Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

Observation Bay, Labour Ward

CRITERIA FOR ADMISSION, DISCHARGE AND TRANSFER INCLUDING RECOVERY, POST OPERATIVE CARE AND THE IDENTIFICATION OF THE SEVERELY ILL OBSTETRIC PATIENT

Amendments			
Date	Page(s)	Comments	Approved by
June 2007		Complete document review	WHCG committee
May 2009		Complete document review	Maternity Guidelines Group
May 2012		Complete document review	Women's Health guidelines group
Feb 2018		Complete document review – no changes	Head of Midwifery
April 2019		Complete document review	Women's Health Governance Group

Compiled by: Dr J Margary, Dr S Soltanifar, Consultant Obstetric Anaesthetists

In Consultation with: Consultant Obstetricians, Labour Ward Forum

Ratified by: Women's Health Guidelines Group

Date Ratified: May 2012
Date Issued: May 2012
Next Review Date: April 2022
Target Audience: Staff working within the maternity services

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

Comments on this document to: Dr James Margary

MATERNITY OBSERVATION BAY

See also:
All Hypertension guidelines
Immediate Care of the Newborn
All Diabetes guidelines
Pregnant Women in Accident and Emergency department
HDU resources folder – common monitoring procedures
Training Needs Analysis
Handover of Care
Maternal transfer of care
Caesarean Section guideline
Anaesthetic guidelines
Guideline for the treatment of sepsis during pregnancy, labour and the puerperium
Trigger list for calling a consultant

Introduction & Purpose

The Maternity Observation Bay has 24 hour/day anaesthetic cover and enables the maternity unit to provide additional monitoring for women who are sick during the childbearing continuum.
This guideline sets out the admission/transfer criteria for the labour ward observation area as well as management and care of women who are admitted including post-operative recovery.

Responsibilities of staff groups

Care is led by a consultant obstetrician with support from a consultant anaesthetist, and is provided by a multidisciplinary team, which may include registered nurses and operating department practitioners (ODP).
The staff to patient ratio should be high to ensure adequate care. If a registered nurse or ODP is assigned to work in the bay the midwifery care of women and babies must be carried out by a midwife. If the midwife has to temporarily leave the bay she/he must formally handover the care of the other mothers and babies to another midwife, this should be documented using SBAR (Situation, Background, Assessment, and Recommendation) principles.

ADMISSION/TRANSFER CRITERIA TO THE OBSERVATION AREA

Admission will be determined on a case by case basis in the context of Labour Ward activity. Women with the following problems shall be considered for care in this area:

- Post Caesarean section or instrumental delivery from theatre.
- Post- PPH > 1000 mls requiring monitoring and/or blood transfusion.
- Management of moderate/severe pre-eclampsia / eclampsia / HELLP
- Perinatal Management of Diabetic Mothers on insulin (see Clamp Regime Protocol).
- Threatened preterm labour
- APH not in labour
- Post transfer from ITU or main theatre

- Women requiring ECG, CVP or other invasive monitoring
- Post operative procedure
- If the Consultant Obstetrician and/or Consultant Anaesthetist consider that additional support or observation is required, they should liaise with the ITU team regarding transfer.
- Women requiring intubation and ventilation and/or renal replacement therapy need to be transferred to the Intensive Therapy Unit
- Where non-invasive ventilation is required the Outreach team should be contacted for support and assessment (pager 8233) prior to transfer to an acute ward

Qualified staff members are responsible for ensuring patients are assessed and monitored appropriately, and cared for within a safe environment. In general staff should ensure that:

- The bed height is in the lowest position, except when direct care or supervision is being given.
- Bed rails are to be fitted and used as appropriate on all beds in the observation bay.
- Patient call bell must be in working order, within the mothers reach and she must have received clear instructions about how and when to call for assistance. Including trying to get up unaided.
- All care should be clearly documented according to unit guidelines
- Monitoring equipment including Non invasive BP monitor, CVP monitor, arterial line monitor, suction, pulse oximeter and oxygen must be checked daily and be fully functional ready for the next admission

On admission to observation bay appropriate monitoring equipment must be immediately attached.

Admissions in the antenatal/early labour period

These women may be following a specific care routine as described in other labour ward guidelines, for example, diabetic women on CLAMP, threatened pre-term labour etc.
Where care provision is not guided by an existing labour ward guideline, or where the guideline is inappropriate for the individual woman for any reason, an individualised plan of care should be made and documented by the obstetric registrar, usually after discussion with a consultant obstetrician**.**

Admissions in the postpartum period

Commonly admissions are post-operative in nature. Immediate postoperative recovery of women in the observation bay is directly supervised by the attending anaesthetist. The observations and monitoring required is dependent on the type of anaesthetic used and operation performed. The anaesthetist will document and instruct the midwife on the level of monitoring of each individual woman. (See Anaesthetic and Caesarean Section guidelines).

ADMISSIONS FOR POST OPERATIVE RECOVERY

Theatre recovery stage

The immediate recovery period occurs in the obstetric theatre located on the labour ward. The anaesthetist recovers the woman in theatre for this short period following completion of the surgical procedure and prior to admission for on-going recovery to the observation bay.
The criteria for transfer from theatre recovery stage following general or regional anaesthesia are;

- Able to maintain own airway

- Breathing regular and above 12 respirations/minute
- Fully conscious

Observation Bay recovery stage

The decision to transfer to the observation area rests with the anaesthetist. An assessment of the woman's condition should be made using the pre delivery observations recorded as a baseline, taking into account peri-operative observations recorded in theatre. This will include wound, lochia, drains and urinary catheter.

Unless an individual plan is clinically indicated and directed by the anaesthetist or obstetric registrar, blood pressure, pulse and respiratory rate will be recorded:

Women with reduced movement should have their Waterlow score re-calculated and pressure area care given regularly. The use of pressure relieving equipment such as the use of air mattresses should be implemented according to need and score.

Observations for first two hours:

- quarter hourly for one hour
- Half hourly for one hour
- Then 4 hourly unless condition warrants more frequent observations. 4 hourly observations must continue for a minimum of 24 hours post delivery.

1) All post caesarean section patients or patients who are cardiovascularly unstable must have non-invasive blood pressure monitoring, ECG and pulse oximetry for a minimum of 30 mins post operatively. The pulse oximeter will give a continuous O_2 saturation measurement; this should be documented every 15 minutes. If the O_2 saturation falls below 95% at any time, this must be immediately reported to the anaesthetist

2) Observe for signs of pallor, cold clammy skin, cyanosis or agitation and monitor level of consciousness.

3) Observe the respiratory rate, rhythm and depth – **respirations must be counted for a full minute.**

4) Observe wound, lochia and drains for evidence of bleeding every 30 mins and report to obstetrician /anaesthetist if excessive bleeding

5) Observe for signs of pain and give analgesia as prescribed and monitor its effect.

6) Temperature should be recorded on return to the ward and monitored 4 hourly unless otherwise directed.

7) Monitor urine output and document as per the specific guidelines (for example – Post-partum haemorrhage, Pre-eclampsia).

8) Maintain an accurate fluid balance chart including any perioperative fluids

If epidural or spinal opiates have been used, respiratory rate and sedation scores must be recorded as indicated above and the woman observed for respiratory depression or excessive drowsiness. Inform medical staff immediately if either occurs.

Findings **must** be recorded on a Maternity Early Obstetric Warning (MEOWS) chart taking actions as indicated by the triggers. Inform the obstetric registrar, shift leader and anaesthetist immediately

of any significant changes in trend of observations recorded. In all cases the shift leader and obstetric registrar must be kept updated of the woman's condition.

Guidance on the back of the MEOWS score chart should be followed.

If the Observation bay is full and the shift leader assesses that none of the women being cared for are able to be moved out then the new post-operative woman should be recovered in a delivery room. She must receive one-to-one care by a registered professional and her condition monitored using the same criteria as above.

Care of the baby

- The midwife remains responsible for the care of the baby, even if a nursery nurse is allocated to the Observation Bay.
- The mother should be supervised when breastfeeding her baby as her level of awareness may be impaired.
- Babies should remain in a cot at the mother's bed side unless the baby is feeding or enjoying 'bonding time' with the parents.
- Some newborns will require specific care as directed in an individual care plan or within the guideline 'Immediate Care of the Newborn'.

Criteria for discharge from the observation bay post operatively

- Discharge from the observation bay in the postoperative period will usually be to the postnatal ward.
- Following an uncomplicated caesarean section or an uncomplicated procedure under a spinal block discharge may be decided by the midwife.
- For midwifery discharge;
    - The MEOWS score must be within normal limits (see MEOWS chart).
    - Catheter draining clear urine in adequate amounts (see MEOWS chart).
    - Following regional block motor function in the lower limbs present.
    - Wound clean & dry
    - Lochia normal
    - Able to tolerate oral fluids
    - Has adequate pain relief

RECOGNITION OF THE SEVERELY ILL WOMAN IN PREGNANCY OR THE IMMEDIATE POSTNATAL PERIOD

The following signs should alert all health professionals that serious illness is a possibility:

- A heart rate over 100 bpm
- A systolic blood pressure reading of over 160mm/Hg or under 90mm/Hg **and/or** a diastolic blood pressure of over 80 mm/Hg
- A temperature over 38 degrees centigrade
- A respiratory rate over 21 breaths per minute.

The respiratory rate is often overlooked but rates over 30 breaths per minute are indicative of a serious problem.

Early obstetric modified early warning system (MEOWS) (See appendix 4)
The MEOWs chart must be used routinely for all women in the observation bay for the early detection of impending maternal collapse. Observations will be at least 4 hourly. The medical management plan should detail the frequency of observations required in all cases. If there is doubt refer to the guideline relevant to the woman's condition.

All the triggers used on the MEOWS chart and help in the timely recognition, treatment and referral of women who have or are developing a critical illness.

Findings **must** be recorded on the (MEOWS) chart taking actions as indicated by the triggers. Inform the obstetric registrar, shift leader and anaesthetist immediately of any significant changes in trend of observations recorded. In all cases the shift leader and obstetric registrar must be kept updated of the woman's condition.

Guidance on the back of the MEOWS score chart should be followed (see appendix 4)
Staff must be aware of their own limitations, the relevant actions to take and how to escalate concerns. (See also trigger list for calling a consultant).

CRITERIA FOR TRANSFER OUTSIDE MATERNITY SERVICES FROM THE LABOUR WARD THEATRE OR OBSERVATION BAY

Transfer from the labour ward theatre/ observation bay into the Critical Care Services. (ITU/Surgical HDU/CCU).

The decision to transfer to Critical Care Services will be made by the Consultant Obstetrician and the Consultant Anaesthetist, or Consultant Physician. The criteria are detailed in the admission/transfer criteria section of this guidance. The process should follow the guidance below.

1. There must be two way consultation / referral between anaesthetic or medical teams and obstetric team.

2. If next of kin are not present on the unit, contact and inform of change in mothers condition.

3. Appropriate guidelines for maternal condition must be followed. The obstetric consultant must be asked to attend if this is requested on the 'trigger list'. Even if the condition causing concerns is not on the trigger list the shift leader or obstetric registrar may ask the consultant obstetrician to attend if they are concerned.

4. Shift leader to liaise with nurse in charge of the neonatal unit to arrange admission of baby to NICU whilst mother in another department.

5. All maternity patients remain under the care of both midwives and obstetricians even if transferred to critical care services. All obstetric decisions remain the responsibility of the maternity team. Only in ITU are the anaesthetic team responsible for leading patient management, in surgical HDU **all** decisions are the responsibility of the maternity team. Details of all women transferred to non-maternity wards or admitted directly to these wards must be recorded in the 'Maternity Outliers Book' which is kept on the Labour ward. This should include a daily update and ongoing management plan.

6. Shift leader to inform maternity bleep holder (day). Out of hours if the shift leader or obstetric registrar is concerned it may be appropriate contact the supervisor of midwives on call for advice.

7. Also refer to Transfer of care guideline

CRITERIA FOR ROUTINE DISCHARGE FROM MATERNITY OBSERVATION BAY

Discharge from the Observation Bay may be to Joan Booker Ward (JBW), to another department within the hospital or an external unit or directly home.

If antenatal women are deemed fit for discharge they should be assessed by the obstetric registrar or consultant. Plan for ongoing care must be made and documented in her handheld notes.

Discharge from the Observation Bay of women in the postnatal period will depend upon their reason for admission.

Women after an uncomplicated caesarean section or an uncomplicated procedure under a spinal block may be discharged by the midwife (see postoperative discharge section above).

Women with more complex histories or significant medical conditions must be reviewed by the obstetric team prior to discharge.

Any specific postnatal instructions/observations should be documented in the health record, if the woman is transferring to JBW there must be a clear plan of management. (See also Transfer of care guideline).

Staff training

All midwifery, nursing, ODP and care support staff attend an annual update session on care in this area. (See training needs analysis) This includes recovery, post-operative care, recognition of the severely ill pregnant woman, actions to be taken if a woman's condition deviates from the normal and use of the MEOWs chart.

Staff must also attend annual updates for maternal resuscitation and skills drills held on the labour ward to simulate emergency situations.
Sessions should also include the management of mental health issues associated with experiencing unexpected illness.

Monitoring:

Compliance with this guideline will be monitored as detailed in the table below. Where monitoring has identified deficiencies, recommendations and an action plan will be developed.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
2.8 Management of the early recognition of severely ill women in the pregnancy or the immediate postnatal period: a. **responsibilities of relevant staff groups** b. **process for the use of a modified early obstetric warning scoring system (MEOWS)** c. guidance for staff on when to involve clinicians from outside the maternity service 2.9 Women receive high dependency care/intensive care in a suitable environment responsibilities of relevant staff groups a. process for ensuring the availability of medical equipment in line with national guidance b. ***guidance for staff on when to involve clinicians from outside of the maternity service*** c. ***agreed criteria for transfer to a high dependency unit/intensive care unit, within or outside of the maternity service*** d. ***requirements of each staff group when transferring women to a high dependency unit/intensive care unit*** e. ***documentation of c), d) and e)*** 5.10 Care of women following general or regional anaesthetic for an operative intervention, which as a minimum must include: a. equipment that should be available, as defined in the AAGBI guidelines b. criteria for transfer to the recovery area c. ***minimum requirements for observations whilst in recovery*** d. ***agreed discharge and transfer criteria from recovery*** e. ***documentation of observations whilst in recovery and agreed discharge and transfer criteria*** f. guidelines for care for the following 24 hours, including frequency of the observations	**Criterion Lead** Sam Soltanifar- Consultant Anaesthetist	Audit tools Appendix 1,2,3 1% or 10 records process for use of MEOWS Daily equipment check log 1% or 10 health records involve clinicians outside the maternity service – Will be part of the audit for discharge from the Observation bay 1% of women who require post op admission to the Observation Bay, documentation of recovery observations on the MEOWS charts and transfer criteria	3 yearly	Labour Ward Forum and Supervisor of Midwives meetings	**Standard Lead** Standard 2. Faris Zakaria- Obstetric Consultant Standard 5. James Thomas Obstetric Consultant Labour ward manager Anaesthetic Consultant team Supervisors of Midwives	Quality & Safety half days Perinatal audit day Staff meetings necessary Communication bulletin as appropriate Individual support if required One or any number of the above

Appendices

Audit tools
1. Equipment checklist audit
2. Observation chart audit tool
3 .Admission and discharge/transfer audit
4 .MEOWs chart

References

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Appendix 1 **Equipment checklist**

Date	**2a**	**2b**	**2c**	**2d**
Monitors/ Pulse Oximeter				
Oxygen				
Suction				
Bed Rails				
Thermometer				
Ski Sheets				
Manual Sphygnomanometer				
Observation Bay equipment trolley incl. Large BP cuff				
Signature			Designation	

Appendix 2

HIGH DEPENDENCY CARE – OBSERVATION CHART AUDIT

Why was the chart being used?

☐ Post operative care

☐ Other, please state ……

Individual care plan clinically indicated? ☐ Yes ☐ No

If NO, are the following documented:

- Quarter hourly for one hour:
  - ☐ Blood Pressure ☐ Pulse ☐ Respiratory Rate ☐ Wound
  - ☐ Lochia ☐ Drains ☐ Urinary Catheter
- Half hourly for one hour:
  - ☐ Blood Pressure ☐ Pulse ☐ Respiratory Rate ☐ Wound
  - ☐ Lochia ☐ Drains ☐ Urinary Catheter
- 4 hourly for 24 hours:
  - ☐ Blood Pressure ☐ Pulse ☐ Respiratory Rate ☐ Wound
  - ☐ Lochia ☐ Drains ☐ Urinary Catheter

Is there documentation that the following have been monitored for a minimum of 1 hour post operatively:

☐ ECG monitoring ☐ Pulse oximetery

Has temperature been documented 4 hourly? ☐ Yes ☐ No

Is there a separate fluid balance chart? ☐ Yes ☐ No

Has the regime for post operative observations been followed? ☐ ☐

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Appendix 3

OBESERVATION BAY – ADMISSION AND DISCHARGE AUDIT

Admission

Under which criteria was the woman admitted?

- Post Caesarean section ☐
- Post PPH > 1000mls requiring monitoring and/or blood transfusion ☐
- Management of moderate/severe pre-eclampsia / eclampsia / HELLP ☐
- Perinatal management of diabetic mothers on insulin ☐
- Threatened preterm labour ☐
- APH not in labour ☐
- Post transfer from ITU or main theatre ☐
- Women requiring ECG, CVP or other invasive monitoring ☐
- Post operative procedure ☐
- None of the above please state reason……..

Discharge

Where was woman discharged to?

☐ Joan Booker Ward ☐ Other Department within hospital

☐ External Unit ☐ Directly home

☐ Other

If Antenatal, has the woman been assessed by and Obstetric Registrar or Consultant?

☐ Registrar ☐ Consultant ☐ No

Who discharged the woman? ☐ Doctor ☐ Midwife

Was this appropriate? i.e. Midwife for uncomplicated episode or following medical review

☐ Yes ☐ No

Management plan

Is there an ongoing management plan? ☐ Yes ☐ No

Did she have an outside referral? ☐ Yes ☐ No

If YES, to whom? _____

Was this appropriate? ☐ Yes ☐ No

EQUALITY IMPACT ASSESSMENT TOOL

Name: Observation Bay, Labour Ward.Criteria for admission, discharge and transfer Including Recovery, post operative care and the indentification of the severely ill obstetric patient

Policy/Service: Maternity Service

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
The Maternity Observation Bay has 24 hour/day anaesthetic cover and enables the maternity unit to provide additional monitoring for women who are sick during the childbearing continuum. This guideline supports evidence based consistent delivery of care in this clinical area.
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?)
There are no identified effects of this guidance on race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
No impact identified
Conclusion • Provide a summary of the overall conclusions
No impact identified
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
None

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 HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	**Observation Bay, Labour Ward.Criteria for admission, discharge and transfer Including Recovery, post operative care and the identification of the severely ill obstetric patient**
Name of Person completing form:	Women's Health guidelines group
Date:	May 2012

Author(s)	Dr J Margery Consultant Anaesthetist Dr Sam Soltanifar Consultant Anaesthetist
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Dr J Margery Consultant anaesthetist
Date of final draft	May 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 Guidelines Group
Is this a new or revised policy/guideline?	revised

Describe the development process used to generate this policy/guideline.
Women's Health Guidelines Group, Labour Ward Forum, Obstetric and Anaesthetic Consultants
Who is the policy/guideline primarily for?
Health Professionals working within the maternity service
Is this policy/guideline relevant across the Trust or in limited areas?
Maternity Services
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Intranet, newsletters, educational half day, training sessions
Describe the process by which adherence to this policy/guideline will be monitored.
See *monitoring section of policy*
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 *reference section of policy*
What (other) information sources have been used to produce this policy/guideline?
See *reference section of policy*
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
No impact
Other than the authors, which other groups or individuals have been given a draft for comment
Obstetric and Anaesthetic Consultants, Women's Health Guidelines Group, Labour Ward Forum,
Which groups or individuals submitted written or verbal comments on earlier drafts?
Any comments received considered by Women's Health Guidelines Group
Who considered those comments and to what extent have they been incorporated into the final draft?
All comments considered
Have financial implications been considered?
Yes