

# **Severely Ill Obstetric Woman Early Recognition and Management Clinical Guideline**

**V4.0**

**May 2025**

## 1. Aim/Purpose of this Guideline

- 1.1. To provide Obstetricians, Anaesthetists, Midwives and Nurses and Allied Healthcare Professionals (NEW 2025) guidance on early recognition and management of the severely ill obstetric patients. This guideline also outlines the care for obstetric patients requiring Enhanced level 1 care or referral for critical care and the criteria for when these patients should be referred to the Critical Care Unit. Also outlined are the minimum monitoring requirements for enhanced level 1 care in the maternity unit and staff responsibilities and training.
- 1.2. 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.
- 1.3. This version supersedes any previous versions of this document.

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

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust      [rch-tr.infogov@nhs.net](mailto:rch-tr.infogov@nhs.net)

## 2. The Guidance

- 2.1. Recent triennial reports show a statistically significant rise in maternal mortality (even with deaths due to COVID-19 excluded). Thrombosis and thromboembolism are the leading cause of maternal mortality, followed by COVID-19 and cardiac disease. Mental-health related deaths remain high on the list after these three (NEW 2025).

Black women are at 3x higher risk, Asian women at 2x higher risk and women from deprived backgrounds at 2x greater risk. The aim is to achieve equitable outcomes as opposed to equality of care. Communication with patients from non-English speaking background must remain a priority. Professional interpreter (in person or remote) should be used for every interaction (Office for Health improvement and disparities 2021) and understanding of conveyed information should be assessed (NEW 2025).

Appropriate management of patients requiring enhanced levels of care in a maternity Consultant led unit leads to a better chance of survival. The Delivery Suite must be staffed by appropriately experienced midwives or nurses and must conform to minimal monitoring and equipment standards. A trained enhanced level 1 care staff member must be allocated on shift to oversee the care of the women. All staff must have annual training in relevant aspects of recognition and care of the severely ill patient with a focus on team-working, human factors, communication, openness and multi-disciplinary team education with consideration of simulation-based training (to develop necessary technical and non-technical skills) (NEW 2025).

The majority of women delivering their babies in the maternity unit will be well women. Some will have been identified as high risk either because of pre-existing co-morbidities or as a result of the pregnancy. The challenge is to identify early, the women who become unwell during their antenatal, intrapartum or postnatal course. Where mothers are cared for will be influenced by the level of care they require and the multidisciplinary competencies.

## **2.2. Antenatal Identification of a High-Risk Patient**

- 2.2.1. At booking all women undergo a maternity risk assessment by the booking midwife. If a risk factor is identified a referral should be made to the Consultant Obstetrician and if indicated the Consultant Anaesthetist for review.
- 2.2.2. For women who are at risk of becoming severely ill, multidisciplinary planning of their pregnancy and intra-partum care should take place. This may involve referral to a Maternal Medicine Clinic or involvement of clinicians from outside the maternity service (e.g. cardiology).
- 2.2.3. Appropriate Venous Thromboembolism (VTE) guidelines according to local and national Royal College of Obstetricians and Gynaecologists (RCOG) guidelines should be adhered to (note errors highlighted nationally as 'non-obstetric' guidelines used) (NEW 2025).
- 2.2.4. The plan should be clearly documented in the woman's notes and on their electronic record and reviewed and updated at each appointment.
- 2.2.5. A letter outlining the woman's condition and the plan for her care should be written and this can be attached to the electronic record by the person making the plan and also the management plan must be updated on the electronic record.

- 2.2.6. The monitoring of these women requires vigilance and an early opportunity to predict and therefore avoid any potential deterioration in their clinical condition; therefore, a Maternity Early Obstetric Warning Scoring system (MEOWS) chart and fluid balance chart must be commenced.

### **2.3. Intrapartum Identification of a High-Risk Patient**

- 2.3.1. For all women admitted to delivery suite the responsible midwife must check the electronic record for any information relevant to the woman's care.
- 2.3.2. On admission a risk assessment should be completed by the admitting midwife and any risk factors identified.
- 2.3.3. Women who have any risk factors identified require an obstetric review within 30 minutes of arrival on delivery suite and this review must be documented in the notes. If the obstetric team are unavailable, it must be clearly documented in the notes why and when a review is expected. The Delivery Suite coordinator should review the patient to assess the urgency. If an obstetric review is required urgently, immediate escalation to the Obstetric Consultant on call should take place. Until the review happens the Delivery Suite coordinator should be kept up to date with any changes.
- 2.3.4. All women who are assessed as high risk must be reviewed by an obstetrician a minimum of 6 hourly and this must be documented by them in the notes. If this timeframe cannot be achieved, the reason why must be documented in the notes and the coordinator informed.

### **2.4. Identification of the Severely Ill Woman**

Maternity Early Obstetric Warning Scoring system (MEOWS) is an essential tool for assessing a woman's clinical condition. All women should have MEOWS on admission. Frequency of further monitoring should be as per the MEOWS trigger score and commence a fluid balance chart.

### **2.5. Management of the Severely Ill Pregnant Women**

Women who have been identified from MEOWS score as MEOWS  $\geq 5$  or 3 in one parameter:

- Follow directions to increase frequency of vital signs monitoring and referral for medical review.
- Instigate management as instructed by medical personnel.
- Blood samples should be taken as appropriate for the clinical situation and sent for immediate analysis, ensuring that the laboratory has been informed that the samples are on route.
- Consider if a urinary catheter should be inserted.

- If score increases and/or the clinical condition continues to deteriorate a Multidisciplinary decision will be taken to decide appropriate escalation of care. Involvement is essential from senior grades of Obstetrician and Anaesthetist and, if the woman has any underlying condition, the opinion of a senior professional with expertise in that condition should be sought.
- One-to-one care should commence.
- Critical care outreach support is available to all women and provide support to midwives delivering enhanced level 1 care (NEW 2025).
- Management of their underlying condition should follow the appropriate guideline e.g. [Sepsis: Management of Maternal Sepsis Clinical Guideline](#).

## 2.6. Defining maternal critical care and criteria for referral

Where mothers are cared for is influenced by various factors including the level of care that they will require. The table below has been derived from the Maternal Critical Care Working group-“Providing equity of critical and maternity care for the critically ill pregnant or recently pregnant woman”.

Level 0	<p><b>Normal care</b></p> <ul style="list-style-type: none"> <li>• Care of low-risk mother.</li> </ul>
Level 1	<ul style="list-style-type: none"> <li>• Women at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward (Delivery Suite) with additional advice and support from the critical care team.</li> <li>• Risk of haemorrhage.</li> <li>• Oxytocin infusion.</li> <li>• Mild pre-eclampsia on oral anti-hypertensives/fluid balance management/prophylactic Magnesium infusions.</li> <li>• Women with managed medical conditions such as congenital heart disease, diabetic on insulin infusion.</li> </ul>
Enhanced Level 1 Care CONSIDER Critical care support/input	<p><b>Women who require Basic Cardiovascular Support (BCVS)</b></p> <ul style="list-style-type: none"> <li>• Intravenous anti-hypertensives and/or Magnesium infusion to control BP in severe pre-eclampsia.</li> <li>• Arterial line for pressure monitoring and sampling.</li> <li>• Peripheral infusion of vasopressor to maintain BP e.g. Metaraminol infusion.</li> <li>• CVP line used for fluid management and CVP monitoring/ central venous drug administration.</li> </ul>
Level 2 REFER FOR Critical care Support	<p><b>Women requiring single organ support</b></p> <ul style="list-style-type: none"> <li>• Basic Respiratory Support (BRS). <ul style="list-style-type: none"> <li>- 50% or more oxygen via face mask to maintain oxygen saturation.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>- Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP).</li> <li>• Advanced Cardiovascular Support (ACVS). <ul style="list-style-type: none"> <li>- Simultaneous use of at least two intravascular anti-arrhythmic/antihypertensive/vasoactive drugs, one of which must be a vasoactive drug.</li> <li>- Need to measure and treat cardiac output.</li> </ul> </li> <li>• Neurological Support. Magnesium infusion to control seizures (not prophylactic) Intracranial pressure monitoring.</li> <li>• Hepatic support. Management of acute fulminant hepatic failure e.g. from HELLP syndrome, or acute fatty liver such that liver transplant is being considered.</li> <li>• Endocrine support. Diabetic Ketoacidosis with severe metabolic disturbance and fluid requirements.</li> </ul>
<p>Level 3</p> <p>REFER FOR Critical care Support</p>	<p><b>Women requiring advanced respiratory support alone or support of two or more organ systems above</b></p> <ul style="list-style-type: none"> <li>• Advanced Respiratory Support (ARS). Invasive mechanical ventilation.</li> <li>• Support of two or more organ systems. Renal support and BRS. BRS/BCVS and an additional organ supported.*</li> </ul> <p>*A BRS/BCVS occurring simultaneously during the episode count as a single organ support.</p>

## 2.7. Criteria for referral to critical care unit (CCU)

2.7.1. Those patients that require Level 2 or Level 3 care as above.

2.7.2. Severe cardiovascular compromise:

- Cardiac arrest.
- Anaphylaxis **not** responding to initial therapy.
- Requirement for inotropes or vasopressors e.g. from severe sepsis.
- Unstable heart rhythm requiring IV therapy or pacing.
- Local anaesthetic toxicity.

2.7.3. Severe respiratory compromise:

- Acute severe asthma **not** responding to initial treatment.
- Deterioration of respiratory function or poor oxygenation e.g. saturations below 92% on 60% oxygen.

2.7.4. Severe CNS compromise:

- Deteriorating conscious level.
- Uncontrollable eclamptic seizures or status epilepticus.

2.7.5. Other systemic failure or deterioration (NEW 2025).

**PLEASE NOTE FOR TRANSFER:**

- **THE BED AND EQUIPMENT WILL FIT INTO THE LIFT ON MATERNITY WITH TWO STAFF MEMBERS.**
- **THE EQUIPMENT AND GREEN GRAB BAG WILL NEED TO BE PLACED ON THE BED TO FIT INTO THE LIFT.**
- **THE BED WILL NOT FIT INTO THE LIFT IF IT HAS BEEN EXTENDED - CHECK PRIOR TO TRANSFER.**

## 2.8. ROLES AND RESPONSIBILITIES OF STAFF GROUPS

A trained enhanced level 1 care staff member must be allocated on shift to oversee the care of the women.

### 2.8.1. Midwives

- Enhanced level 1 Care is required, a Maternity Enhanced Care Unit (MECU) chart should be commenced and the date and time of the step up to Level 1 enhanced care documented in the notes.
- A midwife/nurse with a suitable qualification to undertake one-to-one care.

### 2.8.2. Obstetricians

- Multidisciplinary plans of care should be documented and regularly updated within the maternity notes.
- There should be regular Consultant level involvement in care of patients requiring enhanced level 1 care.

### 2.8.3. Anaesthetists

- All level 1 patients should be flagged up in the multidisciplinary ward round or on admission by the midwife in charge to allow anaesthetic team involvement and review. All reviews and plans should be documented in the maternal notes.

- The Consultant Obstetric Anaesthetist will liaise with the Critical Care Unit Consultant if admission to Critical Care Unit is deemed necessary. Any decisions should be documented in the maternal notes and on the electronic record.

## 2.9. Guidance for staff on when to involve clinicians from outside the maternity service

- 2.9.1. Where women have complications other than common obstetric issues, specialist clinicians should be considered as a source of information and support. The Obstetrician leading the care should consider involving the following specialties if the clinical situation warrants it after discussion with the maternity team and Consultant on call (unless life threatening when direct referral can be made).
- 2.9.2. Specialist clinicians (usually the on-call middle grade or consultant level) should be contacted via the hospital switchboard.
- 2.9.3. All discussions, referrals and consultations by specialist staff outside maternity services should be clearly documented in the maternal notes by the clinician providing care.

## 2.10. Equipment and resources

Each designated level 1 bed space must have the following in line with national guidance:

<b>Within bed space</b>
<p>Oxygen outlet and breathing system for 100% oxygen (ambu/Waters circuit).</p> <ul style="list-style-type: none"> <li>• Pulse oximetry.</li> <li>• Blood pressure measurement.</li> <li>• Electrical sockets.</li> <li>• Suction unit.</li> <li>• Electronic monitor (Mindray monitor) that can record: blood pressure, electrocardiogram (ECG), pulse, oxygen saturations, respirations and invasive monitoring.</li> </ul>
<b>In close proximity for use as required</b>
<ul style="list-style-type: none"> <li>• Intravenous (IV) cannula , blood bottles/syringes/needles/sharps bin.</li> <li>• IV fluids, fluid warmer and infusion pumps.</li> <li>• Continuous ECG monitoring.</li> <li>• 12 lead ECG.</li> <li>• Thermometer.</li> <li>• Forced air warming device.</li> <li>• Defibrillator.</li> <li>• Resuscitation equipment, emergency drug box and emergency airway box.</li> </ul>

- Transfer equipment.
- Emergency Alarm, emergency massive haemorrhage trolley and emergency eclampsia box.
- Telephone and computer terminal for checking blood results, PACS and accessing guidelines.
- Haemacue / co-ox HB (in main theatres/ Critical Care Unit /Neonatal Unit).

## 2.11. Requirements of staff when transferring women to Critical Care Unit

2.11.1. Staff should document their actions as stated below when transferring women.

Staff	Action/requirements
Anaesthetists	<ul style="list-style-type: none"> <li>• Stabilise woman.</li> <li>• Escalate to Consultant Anaesthetist as required.</li> <li>• Agree transfer plan with obstetric and midwifery team. Document discussions and time decision made.</li> <li>• Contact Critical Care Unit and agree transfer plan with senior clinician. Document name of clinician who agrees to the transfer and time decision is made.</li> <li>• Document transfer plan in maternal notes.</li> <li>• Accompany and manage care and safety of woman during transfer to Critical Care Unit (with support of critical care outreach team if available).</li> <li>• Verbal and written handover of care to Critical Care Unit staff using Situation, Background, Assessment, Recommendations, Decision (SBARD).</li> <li>• Complete Datix form.</li> </ul>
Obstetricians	<ul style="list-style-type: none"> <li>• Assist in stabilisation of woman.</li> <li>• Escalate to Consultant Obstetrician as required.</li> <li>• Agree transfer plan with anaesthetic and midwifery team. Document discussions and time decision made.</li> <li>• Agree plan of care in relation to the woman's obstetric requirements, including plan for future reviews and involvement (see above). Document plan in maternal notes and handover information to colleagues.</li> </ul>
Midwives	<ul style="list-style-type: none"> <li>• Assist in stabilisation of woman.</li> <li>• Escalate to Delivery Suite coordinator</li> <li>• Agree transfer plan with anaesthetic and obstetric team. Document discussions and time decision made.</li> </ul>

Staff	Action/requirements
	<ul style="list-style-type: none"> <li>• Agree plan of care in relation to the woman's midwifery requirements, including plan for future reviews and involvement.</li> <li>• Accompany woman to Intensive care unit during transfer.</li> <li>• With anaesthetist provide a verbal and written handover of care to Critical care Unit staff using SBARD.</li> <li>• Ensure all documentation is completed as required prior to transfer.</li> <li>• Document woman's location and condition in the communication book on labour ward. This information needs to be updated daily by the Delivery Suite coordinator and included in the daily handovers.</li> </ul>
Critical Care Unit clinicians	<ul style="list-style-type: none"> <li>• Discuss and agree transfer plan with anaesthetist.</li> <li>• Prepare bed space for transfer.</li> <li>• Receive woman and verbal and written handover from anaesthetist and midwife accompanying woman.</li> <li>• Ensure woman has continued obstetric, anaesthetic and midwifery input during her Critical Care Unit stay (see above).</li> </ul>
Porters	<ul style="list-style-type: none"> <li>• Women will be transferred on beds and will require porters for transferring.</li> <li>• Transfer woman on bed to Critical Care Unit with anaesthetist and midwife accompanying.</li> </ul>
Ward Clerks	<ul style="list-style-type: none"> <li>• Ensure woman is transferred on the Patient Administration System (PAS) system from Maternity to Critical Care Unit.</li> </ul>

2.11.2. Other factors to influence the transfer to Critical Care Unit include:

- Staffing levels and skills mix of the midwives and medical staff on duty.
- Current workload of the clinical area.
- Preference of the obstetric/anaesthetic team managing the woman's care.

2.11.3. Summary:

All hand over of care or transfer to Critical Care Unit should be done using the maternal transfer to Critical Care Unit form (See Appendix 3). The health professional handing over care should use SBARD as a prompt for handing over all relevant information, the person receiving the hand over should repeat back to information they have received. Both health professionals should then sign the form to confirm that handover has been completed.

#### 2.11.4. Incident reporting

Any woman transferred to Critical Care Unit must be Datix reported.

### 3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
<b>Element to be monitored</b>	<ul style="list-style-type: none"> <li>• Use of the MEOWS chart.</li> <li>• Use of Fluid balance chart.</li> <li>• A trained enhanced level 1 care staff member allocated on shift to oversee the care of the women.</li> <li>• Use of the transfer form.</li> <li>• Criteria for transfer to High Dependency Unit/Critical Care Unit.</li> <li>• Communication and documentation:               <ul style="list-style-type: none"> <li>▪ Did the woman require routine observations in the Antenatal/Postnatal period or additional observations in the intrapartum period?</li> <li>▪ Was a MECU chart commenced?</li> <li>▪ Were all vital signs documented and scored on the MECU chart?</li> <li>▪ Was the risk category page on the front of the MEOWS chart correctly followed?</li> <li>▪ If step up to level 2 care was required is a clear plan of escalation written?</li> <li>▪ Was one to one care provided and overseen by a trained enhanced level 1 care staff member?</li> <li>▪ Did the woman have an underlying non obstetric condition?</li> <li>▪ If yes, was a clinician from outside the maternity service consulted?</li> <li>▪ Did the woman require advanced respiratory or cardiovascular support?</li> <li>▪ If yes, was she transferred to Critical Care Unit?</li> <li>▪ If yes, was the appropriate transfer form completed?</li> <li>▪ Has the anaesthetist documented the handover to the Critical Care Unit anaesthetist?</li> </ul> </li> <li>• Has the obstetrician documented the hand over to the Critical Care Unit clinician?</li> </ul>
<b>Lead</b>	Audit midwife.
<b>Tool</b>	Adherence to guidelines will be monitored as part of the ongoing audit process within the department on a Word or Excel template specific to the topic.

Information Category	Detail of process and methodology for monitoring compliance
<b>Frequency</b>	1% or 10 sets, whichever is greater, of all health records of women who have delivered who have required high dependency/intensive care, will be audited over a 12-month period.
<b>Reporting arrangements</b>	<ul style="list-style-type: none"> <li>• A formal report of the results will be received annually at the Audit Review Team (ART) meeting, as per the audit plan.</li> <li>• During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next maternity Patient Safety Meeting and clinical audit forum and an action plan agreed.</li> </ul>
<b>Acting on recommendations and Lead(s)</b>	<ul style="list-style-type: none"> <li>• Any deficiencies identified on the annual report will be discussed at the maternity Patient Safety Meeting and Audit Review Team (ART) meeting.</li> <li>• Action leads will be identified and a time frame for the action to be completed by.</li> <li>• The action plan will be monitored by the Audit Review Team (ART) meeting until all actions complete.</li> </ul>
<b>Change in practice and lessons to be shared</b>	<ul style="list-style-type: none"> <li>• The changes required to practice will be identified and actioned within the time frame agreed on the action plan.</li> <li>• A lead member of the meeting will be identified to take each change forward where appropriate.</li> <li>• The results of the audits will be distributed to all staff through the Patient Safety newsletter/ Audit Review Team (ART) meeting as per the action plan.</li> </ul>

## 4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

## Appendix 1. Governance Information

Information Category	Detailed Information
<b>Document Title:</b>	Severely Ill Obstetric Woman Early Recognition and Management Clinical Guideline V4.0.
<b>This document replaces (exact title of previous version):</b>	Severely Ill Obstetric Woman Early Recognition and Management Clinical Guideline V3.0.
<b>Date Issued/Approved:</b>	May 2025.
<b>Date Valid From:</b>	May 2025.
<b>Date Valid To:</b>	May 2028.
<b>Directorate/Department responsible (author/owner):</b>	Dr Chris Pritchett, Consultant Anaesthetist.
<b>Contact details:</b>	01872 252363.
<b>Brief summary of contents:</b>	To provide obstetricians, anaesthetists, midwives and nurses guidance on early recognition and management of the severely ill obstetric women.
<b>Suggested Keywords:</b>	Severely, ill, obstetric, women, MEOWS, MECU, oxygen, monitoring, transfer, CCU, sepsis.
<b>Target Audience:</b>	<b>RCHT:</b> Yes <b>CFT:</b> No <b>CIOB ICB:</b> No
<b>Executive Director responsible for Policy:</b>	Chief Medical Officer.
<b>Approval route for consultation and ratification:</b>	Maternity Guideline Group.
<b>Manager confirming approval processes:</b>	Caroline Chappell.
<b>Name of Governance Lead confirming consultation and ratification:</b>	Tamara Thirlby.
<b>Links to key external standards:</b>	None Required.
<b>Related Documents:</b>	<ul style="list-style-type: none"> <li>Department of Health DH 2000: Comprehensive Critical Care. London.</li> <li>Department of Health 2007: The Confidential Enquiry into Maternal Deaths. CEMACH.</li> </ul>

Information Category	Detailed Information
	<ul style="list-style-type: none"> <li>• RCOG 2007: Safer Childbirth, Minimum Standards for the Organisation and Delivery of Care in Labour. London.</li> <li>• CCIAG – Critical Care Information Advisory Group.</li> <li>• CCMDS – Critical Care minimum Dataset- a database developed by CCIAG in 2006 updated in 2008 to include data collected from Obstetric critical care patients within maternity units.</li> <li>• MBRRACE (2024) 2020-2022 Saving lives: improving mothers Care.</li> <li>• Dellinger RP, Levy MM, Carlet JM, Bion J, Parker MM, Jaeschke R, et al.; International Surviving Sepsis Campaign Guidelines Committee; American Association of Critical-Care Nurses; American College of Chest Physicians; American College of Emergency Physicians; Canadian Critical Care Society; European Society of Clinical Microbiology and Infectious Diseases; European Society of Intensive Care Medicine; European Respiratory Society; International Sepsis Forum; Japanese Association for Acute Medicine; Japanese Society of Intensive Care Medicine; Society of Critical Care Medicine; Society of Hospital Medicine; Surgical Infection Society; World Federation of Societies of Intensive and Critical Care Medicine. Surviving Sepsis Campaign: international guidelines for management of severe sepsis and septic shock. Crit Care Med 2008;36:296–327.</li> <li>• Maternity Critical Care Working Group. Providing Equity of Critical and Maternity Care for the Critically Ill or Recently Pregnant Woman. London: Royal College of Anaesthetists 2011.</li> <li>• The Association of Anaesthetists of Great Britain and Ireland Obstetric Anaesthetists' Association. (2005). <u>OAA/AAGBI Guidelines for Obstetric Anaesthetic Services Revised Edition 2005.</u> London: The Association of Anaesthetists of Great Britain and Ireland Obstetric Anaesthetists' Association.</li> </ul>

Information Category	Detailed Information
	<ul style="list-style-type: none"> <li>Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. London: RCOG Press.</li> <li>MBRRACE-UK. Saving Lives, Improving Mothers' Care 2009-2012.</li> </ul>
<b>Training Need Identified?</b>	<ul style="list-style-type: none"> <li>All midwives, obstetricians and obstetric Anaesthetists will attend annual training on the recognition and management of the critically ill woman, including the use of the MEOWS chart.</li> <li>All midwives, obstetricians and obstetric Anaesthetists will attend annual training in maternal Basic Life Support.</li> </ul>
<b>Publication Location (refer to Policy on Policies – Approvals and Ratification):</b>	Internet and Intranet.
<b>Document Library Folder/Sub Folder:</b>	Clinical / Midwifery and Obstetrics.

### Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
November 2004	V1.0	Initial Issue: Guidelines for the Transfer of Patients to High Dependency / Intensive Care.	Dr Bill Harvey Consultant Anaesthetist.
January 2010	V1.1	Addition of recognition of the severely ill obstetric woman, use of MEOWS and SBARD.	Dr Catherine Ralph Consultant Anaesthetist.
March 2012	V1.2	Inclusion of recognition and management of maternal sepsis and compliance monitoring.	Dr Catherine Ralph Consultant Anaesthetist.
August 2012	V 1.3	Changes to compliance monitoring only.	Dr Catherine Ralph Consultant Anaesthetist.

Date	Version Number	Summary of Changes	Changes Made by
July 2015	V 1.4	Proforma includes documentation of vaginal packs/Bakri Balloon situ on transfer to Critical Care Unit.	Dr Sam Banks Consultant Anaesthetist.
September 2017	V1.5	All women must have initial MEOWS score undertaken (with exception of oxygen saturation in the community). Staff caring for woman with level 2 HDU care must have appropriate HDU qualification and provide one to one care.	Angela Whittaker, inpatient matron. Dr Sam Banks, Consultant Anaesthetist.
March 2018	V2.0	Inclusion of detailed HDU care, see New 2018 in body of text.	Helen Odell, Patient Safety Lead and maternity guidelines group.
June 2018	V2.1	Change from level 2 HDU care to enhanced level 1 care on delivery suite and HDU chart removed and replaced with MEOWS and fluid balance chart, audit standards altered to reflect change. Document title changed.	Helen Odell, safety and quality lead and Sally Nash, Consultant Anaesthetist.
May 2020	V2.2	Addition of inclusion statement (1.4). High risk women review within 30 minutes of arrival on delivery suite (2.3.3.). High risk women being reviewed 6 hourly on delivery suite (2.3.4.).	Julie Walton Audit Midwife.
October 2020	V2.3	Addition of requirement for a trained enhanced level 1 care staff member must be allocated on shift to oversee the care of the women (NEW 2020).	Josie Dodgson Patient Safety Midwife.
July 2021	V3	Full version update – as detailed in body of text.	Rachel Mullins Practice Development Midwife.
May 2025	V4.0	Full version update – as detailed in body of text.	Dr Chris Pritchett, Consultant Anaesthetist.

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

**All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.**

**This document is only valid on the day of printing.**

**Controlled Document.**

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

## Appendix 2. Equality Impact Assessment

### Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team  
[rcht.inclusion@nhs.net](mailto:rcht.inclusion@nhs.net)

Information Category	Detailed Information
<b>Name of the strategy/policy/proposal/service function to be assessed:</b>	Severely Ill Obstetric Woman Early Recognition and Management Clinical Guideline V4.0.
<b>Directorate and service area:</b>	Obstetrics and Gynaecology.
<b>Is this a new or existing Policy?</b>	Existing.
<b>Name of individual completing EIA</b> (Should be completed by an individual with a good understanding of the Service/Policy):	Dr Chris Pritchett, Consultant Anaesthetist.
<b>Contact details:</b>	01872 252363.

Information Category	Detailed Information
<b>1. Policy Aim - Who is the Policy aimed at?</b> (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide obstetricians, anaesthetists, midwives and nurses guidance on early recognition and management of the severely ill obstetric women.
<b>2. Policy Objectives</b>	To recognise a deteriorating obstetric woman and ensure swift management appropriate to her needs.
<b>3. Policy Intended Outcomes</b>	Safe outcome for pregnant and newly delivered women.
<b>4. How will you measure each outcome?</b>	Compliance Monitoring Tool.
<b>5. Who is intended to benefit from the policy?</b>	All pregnant and newly delivered women.

Information Category	Detailed Information
<b>6a. Who did you consult with?</b> (Please select Yes or No for each category)	<ul style="list-style-type: none"> <li>• Workforce: Yes</li> <li>• Patients/visitors: No</li> <li>• Local groups/system partners: No</li> <li>• External organisations: No</li> <li>• Other: No</li> </ul>
<b>6b. Please list the individuals/groups who have been consulted about this policy.</b>	<b>Please record specific names of individuals/groups:</b> Maternity Guideline Group.
<b>6c. What was the outcome of the consultation?</b>	Guideline Agreed.
<b>6d. Have you used any of the following to assist your assessment?</b>	<b>National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:</b>

**7. The Impact**

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
<b>Age</b>	No	
<b>Sex</b> (male or female)	No	
<b>Gender reassignment</b> (Transgender, non-binary, gender fluid etc.)	No	
<b>Race</b>	No	
<b>Disability</b> (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
<b>Religion or belief</b>	No	
<b>Marriage and civil partnership</b>	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

**A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.**

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: Chris Pritchett, Consultant Anaesthetist.

**If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:**  
[Section 2. Full Equality Analysis](#)

# Appendix 3. Maternal Transfer to Intensive Care Unit

Maternal identification sticker Name: _____ Hospital number: _____ Date of birth: _____ NHS number: _____
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## Maternal Transfer to Intensive Care Unit (ICU) Summary

**Midwife to complete for ALL maternal transfers**

To be completed in black ink (tick boxes, circle or complete areas) this summary should accompany the patient and case notes to the referring unit

Decision date & time		Transfer from:	
Name of health professional making decision		Transfer to:	
Name of health professional contacting ICU		Name of health professional accepting transfer	
Rational for transfer discussed with woman	Yes / No	Time transfer commenced	
Next of kin informed	Yes/No	Time transfer completed	

**Situation:**

Identify yourself the site/unit you are calling from:

- I am and current location
- The problem is...

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**Background:**

- Risk factors:  
\_\_\_\_\_
- Medical problems, if any:  
\_\_\_\_\_
- Obstetric history  
\_\_\_\_\_
- Current pregnancy  
\_\_\_\_\_  
(scan report, blood tests etc;)

**Assessment:**

Maternal Vital signs: \_\_\_\_\_

Abdominal palpation: \_\_\_\_\_

Vaginal examination: \_\_\_\_\_

Fetal wellbeing: \_\_\_\_\_

Vaginal Packs in situ Yes/ No

Uterine Balloon in Situ Yes/No

**Recommendation & Plan of Management:**

Management plan by transferring midwife: \_\_\_\_\_

Telephone recommendations by receiving unit: \_\_\_\_\_

Signature of transferring midwife/nurse: \_\_\_\_\_

Printed name of transferring midwife/nurse: \_\_\_\_\_

Signature of receiving Midwife/Nurse: \_\_\_\_\_

Printed name of receiving Midwife/Nurse: \_\_\_\_\_

Date and time: \_\_\_\_\_

## **Appendix 4. SBARD - Situation - Background - Assessment – Recommendation and Decision**

### **What is it and how can it help me?**

SBAR is an easy to remember mechanism to frame conversations, especially critical ones, requiring a clinician's immediate attention and action. It enables staff to clarify what information should be communicated between members of the team, and how. It can also help to develop teamwork and foster a culture of patient safety.

The tool consists of standardised prompt questions within four sections, to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition.

The tool helps staff anticipate the information needed by colleagues and encourages assessment skills. Using SBAR prompts staff to formulate information with the right level of detail. The use of SBAR prevents the hit and miss process of 'hinting and hoping'.

### **How to use it**

#### **S Situation:**

- Identify yourself the site/unit you are calling from:
  - I am and current location/
  - I am...
  - The problem is...
- Identify the patient by name and the reason for your report:
  - I am calling about...
  - She was low risk, but...
- Describe your concern:
  - I am calling because I am concerned that...

Firstly, describe the specific situation about which you are calling, including the patient's name, consultant, patient location, code status, and vital signs.

#### **B Background:**

- Give the patient's reason for admission:
  - Woman's/Baby's condition has changed.
- Explain significant medical history:
  - She was low risk or has had one episode of raised blood pressure.

- You then inform the consultant of the patient's background: admitting diagnosis, date of admission, prior procedures, current medications, allergies, pertinent laboratory results and other relevant diagnostic results. For this, you need to have collected information from the patient's chart, flow sheets and progress notes:
  - Her observations are...
  - The fetal heart was...and is now...
  - Her progress has...and she has been in labour for...

#### **A Assessment:**

- Vital signs:
  - Her vital signs are...
  - I think the problem is...
- Contraction pattern, progress in labour, breech presentation in labour or APH:
  - I feel there is no/slow progress or cervical dilatation has not improved
  - I think the presentation is breech and she's in labour
  - She's in pre-term labour
  - She's bleeding...
- Clinical impressions, concerns:
  - The fetal heart has changed from...to...
  - It may be a Postpartum /Antepartum Haemorrhage.

#### **R Recommendation:**

- Explain what you need - be specific about request and time frame:
  - I wish to transfer her now.
- Make suggestions:
  - She requires a medical assessment.
  - She's now a higher risk...
- Clarify expectations:
  - She needs immediate transfer to hospital.

## **Recommended uses and settings for SBAR:**

- Urgent or non-urgent communications.
- Conversations with a doctor or midwife, either in person or over the phone:
  - Particularly useful in nurse to doctor communications  
Also helpful in doctor-to-doctor consultation.
- Discussions with allied health professionals:
  - Respiratory therapy.
  - Physiotherapy.
- Conversations with peers:
  - Change of shift report.
- Escalating a concern.

Hospitals using SBAR have found the following useful:

- Notepads or paper with the tool printed on them.
- Pocket cards.
- Stickers on or next to telephones to act as a visual prompt.