Ashford and St. Peter's Hospitals
NHS Foundation Trust

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

Attendance at the Emergency Department and admission elsewhere in the hospital of pregnant and recently delivered women

Amendments			
Date	Page(s)	Comments	Approved by
Oct 2012	Whole document review		Women's Health Guidelines Group
March 2018	Whole document review	Vital Pac additions	Women's Health Guidelines Group
March 2024	Whole document review whole	Change to gestation in ED Locations for referral in Maternity link added.	Women's Health Guidelines Group

Initially Compiled by: Jacqui Rees, Women's Health Clinical Governance Manager
Gill Nelson, Business Unit Services Manager

In Consultation with: Consultant Obstetricians & Gynaecologists
Accident and emergency department
Labour Ward Forum

Ratified by: Women's Health Guidelines Group

Date Ratified: October 2012

Date Issued: October 2012

Next Review Date: March 2027

Target Audience: Staff working in Emergency Care and Women's Health Services including
Maternity at Ashford & St. Peters Hospital

Impact Assessment Carried Out By: Women's Health Guidelines Group

Comments on this document to: Abigail Le Bas, O&G Consultant
Karin Leslie, Obstetrics Consultant

Pregnant and Recently Delivered Women Who Attend the Emergency or other Hospital Departments

See also: EPU Referral pathway for pain and bleeding in early pregnancy
Safeguarding children and vulnerable women

Introduction:
This guideline seeks to set out the expectations in relation to the care management of pregnant women who are being cared for by Ashford & St Peters Hospital services other than the Maternity Services

Women who are under 16 weeks pregnant are advised to contact NHS 111, their GP, or to attend ED, if they have symptoms which concern them.

If they are under 12 weeks pregnant, they may also contact the Early Pregnancy Unit (EPU), Monday – Friday 0900-16.00hrs (excluding Bank Holidays) if they have pregnancy-related symptoms.

Pregnant women booked for delivery at Ashford and St. Peter's Hospital (ASPH) NHS Trust, who are 16 weeks gestation or more, are advised to contact the Pregnancy Advice Line, Maternity Triage Unit, their Community Midwife, General Practitioner, or the Maternity Day Assessment Unit (MDAU) if they have symptoms which concern them.

For women who are over 16 weeks but do not have a pregnancy-related concern, the most appropriate place for emergency care remains ED rather than a maternity care setting.

This guideline should be followed for all pregnant women who present to ED following an accident/injury, domestic abuse or with a medical problem.

Initial Assessment:

A senior ED doctor should triage the patient and confirm gestation.

Where appropriate the gynaecology (<16 weeks) or obstetric (≥16 weeks) on call team should be asked to review.

It is recognised that overnight there may be a delay in review due to other conflicting demands and one O&G SHO and SpR on site. Where safe and appropriate, and with the express consent of the O&G registrar and LW midwife-in-charge, pregnant patients may be transferred to LW from ED to facilitate more prompt review. It may then be necessary to move the patient back to ED after assessment, to either await a bed for admission or further treatment.

Pregnancy Related Problems:
If a birth appears imminent, contact Labour Ward and a midwife will attend ED Department immediately. In gestations of 22 weeks or more, then 2222 'Obstetric Priority' is the appropriate call to ensure neonatal, obstetric, midwifery and anaesthetic attendance.
If the woman is over 16 completed weeks of pregnancy, a call should be made to the maternity bleep holder (bleep 5083) to arrange transfer to labour ward. ASPH does not have a gynaecology ward, or trained staff on a general surgical ward. Therefore, a maternity setting remains the most appropriate place for admission in the context of threatened late miscarriage.

If the woman is less than 12 completed weeks gestation, and presents with pelvic pain and or vaginal bleeding refer to EPU guideline:

http://trustnet/docsdata/gynaecology/REFERRAL%20PATHWAY%20FOR%20PAIN%20AND%20BLEEDING%2 0IN%20EARLY%20PREGNANCY%202017.docx

Unexpected delivery of non-viable baby in ED:

As stated above if birth appears imminent, please escalate promptly and transfer the patient to LW if they are more than 12 weeks gestation.
It is not planned that any 12-16-week miscarriages should occur in ED despite the change in gestation threshold to be seen in maternity triage.
However, the clinical picture can sometimes change quickly and it is anticipated delivery may occur in ED on occasion.

In the event of imminent delivery of 12-16 week baby in ED with no time to transfer to LW:

1. Inform the gynaecology registrar and SHO, LW midwife in charge
2. Inform the gynaecology consultant on call if between 9-5pm Mon-Fri
3. Move the patient to a side room if possible
4. Ensure IV access, FBC, 2 G&S
5. Offer appropriate analgesia(this could include but is not limited to paracetamol, codeine, Entonox, penthrox)
6. Capture all blood loss and weigh
7. Retrieve the birth pack from the designated storage space
8. If time allows, talk to the patient and any birthing partner about whether they wish to see baby immediately when they are born
9. If the patient needs to go to the toilet, a bowl should be placed in the toilet to avoid inadvertent delivery into the toilet.
10. When baby is born, place baby in receiving wicker basket lined with a blanket. Document time of birth and staff members present.
11. NB Placing baby in a vomit bowl, tray, or other type of receiver is not appropriate.
12. Baby may be born with signs of life.
13. NB Reflexive movements are not considered signs of life.
14. (WHO definition: spontaneous breathing, spontaneous heartbeat, twitching or other active body movement)
15. **If signs of life are present** then a senior doctor must be called to observe signs of life.
16. Parents will need support to hold their baby if they wish or a member of staff should care for baby until baby passes.
17. Doctor to return when signs of life cease and certify death of baby.
18. Doctor to decide whether they can certify cause of death e.g. extreme prematurity or whether they feel circumstances require further investigation and the coroner needs to be involved. This would be very rare but we have had cases in the past e.g. domestic violence, self-harm.
19. **If no signs of life are present** Nurse/ practitioner present must complete the cremation form confirming that baby was born with no signs of life.
20. This form must accompany the mother and be given to the maternity staff when mother is transferred to the labour ward.
21. Baby and placenta may be born together. If so, keep placenta attached until gynaecology/midwifery staff arrive.
22. If baby is born and placenta is still in-situ, apply 2 cord clamps to a midsection of the cord and then cut between the 2 clamps.
23. The placenta can commonly take another 30 minutes to separate.
24. If the placenta has not separated after 30 minutes, 200mg misoprostol can be given vaginally or orally to aid separation.

25. If there is brisk bleeding after delivery of baby, a surgical Evacuation of Retained Products of Conception (ERPC) under general anaesthetic may be required. This can be performed in main theatres or in LW theatres depending on availability and the whole clinical picture.
26. In some circumstances it may be appropriate to transfer the patient to a LW after delivery of the baby but with the placenta still in-situ. This would require face to face review by the O&G registrar/consultant to ensure the risk of patient deterioration or post-partum haemorrhage during transfer is as low as possible.
27. Baby should be cared for sensitively. It should be placed in the receiving basket and then in a container labelled with the mother's details and date of delivery. Baby should stay with the mother if they wish. If they do not wish to keep baby with them, then baby should be taken to LW and given directly to the midwife-in-charge who will supervise correct placement and check-in to the LW Daffodil Support Room fridge. It is not appropriate for a porter to transfer baby.
28. It is not expected that any patient who delivers their baby in ED will be discharged home from ED. The expected process is that they will be admitted for observation, time for memory making with baby and appropriate time to discuss their choices for baby including funeral, post-mortem and cremation. For any patient that does wish to be discharged directly from ED, then the wishes for care of baby and appropriateness for post-mortem discussed and consent for post-mortem signed.
29. This will include wishes for private cremation/burial, hospital cremation/burial and sensitive disposal.
30. The decision to take baby home should also be discussed and relevant paperwork completed and leaflet given to parents 'taking your deceased baby home'. If the mother is discharged from A&E and leaves her baby, the baby should be labelled and taken to the labour ward, cold storage, where the bereavement midwives will prepare the baby for transfer to the mortuary.
31. Contact card for the bereavement midwives should be given to parents. The bereavement midwives will contact all patients unless they specifically request not to be contacted.

Apparent Non-Pregnancy Related Problems:

The woman, who presents to the Emergency Department with a non-pregnancy related problem, will still need careful assessment of her pregnancy and should be a discussed with the gynaecology team if up to 16 weeks and the obstetric team from 16 weeks gestation onwards. When assessing these women, remember that certain serious pregnancy related problems can be misdiagnosed.

If the condition of the woman warrants admission to a medical/surgical ward the obstetric registrar and maternity bleep holder must be informed and they will ensure her details are written on the labour ward board. The senior midwife in charge must ensure that she is discussed at the board round with the consultant and obstetric registrar and reviewed as appropriate to monitor the maternal and fetal wellbeing.

Should the woman require admission to ITU or HDU the on call registrar who must decide whether immediate consultant obstetrician/gynaecologist involvement is required (Please refer to the Trigger list for calling a consultant and the head of Midwifery).

A pregnant (or postnatal) woman with a suspected VTE, at any gestation, must be managed in conjunction with the Obstetric/Gynaecology on call team. The most appropriate ward for admission will depend on the whole clinical picture and gestation. If the woman is unwell she must be managed by the ED/medical/critical care teams who must discuss her treatment with the on call O&G registrar.

PLEASE NOTE when carrying out observations, the maternity early warning score (MEWS) must be used. This is not available on Cerner and therefore all observations must also be documented on a paper copy of the MEWS chart to ensure early recognition and escalation of the pregnant patient.

Pregnant Women Who Are Unbooked:
Any woman, who presents to Emergency Department and is apparently pregnant, at any gestation, must be asked if she has booked for maternity care. If she is not booked, the Labour Ward Shift Leader should be informed and will make a referral to the Community Midwifery Team. The Community Midwifery Team will ensure a booking appointment is made.

The Emergency department will need to provide the following information:

- Full Name
- Hospital Number
- Date of Birth
- Address
- Contact telephone number
- GP details
- Approximate Gestation

Road Traffic Accident (RTA)
Any pregnant woman involved in an RTA, however minor, must have an assessment of maternal and fetal wellbeing by a midwife or an obstetrician. If the condition of the woman is serious following the RTA, the Emergency team will initiate management and the obstetric registrar and Labour Ward Team Leader should be informed as soon as possible in case an emergency delivery is required. If the woman is well it may be appropriate for her injuries to be managed in ED and then transfer arranged to the maternity department for review.

Domestic Abuse
If a pregnant woman attends Emergency department having experienced domestic abuse the Labour Ward Team Leader must be informed, so that follow up by the community midwife can be arranged and for necessary referrals to be made. During office hours support and advice should be sought from the named midwife for safeguarding on extension 3962. Physical injuries must be managed by ED. If appropriate she may then be transferred to the maternity unit for ongoing management.

Postnatal Period
The postnatal period extends to 42 days following delivery. Should a mother be referred to the Emergency Department in the postnatal period there should be an initial assessment by the ED Department staff and appropriate measures taken to address the woman's immediate problems. Ongoing management must be discussed with the O&G on call registrar.
They will advise on the appropriate management. If admission to ASPH is necessary during the postnatal period the woman may be admitted to the postnatal ward, Labour Ward or other hospital department as appropriate. Where the women is admitted to a department other than the Maternity unit; the Obstetric registrar must inform the Labour Ward Team Leader, who will ensure her details are documented in the Maternity Outliers Book. Midwifery/Obstetric follow up for postnatal inpatients must be arranged.

Maternal Deaths
We have a statutory requirement to report all Maternal Deaths during pregnancy and up to 1 year following birth, miscarriage or termination of pregnancy irrespective of the reason for that death. The maternity services will coordinate all reporting to MBRRACE. If a woman meets these criteria, the maternity bleep holder must be informed and she will make the necessary arrangements for reporting.

See guideline for Maternal Death.

Mental Health
Any pregnant or postnatal woman attending ED suffering from mental illness the labour ward team leader should be informed and the Perinatal Mental Health Lead Midwife should be contacted. Any

admissions to the Abraham Cowley Unit should be made in consultation with the obstetric registrar and documented in the Maternity Outliers book as described above.

Monitoring
Compliance with this guideline will be monitored 3 yearly by review of maternity records as detailed in the table below. Where deficiencies are identified action plans will be developed and changes implemented and disseminated as required.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
A. which women attending the emergency department should be seen by an experienced doctor from the obstetric/gynaecology team or a midwife **B. requirement that the care of pregnant women with non-obstetric problem(s) who require admission should be discussed and planned with the local obstetric team** **C. system for ensuring that the on-call obstetric consultant is aware of all sick pregnant women in the hospital who have a non-obstetric problem** **D. system for ensuring that the on call obstetric consultant is aware of all sick pregnant women in the hospital who have a problem related to their pregnancy**	Jacqui Rees	Audit tool attached in appendix 4	3 yearly	Perinatal mortality meeting or Clinical Governance group. A & E Clinical governance group	Clinical manager A & E, Clinical manager Labour ward. Matron for maternity services.	Communication bulletin, Quality and Safety half days. Departmental newsletters including trust lessons learned newsletter. Staff meetings and any other meeting as appropriate.

References

Bewley S, Friend J, Mezey G editors 1997. Violence against Women. London RCOG press. Royal College of Midwives. 1997 Domestic abuse in Pregnancy. Position paper No 19. London: Royal College of Midwives

Confidential Enquiries into Maternal Deaths in the United Kingdom. (CEMACE) (2011). Saving Mothers' Lives: Reviewing Maternal Deaths to make Motherhood Safer: 2006-2008. London: Wiley- Blackwell. Available at: http:///www.rcog.org.uk

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) Available at: https://www.npeu.ox.ac.uk

Name:

Hospital Number

Date of birth

CONTACT DOCTOR FOR EARLY INTERVENTION IF ONE RED OR TWO AMBERS ARE SCORED AT ANY ONE TIME

	Date :																		
	Time :																		
TEMP •	39																		39
	38																		38
	37																		37
	36																		36
	35																		35
Saturations	95-100%																		95-100%
	<95%																		<95%
Administered O_2 (L/min.)																			%
RESP (write rate in corresp. box)	>30																		>30
	21-30																		21-30
	11-20																		11-20
	0-10																		0-10
HEART RATE •	170																		170
	160																		160
	150																		150
	140																		140
	130																		130
	120																		120
	110																		110
	100																		100
	90																		90
	80																		80
	70																		70
	60																		60
	50																		50
	40																		40
SYSTOLIC BLOOD PRESSURE ▲	200																		200
	190																		190
	180																		180
	170																		170
	160																		160
	150																		150
	140																		140
	130																		130
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	110																		110
	100																		100
	90																		90
	80																		80
	70																		70
	60																		60
	50																		50
DIASTOLIC BLOOD PRESSURE ▼	130																		130
	120																		120
	110																		110
	100																		100
	90																		90
	80																		80
	70																		70
	60																		60
	50																		50
	40																		40
DRUGS																			
URINE OUTPUT	Amount (mls)																		Amount (mls)
Proteinuria	Protein ++																		Protein ++
	Protein >++																		Protein >++
NEURO RESPONSE (□)	Alert																		Alert
	Voice																		Voice
	Pain																		Pain
	Unresponsive																		Unresponsive
Pain Score (no.)	0-1																		0-1
	2-3																		2-3
Lochia	Normal																		Normal
	Heavy / Fresh Offensive																		Heavy / Fresh Offensive
Looks unwell	NO (□)																		NO (□)
	YES (□)																		YES (□)
TOTAL AMBER SCORES																			
TOTAL RED SCORES																			

Pain score: 0= No pain 1= Mild 2= Moderate 3= Severe. Please note this is not an assessment of contraction strength and duration which should be documented on the partogram

(Back page of Obstetric Early Warning Chart)

Contact doctor for early intervention if patient triggers One Red or Two Amber scores at any one time

Once referred to a doctor the following action must be taken

1. Registrar: assess the patient and complete a written care management plan in the obstetric notes
2. Plan must be followed and the patient reviewed after 30 minutes. Repeat the mews score at this time
3. If abnormal parameters persist further treatment must be discussed with the labour ward consultant/on call consultant. The labour ward anaesthetist should also be involved in discussion/management

The Obstetric anaesthetist should alert the outreach team 8233 if transfer to HDU/ICU is being considered (even if transfer not imminent)

Appendix 3

Pregnant Outliers Communication Book-Process for Doctors and Midwives

If the condition of the woman warrants admission to a medical/surgical ward the obstetric registrar and maternity bleep holder must be informed and they will ensure her details are documented in the Obstetric Outliers Book and that she is reviewed as appropriate to monitor the maternal and fetal wellbeing. The consultant obstetrician should be informed of the admission.

A pregnant woman who is admitted to a clinical area outside of maternity should be monitored by using the Maternity Obstetric Warning System (MEWS). MEWS charts are available from Labour ward and can be printed from Appendix 1 of this guidelines and nurses can seek guidance from the Labour Ward Team Leader on extension 2399/2864 on their usage and completion.

At handover on the labour ward all pregnant outliers must be discussed and an ongoing management plan agreed. Arrangements will be made for midwifery and/or obstetric monitoring and this should be documented in this book and the woman's notes
All doctors must sign the outlier's book against current inpatients at handover time and update management plan as appropriate.

Appendix 4

Admissions to the Emergency Department – Audit Tool

Q1, Has the woman attended the Emergency Department with a pregnancy related problem?

☐ Yes → Go to Q2 ☐ No → Go to Q4

Q2, Gestation at time of attendance:

☐ < 12 weeks gestation → Go to Q3 ☐ > 12 weeks gestation → Go to Q4

Q3, Was this attendance discussed with the

☐ EPU
OR out of hours (15.00 – 09.00)
☐ Managed by Emergency Department staff

Q4, ☐ Maternity bleep holder contacted

Q5, Was the woman admitted to a hospital department other than maternity?

☐ Admitted to Medical / Surgical Ward → Go to Q6 ☐ ITU / HDU → Go to Q7

Q6, ☐ Obstetric Registrar informed

☐ Maternity bleep holder informed

☐ Maternity Outliers Book completed → Go to Q8

☐ Consultant team informed within 24 hours

Q7, ☐ On call Registrar called consultant

Q8, ☐ Has MEOWS chart been used for monitoring If admitted to a clinical area outside Maternity (not ITU)

Other issues:

VTE

Q9, ☐ Managed in conjunction with Obstetrics on call team

☐ Transferred to Labour Ward (if clinically well)

☐ Managed by Emergency Department (if clinically unwell)

RTA

Q10, ☐ Assessment by Midwife or Obstetrician

Domestic Abuse

Q11, ☐ Labour Ward Team Leader informed

EQUALITY IMPACT ASSESSMENT TOOL

Name: Pregnant and Recently Delivered Women Who Attend the Emergency or other Hospital Departments
Service relevant to: Women's Health services, Maternity services, Emergency department

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
This guideline seeks to set out the expectations in relation to the care management of pregnant women who are being cared for by Ashford & St Peters hospital services other than the Maternity Services The maternity guidelines group completed the impact assessment
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
Consultation regarding equality issues was not required as impact considered minimal
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
Communication with patients regarding any pregnancy where their first language is not English is mitigated via referral to the trust interpreting policy
Conclusion □ Provide a summary of the overall conclusions
Minimal impact identified Controls in place

Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
Assessment will be reviewed along with any updating or revisions of the guidance required

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	Religion or belief (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	Sexual orientation including lesbian, gay and bisexual people (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	Age (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	Social class (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact Maria Crosbie, HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	Pregnant and Recently Delivered Women Who Attend the Emergency or other Hospital Departments …….
Name of Person completing form:	…Laura Carr…….
Date:	…October 2012…….

Author(s)	J Rees
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	J Rees
Date of final draft	October 2012
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?	Yes
By whom:	Women's Health Guideline Group
Is this a new or revised policy/guideline?	revised

Describe the development process used to generate this policy/guideline. Who was involved, which groups met, how often etc.?
All consultant Obstetricians & Gynaecologists, senior midwives, A & E department, labour ward forum
Who is the policy/guideline primarily for?
Staff caring for any woman who is pregnant as an inpatient at Ashford & St. Peters Hospitals
Is this policy/guideline relevant across the Trust or in limited areas?
Across the trust
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Newsletters, trust net, intranet departmental sites
Describe the process by which adherence to this policy/guideline will be monitored. (This needs to be explicit and documented for example audit, survey, questionnaire)
This policy will be monitored via the Pregnant outliers book entries and the attached audit tool
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
See references
What (other) information sources have been used to produce this policy/guideline?
NHSLA CNST Maternity Standards April 2009
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
Yes
Other than the authors, which other groups or individuals have been given a draft for comment?(e.g. staff, unions, human resources, finance dept., external stakeholders and service users)

All Consultants senior midwives, A & E department
Which groups or individuals submitted written or verbal comments on earlier drafts?
All of the above
Who considered those comments and to what extent have they been incorporated into the final draft?

Locations for Referral in Maternity Table Mar 2024.pdf (asph.nhs.uk)