Severely Ill Obstetric Woman
Early Recognition and Management

Clinical Guideline V2.1

June 2018
1. **Aim/Purpose of this Guideline**
   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 (New 2018) 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 (New 2018).

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. All staff must have annual training in relevant aspects of recognition and care of the severely ill patient (New 2018).

   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**
   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.

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

   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 (New 2018). 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 (New 2018).
2.3. Intrapartum Identification of a High Risk Woman

For all women admitted to delivery suite the responsible midwife must check E3 for any information relevant to the woman’s care. On admission a risk assessment should be completed by the admitting midwife and any risk factors identified. For women with existing risk factors or risk factors identified in the admission risk assessment, the duty Obstetrician should be informed and a plan of care documented in the woman’s notes.

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 (New 2017) (except for oxygen saturation in the community). Frequency of further monitoring should be as per the MEOWS trigger score (New 2017) and commence a fluid balance chart (New 2018).

2.5. Management of the Severely Ill Pregnant Women (New 2017)

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 (New 2018)

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 (New 2018)

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) *(New 2018)*

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 *(New 2018)*.

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

**Equipment:** 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)

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### 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

<table>
<thead>
<tr>
<th>Staff</th>
<th>Action/requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetists</td>
<td>• Stabilise woman</td>
</tr>
<tr>
<td></td>
<td>• Escalate to Consultant Anaesthetist as required</td>
</tr>
<tr>
<td></td>
<td>• Agree transfer plan with obstetric and midwifery team. Document discussions and time decision made</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• Document transfer plan in maternal notes</td>
</tr>
<tr>
<td></td>
<td>• Accompany and manage care and safety of woman during transfer to Critical Care Unit</td>
</tr>
<tr>
<td></td>
<td>• Verbal and written handover of care to Critical Care Unit staff using SBAR</td>
</tr>
<tr>
<td></td>
<td>• Complete DATIX form</td>
</tr>
<tr>
<td>Obstetricians</td>
<td>• Assist in stabilisation of woman</td>
</tr>
<tr>
<td></td>
<td>• Escalate to Consultant Obstetrician as required</td>
</tr>
<tr>
<td></td>
<td>• Agree transfer plan with anaesthetic and midwifery team.</td>
</tr>
<tr>
<td>Staff</td>
<td>Action/requirements</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Staff                         | Document discussions and time decision made  
• 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       | 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

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Use of the MEOWS chart</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use of the Fluid balance chart</td>
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<tr>
<td></td>
<td>Care by appropriate trained staff</td>
</tr>
<tr>
<td></td>
<td>Use of the transfer form</td>
</tr>
<tr>
<td></td>
<td>Criteria for transfer to HDU/Critical Care Unit</td>
</tr>
<tr>
<td></td>
<td>Communication and documentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tool</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Did the woman require routine observations in the AN/PN period or additional observations in the intrapartum period?</td>
</tr>
<tr>
<td></td>
<td>• Was MEOWS chart commenced?</td>
</tr>
<tr>
<td></td>
<td>• Was a fluid balance chart commenced?</td>
</tr>
<tr>
<td></td>
<td>• Were all vital signs documented and scored on the MEOWS chart?</td>
</tr>
<tr>
<td></td>
<td>• Was the risk category page on the front of the MEOWS chart correctly followed?</td>
</tr>
<tr>
<td></td>
<td>• If step up to level 2 care was required is a clear plan of escalation written?</td>
</tr>
<tr>
<td></td>
<td>• Was one to one care provided by an appropriate trained midwife/nurse?</td>
</tr>
<tr>
<td></td>
<td>• Did the woman have an underlying non obstetric condition?</td>
</tr>
<tr>
<td></td>
<td>• If yes, was a clinician from outside the maternity service consulted?</td>
</tr>
<tr>
<td></td>
<td>• Did the woman require advanced respiratory or cardiovascular support?</td>
</tr>
<tr>
<td></td>
<td>• If yes, was she transferred to Critical Care Unit?</td>
</tr>
<tr>
<td></td>
<td>• If yes, was the appropriate transfer form completed?</td>
</tr>
<tr>
<td></td>
<td>• Has the anaesthetist documented the handover to the Critical Care Unit anaesthetist?</td>
</tr>
<tr>
<td></td>
<td>• Has the obstetrician documented the hand over to the Critical Care Unit clinician</td>
</tr>
</tbody>
</table>

| 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.  |
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>Severely Ill Obstetric Woman Early Recognition and Management Clinical Guideline V2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>7th June 2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>7th June 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>7th June 2021</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Dr Sam Banks Consultant Anaesthetist</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 250000</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>To provide obstetricians, anaesthetists, midwives and nurses guidance on early recognition and management of the severely ill obstetric women.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Severely, ill, obstetric, women, MEOWS, oxygen, monitoring, transfer, ICU, sepsis.</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT CFT KCCG</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>7th June 2018</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Severely Ill Woman – Obstetric High Dependency and the Management and Early Recognition Of V2.0</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Maternity Guidelines Group Maternity Governance Obstetrics and Gynaecology Directorate Policy Review group Divisional Board for approval</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Tunde Adewopo</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not required</td>
</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed} Name: Caroline Amukusana</td>
</tr>
</tbody>
</table>
**Related Documents:**

- Department of Health DH 2000: Comprehensive Critical Care. London
- Department of Health 2007: The Confidential Enquiry into Maternal Deaths.CEMACH
- 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) 2008-2012 Saing 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

- 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


- 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.
Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2004</td>
<td>V1.0</td>
<td>Initial Issue: Guidelines for the Transfer of Patients to High Dependency / Intensive Care</td>
<td>Dr Bill Harvey Consultant Anaesthetist</td>
</tr>
<tr>
<td>January 2010</td>
<td>V1.1</td>
<td>Addition of recognition of the severely ill obstetric woman, use of MEOWS and SBAR</td>
<td>Dr Catherine Ralph Consultant Anaesthetist</td>
</tr>
<tr>
<td>March 2012</td>
<td>V1.2</td>
<td>Inclusion of recognition and management of maternal sepsis and compliance monitoring</td>
<td>Dr Catherine Ralph Consultant Anaesthetist</td>
</tr>
<tr>
<td>August 2012</td>
<td>V1.3</td>
<td>Changes to compliance monitoring only</td>
<td>Dr Catherine Ralph Consultant Anaesthetist</td>
</tr>
<tr>
<td>2nd July 2015</td>
<td>V1.4</td>
<td>Proforma includes documentation of vaginal packs/Bakri Balloon situ on transfer to Critical Care Unit</td>
<td>Dr Sam Banks Consultant Anaesthetist</td>
</tr>
<tr>
<td>5th September 2017</td>
<td>V1.5</td>
<td>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.</td>
<td>Angela Whittaker, inpatient matron. Dr Sam Banks, Consultant Anaesthetist</td>
</tr>
<tr>
<td>14th March 2018</td>
<td>V2.0</td>
<td>Inclusion of detailed HDU care, see New 2018 in body of text</td>
<td>Helen Odell, Patient Safety Lead and maternity guidelines group</td>
</tr>
<tr>
<td>7th June 2018</td>
<td>V2.1</td>
<td>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.</td>
<td>Helen Odell, safety and quality lead and Sally Nash, Consultant Anaesthetist</td>
</tr>
</tbody>
</table>

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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 Form

This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Directorate and service area: Obs &amp; Gynae Directorate</th>
<th>Is this a new or existing Policy?</th>
<th>Existing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of individual completing assessment: Dr Sam Banks</td>
<td>Name of the strategy / policy / proposal / service function to be assessed</td>
<td>Observatory Service Function Director</td>
<td>Directorate and service area: Obs &amp; Gynae Directorate</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>Existing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of individual completing assessment: Dr Sam Banks</td>
<td>Telephone: 01872 250000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Policy Aim**

   *Who is the strategy / policy / proposal / service function aimed at?*

   To provide obstetricians, anaesthetists, midwives and nurses guidance on early recognition and management of the severely ill obstetric women.

2. **Policy Objectives**

   To recognise a deteriorating obstetric woman and ensure swift management appropriate to her needs.

3. **Policy – intended Outcomes**

   Safe outcome for pregnant and newly delivered women.

4. **How will you measure the outcome?**

   Compliance Monitoring Tool

5. **Who is intended to benefit from the policy?**

   All pregnant and newly delivered women.

6a Who did you consult with? Workforce Patients Local groups External organisations Other

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

   - Clinical Guideline Group
   - Maternity Governance
   - Obstetrics and Gynaecology Directorate
   - Divisional board
   - Policy review group

   **Please record specific names of groups**

   Guideline approved.

   **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 impact you need to repeat the consultation step.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td></td>
<td>X</td>
<td></td>
<td>All pregnant and newly delivered women</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td></td>
<td>X</td>
<td></td>
<td>All pregnant and newly delivered women</td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td></td>
<td>X</td>
<td></td>
<td>All pregnant and newly delivered women</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td></td>
<td>X</td>
<td></td>
<td>All pregnant and newly delivered women</td>
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<tr>
<td>Marriage and Civil partnership</td>
<td></td>
<td>X</td>
<td></td>
<td>All pregnant and newly delivered women</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td>X</td>
<td></td>
<td>All pregnant and newly delivered women</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
<td>X</td>
<td></td>
<td>All pregnant and newly delivered women</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No | X |
9. If you are not recommending a Full Impact assessment please explain why.
Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

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

Signed Sarah-Jane Pedler
Date 7th June 2018
# Appendix 3.

## 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.

<table>
<thead>
<tr>
<th>Decision date &amp; time</th>
<th>Transfer from:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of health professional making decision</th>
<th>Transfer to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of health professional contacting ICU</th>
<th>Name of health professional accepting transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rational for transfer discussed with woman</th>
<th>Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Next of kin informed</th>
<th>Yes/No</th>
<th>Time transfer commenced</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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
  o I am and current location
  o I am…
  o The problem is…
• Identify the patient by name and the reason for your report
  o I am calling about…
  o She was low risk, but…
• Describe your concern
  o 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
  o Woman's/Baby's condition has changed
• Explain significant medical history
  o 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.
  o Her observations are…
  o The fetal heart was…and is now…
  o Her progress has…and she has been in labour for…

A Assessment:
• Vital signs
  o Her vital signs are…
  o I think the problem is…
• Contraction pattern, progress in labour, breech presentation in labour or APH
  o I feel there is no/slow progress or cervical dilatation has not improved
  o I think the presentation is breech and she’s in labour
  o She’s in pre-term labour
• She’s bleeding…

• Clinical impressions, concerns
  o The fetal heart has changed from…to…
  o It may be a PPH/APH

R Recommendation:
• Explain what you need - be specific about request and time frame
  o I wish to transfer her now
• Make suggestions
  o She requires a medical assessment
  o She’s now a higher risk…
• Clarify expectations
  o 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
  o Particularly useful in nurse to doctor communications
    Also helpful in doctor to doctor consultation
• Discussions with allied health professionals
  o Respiratory therapy
  o Physiotherapy
• Conversations with peers
  o 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