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Royal Cornwall Hospitals NHS Trust

Severely Ill Obstetric Woman Early Recognition and Management Clinical Guideline

V3.0

July 2021

1. Aim/Purpose of this Guideline

1.1. To provide Obstetricians, Anaesthetists, Midwives and Nurses guidance on early recognition and management of the severely ill obstetric women. 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 version supersedes any previous versions of this document.

1.3. 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 (NEW 2020).

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

The Trust has a duty under the Data Protection Act 2018 and 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 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 General Data Protection Regulations 2016/679 please see the *Information Use Framework Policy* or contact the Information Governance Team rch-tr.infogov@nhs.net

2. The Guidance

2.1. Introduction

The most recent triennial reports highlight delays in the recognition and treatment of life-threatening illness in obstetric patients, resulting in Critical Care Unit admissions and deaths. 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 (NEW 2020). All staff must have annual training in relevant aspects of recognition and care of the severely ill patient.

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 Woman

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.

2.2.3. The plan should be clearly documented in the woman's notes and on their electronic record E3 and reviewed and updated at each appointment.

2.2.4. A letter outlining the woman's condition and the plan for her care should be written and this can be attached to E3 by the person making the plan and also the management plan must be updated on E3.

2.2.5. 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 MEOWS chart and fluid balance chart must be commenced.

2.3. Intrapartum Identification of a High Risk Woman

2.3.1. For all women admitted to delivery suite the responsible midwife must check E3 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 co-ordinator 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 co-ordinator should be kept up to date with any changes. (NEW 2020)

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 the reason why must be documented in the notes and the coordinator informed. (NEW 2020)

2.4. Identification of the 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 (except for oxygen saturation in the community). 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 ≥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 clinical condition continue 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.
- Management of their underlying condition should follow the appropriate guideline e.g. Sepsis; recognition and management of antenatal and post-natal 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	**Normal ward care** Care of low risk mother
Level 1	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. Risk of haemorrhage Oxytocin infusion Mild pre-eclampsia on oral anti-hypertensives/fluid balance management/prophylactic Magnesium infusions Women with managed medical conditions such as congenital heart disease, diabetic on insulin infusion
Enhanced Level 1 Care	**Women who require Basic Cardiovascular Support (BCVS)** Intravenous anti-hypertensives and/or Magnesium infusion to control BP in severe pre-eclampsia Arterial line for pressure monitoring and sampling Peripheral infusion of vasopressor to maintain BP eg. Metaraminol infusion CVP line used for fluid management and CVP monitoring/ central venous drug administration
Level 2 REFER FOR Critical care Support	Women requiring single organ support. Basic Respiratory Support (BRS) - 50% or more oxygen via face mask to maintain oxygen saturation Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) Advanced Cardiovascular Support (ACVS) Simultaneous use of at least two intravascular anti-arrhythmic/antihypertensive/vasoactive drugs, one of which must be a vasoactive drug. Need to measure and treat cardiac output Neurological Support Magnesium infusion to control seizures (not prophylactic) Intracranial pressure monitoring Hepatic support Management of acute fulminant hepatic failure eg from HELLP syndrome, or acute fatty liver such that liver transplant is being considered Endocrine support Diabetic Ketoacidosis with severe metabolic disturbance

	and fluid requirements (critical care unit)
Level 3 REFER FOR Critical care Support	Women requiring advanced respiratory support alone or support of two or more organ systems above. Advanced Respiratory Support (ARS) - invasive mechanical ventilation Support of two or more organ systems - Renal support and BRS - BRS/BCVS and an additional organ supported * *A BRS/BCVS occurring simultaneously during the episode count as a single organ support

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.

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 WITHIN THE BED TO FIT INTO THE LIFT. THE BED WILL NOT FIT INTO THE LIFT IF IT HAS BEEN EXTENDED SO ENSURE YOU CHECK IT IS STANDARD 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 (NEW 2020).

2.8.1. **Midwives**

- Enhanced level 1 Care is required, a MEOWS chart and fluid balance 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, e.g. HEAD 346 should undertake one-to-one care (see SOP to be used in case of maternity woman requiring enhanced care on Delivery Suite).

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 E3.

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:

Within bed space

Oxygen outlet and breathing system for 100% oxygen (ambu/Waters circuit) • Pulse oximetry • Blood pressure measurement • Electrical sockets • Suction unit • Electronic monitor (Phillips monitor) that can record: blood pressure, ECG, pulse, SpO2, respirations and invasive monitoring.
In close proximity for use as required
• IV cannula , blood bottles/syringes/needles/sharps bin • IV fluids, fluid warmer and infusion pumps • Continuous ECG monitoring • 12 lead ECG • Forced air warming device • Defibrillator • Resuscitation equipment, emergency drug box and emergency airway box • 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 /NNU)

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	• Stabilise woman • Escalate to Consultant Anaesthetist as required • Agree transfer plan with obstetric and midwifery team. Document discussions and time decision made • 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 • Document transfer plan in maternal notes • Accompany and manage care and safety of woman during transfer to Critical Care Unit • Verbal and written handover of care to Critical Care Unit staff using SBAR • Complete DATIX form
Obstetricians	• Assist in stabilisation of woman • Escalate to Consultant Obstetrician as required • Agree transfer plan with anaesthetic and midwifery team. Document discussions and time decision made

Staff	Action/requirements
	• 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
Midwives	• Assist in stabilisation of woman • Escalate to Labour ward coordinator • Agree transfer plan with anaesthetic and obstetric team. Document discussions and time decision made • Agree plan of care in relation to the woman's midwifery requirements, including plan for future reviews and involvement • Accompany woman to Intensive care unit during transfer • With anaesthetist provide a verbal and written handover of care to Critical care Unit staff using SBARD • Ensure all documentation is completed as required prior to transfer • Document woman's location and condition in the communication book on labour ward. This information needs to be updated daily by the LW coordinator and included in the daily handovers.
HDU/ Critical Care Unit clinicians	Discuss and agree transfer plan with anaesthetist Prepare bed space for transfer Receive woman and verbal and written handover from anaesthetist and midwife accompanying woman Ensure woman has continued obstetric, anaesthetic and midwifery input during her Critical Care Unit stay (see above)
Porters	Women will be transferred on beds and will require porters for transferring Transfer woman on bed to Critical Care Unit with anaesthetist and midwife accompanying
Ward Clerks	Ensure woman is transferred on the PAS system from Maternity to Critical Care Unit

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 SBAR 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

Element to be monitored	Use of the MEOWS chart Use of the Fluid balance chart A trained enhanced level 1 care staff member allocated on shift to oversee the care of the women (NEW 2020) Use of the transfer form Criteria for transfer to HDU/Critical Care Unit Communication and documentation • Did the woman require routine observations in the AN/PN period or additional observations in the intrapartum period? • Was MEOWS chart commenced? • Was a fluid balance chart commenced? • Were all vital signs documented and scored on the MEOWS chart? • Was the risk category page on the front of the MEOWS chart correctly followed? • If step up to level 2 care was required is a clear plan of escalation written • Was one to one care provided and overseen by a trained enhanced level 1 care staff member? NEW 2020) • Did the woman have an underlying non obstetric condition? • If yes, was a clinician from outside the maternity service consulted? • Did the woman require advanced respiratory or cardiovascular support? • If yes, was she transferred to Critical Care Unit? • If yes, was the appropriate transfer form completed? • Has the anaesthetist documented the handover to the Critical Care Unit anaesthetist? • Has the obstetrician documented the hand over to the Critical Care Unit clinician
Lead	Audit midwife
Tool	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.
Frequency	• 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
Reporting arrangements	• A formal report of the results will be received annually at the maternity Forum and clinical audit forum, as per the audit plan • 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.
Acting on recommendations and Lead(s)	• Any deficiencies identified on the annual report will be discussed at the maternity Patient Safety Meeting and clinical audit forum 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 Forum and clinical audit forum until all actions 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 audits will be distributed to all staff through the Patient Safety newsletter/audit forum as per the action plan

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, Inclusion & Human Rights 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

Document Title	Severely Ill Obstetric Woman Early Recognition and Management Clinical Guideline V3.0		
This document replaces (exact title of previous version):	Severely Ill Woman – Obstetric High Dependency and the Management and Early Recognition Of V2.3		
Date Issued/Approved:	July 2021		
Date Valid From:	July 2021		
Date Valid To:	July 2024		
Directorate / Department responsible (author/owner):	Dr Sam Banks Consultant Anaesthetist		
Contact details:	01872 250000		
Brief summary of contents	To provide obstetricians, anaesthetists, midwives and nurses guidance on early recognition and management of the severely ill obstetric women.		
Suggested Keywords:	Severely, ill, obstetric, women, MEOWS, oxygen, monitoring, transfer, ICU, sepsis.		
Target Audience	RCHT	CFT	KCCG
	✓		
Executive Director responsible for Policy:	Medical Director		
Approval route for consultation and ratification:	Maternity Guidelines Group Care Group Board		
General Manager confirming approval processes	Mary Baulch		
Name of Governance Lead confirming approval by specialty and care group management meetings	Caroline Amukusana		
Links to key external standards	CNST 2.8 & 2.9 & 1.9 & 1.10		
Related Documents:	• Department of Health DH 2000: Comprehensive Critical Care. London • Department of Health 2007:The Confidential Enquiry into Maternal Deaths.CEMACH • RCOG 2007: Safer Childbirth, Minimum Standards for the Organisation and Delivery of Care in Labour. London. • CCIAG – Critical Care Information Advisory Group. • 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. • MBRRACE (2014) 2008-2012Saing lives: improving mothers Care • 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 • 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 • The Association of Anaesthetists of Great Britain and Ireland Obstetric Anaesthetists' Association. (2005). OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services Revised Edition 2005.* London: The Association of Anaesthetists of Great Britain and Ireland Obstetric Anaesthetists' Association. • 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. • MBRRACE-UK. *Saving Lives, Improving Mothers' Care* 2009-2012

	• CEMACE. *Saving Mother's Lives: reviewing maternal deaths to make motherhood safer-2006-08.* CEMACE London			
Training Need Identified?	• There is a rolling programme to ensure all core delivery suite staff undertakes Head 346 degree (level 6) assessment, management and escalation of the acutely ill adult. • 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. • All midwives, obstetricians and obstetric Anaesthetists will attend annual training in maternal BLS.			
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

Date	**Version No**	**Summary of Changes**	**Changes Made by** *(Name and Job Title)*
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 SBAR	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
2nd 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
5th 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

14th 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
7th 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 boy of text	Rachel Mullins Practice Development Midwife

Appendix 2. Equality Impact Assessment

<table>
<tr><th colspan="6">Section 1: Equality Impact Assessment Form</th></tr>
<tr><td colspan="6">Name of the strategy / policy /proposal / service function to be assessed
Severely Ill Obstetric Woman Early Recognition and Management Clinical Guideline V3.0</td></tr>
<tr><td colspan="3">Directorate and service area:
Obstetrics and Gynaecology</td><td colspan="3">Is this a new or existing Policy?
Existing</td></tr>
<tr><td colspan="3">Name of individual/group completing EIA
Dr Sam Banks</td><td colspan="3">Contact details:
01872 250000</td></tr>
<tr><td>1. Policy Aim
Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">To provide obstetricians, anaesthetists, midwives and nurses guidance on early recognition and management of the severely ill obstetric women.</td></tr>
<tr><td>2. Policy Objectives</td><td colspan="5">To recognise a deteriorating obstetric woman and ensure swift management appropriate to her needs.</td></tr>
<tr><td>3. Policy Intended Outcomes</td><td colspan="5">Safe outcome for pregnant and newly delivered women.</td></tr>
<tr><td>4. How will you measure the outcome?</td><td colspan="5">Compliance Monitoring Tool</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">All pregnant and newly delivered women.</td></tr>
<tr><td rowspan="3">6a). Who did you consult with?

b). Please list any groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Please record specific names of groups:

Maternity Guideline Group
Care Group Board</td></tr>
<tr><td>c). What was the outcome of the consultation?</td><td colspan="5">Agreed</td></tr>
</table>

7. The Impact

Please complete the following table. If you are unsure/don't know if there is a negative impact you need to repeat the consultation step.				
Are there concerns that the policy **could** have a positive/negative impact on:				
Protected Characteristic	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		**X**		
Sex (male, female non-binary, asexual etc.)		**X**		
Gender reassignment		**X**		
Race/ethnic communities /groups		**X**		
Disability (learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions)		**X**		
Religion/ other beliefs		**X**		
Marriage and civil partnership		**X**		
Pregnancy and maternity		**X**		
Sexual orientation (bisexual, gay, heterosexual, lesbian)		**X**		

If all characteristics are ticked 'no', and this is not a major working or 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:	Dr Sam Banks

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 debby.lewis@nhs.net

Appendix 3.

Maternal identification sticker Name: Hospital number: Date of birth: NHS number:

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…

_____
_____
_____
_____
_____
_____

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.

SBAR - Situation - Background - Assessment – Recommendation & 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 PPH/APH

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