you have ticked 'yes' to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here: Section 2. Full Equality Analysis

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead india.bundock@nhs.net
Appendix 3.

SWASFT AMBULANCE TRANSFER: MATERNAL and NEONATAL

The ambulance service provides a category 1 emergency response that will not be diverted to other incidents for patients who are in cardiac arrest or an immediately life threatening situation. Examples of situations requiring a category 1 response are:

- Active seizure/eclamptic fit
- PPH - significant uncontrolled bleeding with maternal compromise
- Delayed first and second stage labour with confirmed fetal compromise
- APH – significant blood loss/signs of abruption with confirmed maternal compromise
- Thick meconium with confirmed fetal compromise
- Cord prolapse
- Shoulder dystocia in which the baby has been unable to be delivered
- Neonatal resuscitation

In exceptional circumstances a woman may not meet the definition for a category 1 response but you may feel that a category 1 response is required e.g. PPH where immediate transfer from a birth centre/home is required. In these circumstances please apply the following procedure:

- Dial 999
- When asked what is wrong with the patient state the presenting condition; this will initially trigger a category 2 response
- When triage commences, advise the call taker that you require a category 1 response and you wish to speak immediately to a clinical supervisor
- Once transferred to the Clinical Supervisor explain the situation. Where it is agreed to be appropriate, the Clinical Supervisor will over-ride the system and confirm a response

The call sequence above is only to be used for those patients deemed to be suffering an immediate threat to life.

For all other emergencies, a category 2 (category 2) level ‘lights and sirens’ response will still be provided but may be diverted to more serious category 1 calls. Category 2 calls will not be diverted to lower level categories. Examples of situations given by SWAST requiring a category 2 response are:

- PPH – minimal bleeding and no patient compromise
- Thin meconium – no suspected fetal compromise
- Delayed first and second stage labour with suspected fetal compromise
- Uncomplicated fetal tachycardia
- APH – small amount of blood loss but no maternal compromise
- Retained placenta

You can also request an urgent ambulance response within 1, 2 or 4 hours for incidents not deemed category 1 or category 2.
The following examples provided by RCHT may be considered as urgent but not **category 1** or **category 2**:

- Delay in progress of labour
- Maternal observations deviating from normal but woman asymptomatic and MEOWs score is 4 or less
- Meconium Liquor and birth not imminent
- Request for further analgesia
- Perineal repair requiring obstetric intervention where bleeding is no concern
- Small APH with no maternal compromise
- Retained placenta without significant blood loss
- Baby born in the community who did not meet the criteria for community birth*
- Baby born with minor abnormality not causing compromise but requiring paediatric assessment*
- Baby born IUGR requiring paediatric assessment*

*These babies can be managed appropriately in the community while you await the ambulance, making sure the baby is kept warm, infant feeding has commenced and the parents are advised appropriately.

Shout for **HELP** and assess patient
Request cardiac arrest trolley with AED and perimortum C/S pack

**Signs of life?**

**NO**

**Left lateral tilt**

Call **2222** and state "**Maternal cardiac arrest**" and request the arrest team, Obstetric registrar and an obstetric anaesthetist.

**CPR 30:2 at a rate of 100-120 compressions a minute**
With oxygen and airway

Apply ECG pads /monitor

**Advanced Life Support**
When Resuscitation Team arrives

*Deliver baby as soon as it is clear there is no response to CPR*

**Successful**
Stabilise
Transfer – Delivery Suite or ITU

Continue life support until successful or decision to discontinue

**Basic Life Support**
**CPR 30:2 if 2 people. Compressions only if single handed**