Frimley Health
NHS Foundation Trust

Antenatal and Postnatal Women who attend the Emergency Department or are admitted outside the Maternity Department

Key Points

- Any woman that attends or needs to be admitted to the Trust during the childbearing continuum is managed promptly whether or not her primary clinical presentation is obstetric related, and communication links are established and maintained with the obstetric/midwifery teams in order to provide the most appropriate care.
- If a birth appears imminent, contact Labour Ward and a Midwife will attend the location immediately
- Follow the flow chart at Appendix 1

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Professional Midwifery Advocate (PMA)	Amanda Dennett
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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.	

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
V1	September 2020	C Brown, C Smith-White	Final	First cross-site guideline
V2	February 2023	C Brown	Final	Full review

Related Documents

See References.

Abbreviations

CP-IS	Child Protection - Information Sharing
CTG	Cardiotocograph
ED	Emergency Department
IA	Intermittent Auscultation
ITU	Intensive care unit
MAC	Maternity Assessment Centre (involves Triage and Day Assessment Unit)
MEOWS	Modified Early Obstetric Warning System

Contents

1. INTRODUCTION

Women who are booked to deliver within the Trust are informed early in their pregnancy to contact their Midwife, GP, or MAC after 16/40 if they have a pregnancy related problem. However, pregnant/postpartum women do present to other areas of the Trust such as ITU/HDU, Coronary Care, and the Emergency Department (ED) etc., following an accident/injury, domestic violence, un-booked for maternity care or with a medical problem. In such cases this guideline should be followed. The aim of this guideline is to ensure that any woman that attends or needs to be admitted to the Trust during the childbearing continuum is managed promptly whether or not her primary clinical presentation is obstetric related, and communication links are established and maintained with the obstetric/midwifery teams in order to provide the most appropriate care.

2. PREGNANT/POSTPARTUM WOMEN WHO ATTEND THE EMERGENCY DEPARTMENT OR OTHER DEPARTMENTS OUTSIDE OF MATERNITY

On Arrival to ED the woman should be assessed initially by ED staff and appropriate measures taken. Any woman with a positive pregnancy test or has delivered within the last 42 days (livebirth, termination or miscarriage of pregnancy included) should be assessed using the Modified Early Obstetric Warning System (MEOWS).

If a birth appears imminent, contact Labour Ward and a Midwife will attend the location immediately.

Pregnancy less than 16 weeks gestation: Women should be discussed with or referred to the Gynae SHO (bleep FPH 5061/WPH 4239) if they have a pregnancy-related problem. Women of childbearing age attending with abdominal symptoms should have beta-hCG urine testing to exclude pregnancy.

Pregnancy more than 16 weeks gestation: Call Labour Ward Triage (FPH 134035) / MAC (WPH 154520) and speak to the midwife in charge, who should liaise with the Labour Ward coordinator to discuss the care of the woman and the appropriate place for her to be reviewed.

If there is a serious concern about a woman, for example massive haemorrhage or seizure, dial 2222 and state: ‘Obstetric Emergency’ and your location.

A Midwife should attend the department and complete a full antenatal assessment of the patient and document under the current hospital encounter, on notes using SmartText ‘Maternity Outlier’ and change speciality to obstetrics. Refer to the ‘*Antenatal fetal heart rate monitoring’* guideline and make an individualised plan on whether the patient requires a CTG or IA. The midwife should ensure that appropriate referrals are made (Appendix 1).

The woman may present to ED with a non-pregnancy related problem but should consider that other serious pregnancy-related problems could manifest as other conditions such as Deep Vein Thrombosis, Pulmonary Embolism and Pre-eclampsia.

Pregnant women with the following must be reviewed by an obstetric registrar (FPH 5390 / WPH 4842) urgently:

- Women involved in a serious road traffic collision
- Abdominal pain
- Epigastric pain
- Severe headache
- Hypertension
- Proteinuria
- Breathlessness
- Pyrexia
- Chest pain
- Back pain
- Abnormal vaginal discharge or unexplained vaginal wetness (to eliminate spontaneous rupture of membranes).
- Vaginal Bleeding **(*Ensure that all patients with active heavy vaginal bleeding, regardless of gestation are cared for in a private cubicle and that they are provided with sanitary pads and disposable underwear).***

If the woman is **medically fit** to be discharged home from ED and still awaiting obstetrician/midwife review, ED staff can refer the woman to maternity triage via telephone call to the department to be assessed from an obstetric perspective using a SBAR handover.

Pregnant women who are unbooked: Any woman who presents to the ED and is pregnant at any gestation, must be asked if she has booked for maternity care at this trust or another trust. If she has not, the Labour Ward Coordinator (at FPH) and MAC Midwife (at WPH) must be informed and will arrange for a midwife to book the woman for maternity care. If late booking/concealed pregnancy or no pregnancy records present, CP-IS checks must be performed. The safeguarding midwife should be informed of attendance (FPH 07721 237435 / WPH 07776 475084)

Rhesus negative women: Depending on gestation, rhesus negative pregnant women should be offered antenatal anti-D prophylaxis following a sensitising event in line with the trust guideline *'Blood transfusion policy for adult patients with related guidelines'*.

Domestic Violence: If a pregnant woman attends ED who has experienced domestic abuse, inform Labour Ward Coordinator (at FPH) and MAC Midwife (at WPH), complete the safeguarding tab on epic and inform the Safeguarding Midwife (FPH 07721 237435 / WPH 07776 475084) to follow up. Details of the incident should be documented in full in the patient's hospital records. ED staff must follow departmental safeguarding processes.

Mental Health: If there are concerns regarding mental health, contact the Perinatal Mental Health Midwife (FPH 07721 237434, fhft.pmhmidwives@nhs.net / WPH 07789 868268, fhft.pmhmidwiveshwph@nhs.net) alongside Psych liaison. If admission is required for mental

health concerns, the maternity department may not be a suitable place.

Alcohol/Drug Abuse: If attendance due to alcohol and/or drug overdoses, inform Labour Ward Coordinator (at FPH) and MAC Midwife (at WPH), complete safeguarding tab and inform the Safeguarding Midwife (FPH 07721 237435 / WPH 07776 475084) to follow up. ED staff must follow departmental safeguarding processes.

Road traffic collision (RTC): Any pregnant woman involved in a RTC, however minor, must have an assessment of maternal and fetal wellbeing by a midwife or an obstetrician. If the woman is in serious condition, the ED team should initiate management and care and then inform the obstetric registrar and Labour Ward Coordinator (at FPH) and MAC Midwife (at WPH) as soon as possible.

3. PREGNANT WOMEN REQUIRING ADMISSION TO OTHER WARDS

If the woman requires admission this should be discussed with the obstetric team and the most appropriate clinical location should be considered. The labour ward coordinator and consultant obstetrician **must be informed and given the location of admission.**

All admissions of pregnant women to other wards are to be highlighted as high risk and documented on the Labour Ward board. A full antenatal assessment should be carried out by the midwife daily and documented on epic. **Ensure all observations are taken using a MEOWs chart.**

A senior member of the Obstetric team must see all admissions and an on-going plan should be developed in conjunction with the speciality medical team to ensure appropriate monitoring of maternal and/or fetal wellbeing. If the woman requires admission to ITU/HDU, the Obstetric Consultant on call should be notified immediately.

Refer to the '*Thromboprophylaxis and the treatment of Venous Thromboembolism in Pregnancy and the Puerperium'* guideline to assess VTE risk.

4. WOMEN SEEN IN THE POSTNATAL PERIOD

If the woman is less than 28 days following childbirth, the woman may be seen in labour ward triage if the woman has a well-recognised pregnancy related complication such as sepsis or postpartum haemorrhage and can be admitted to the maternity unit.

The postnatal period extends up to 42 days following delivery. There should be an initial assessment by the ED staff and appropriate measures taken to address the women's symptoms/complaint and observations taken using a MEOWs chart If the woman has recognised pregnancy related complications, the obstetric registrar should be informed. The obstetric registrar will see the woman in ED and advice on the appropriate management. If hospital admission is necessary during the postnatal period and over 28 days, the bed manager should be consulted. The obstetric consultant should be informed of all postnatal admissions.

Postnatal women should be reviewed by an SHO and discussed with an obstetric registrar or above prior to being admitted to the postnatal ward.

5. POSTPARTUM WOMEN REQUIRING ADMISSION TO OTHER WARDS

If the mother is admitted in the immediate postnatal period (up to 28 days post-delivery) the labour coordinator is to be informed. Routine postnatal examinations of mother and baby must continue to be carried out by a midwife. Depending on the level of health care support required of an unwell mother, the Trust, whilst considering the baby's safety, will attempt to facilitate the baby remaining with the mother regardless of feeding method. The woman should be admitted to the appropriate area for their clinical need. If the baby is admitted with the mother, a side room is recommended.

It may sometimes not be possible or safe to do so and alterative arrangements for the care of her baby may be required if the woman's clinical situation changes and if the mother becomes seriously ill, e.g., admission to ITU or undergoing emergency surgery.

The woman should have a readily available designated member of staff such as a Maternity Care Assistant to come and support with feeding and the care of the infant, if this is required. If staffing does not allow the Senior Midwife on-call should be informed to make appropriate arrangements to provide sufficient postnatal support and care to the woman.

Breast pumps and kits are available from the postnatal ward if required for admission. These will be logged which ward has borrowed the pump and will expect it to be returned after use. Pump kits are single use and remain with the mother. Expressed breast milk or formula may be kept in a designated infant milk fridge on the postnatal ward.

A cot will be required and obtained from the maternity department. Please ensure co-sleeping is discouraged.

6. MATERNAL DEATHS

Maternity services have a statutory requirement to report all maternal deaths up to 1 year following birth, miscarriage or termination of pregnancy, irrespective of the reason for death. If the woman meets criteria, inform the labour ward coordinator.

7. COMMUNICATION

If there are communication issues (e.g., English as a second language, learning difficulties, blindness/partial sightedness, deafness) staff will take appropriate measures to ensure the patient (and her partner, if appropriate) understand the actions and rationale behind them such as using the Trust interpretation services.

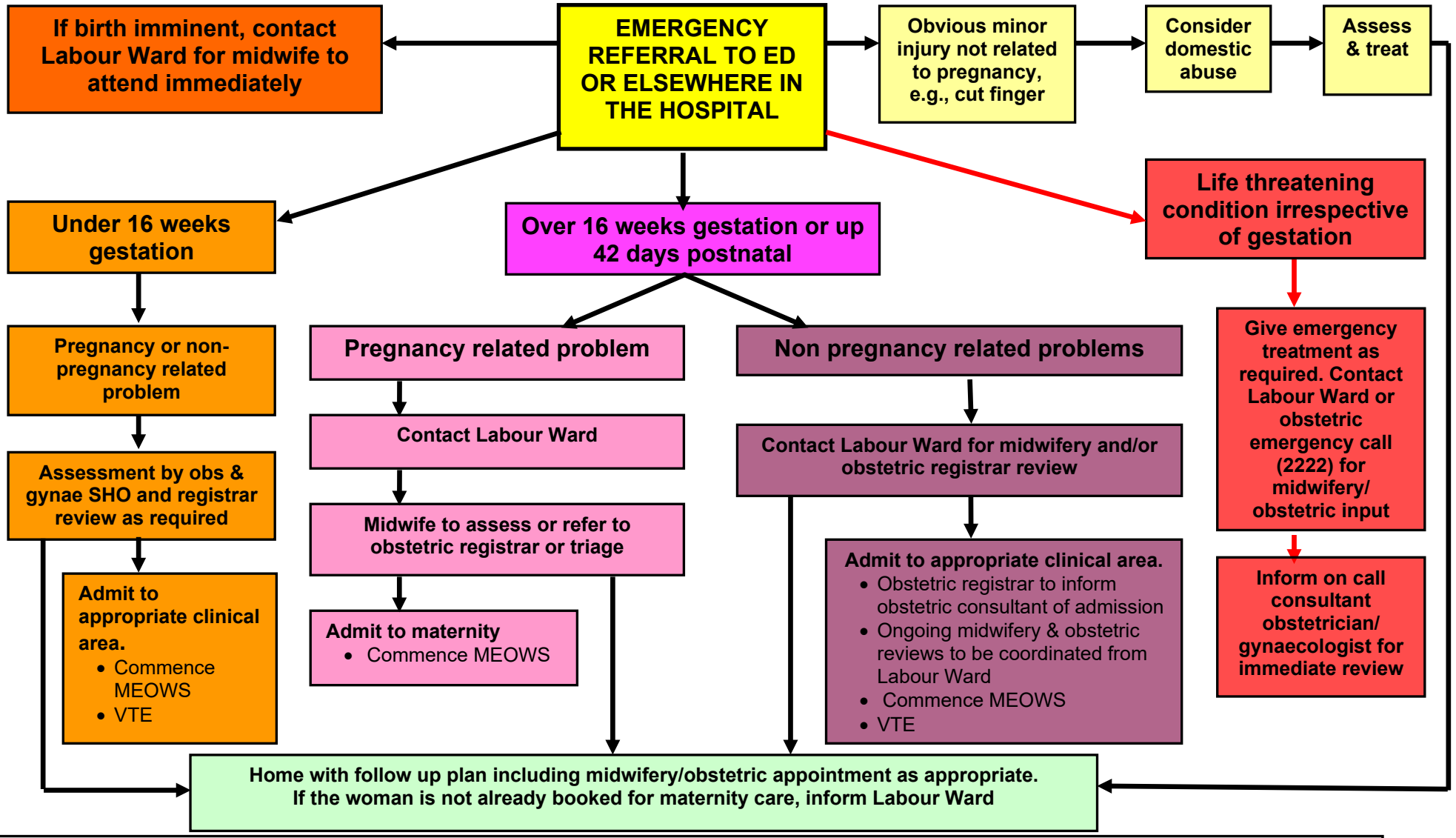
8. AUDITABLE STANDARDS AND MONITORING

- The management of all pregnant women attending ED.
- If the woman is admitted to another department in the Trust was the MEOWS Chart used?
- Was the obstetric consultant informed about all sick pregnant women admitted to hospital?

REFERENCES

1. Frimley Health NHS Foundation Trust (2020) *Deterioration in pregnant or recently delivered women: Recognition and use of the modified early obstetric warning system (MEOWS)*.
2. Frimley Health NHS Foundation Trust (2022) *Antenatal fetal heart rate monitoring*.
3. Frimley Health NHS Foundation Trust (2022) *Thromboprophylaxis and the treatment of Venous Thromboembolism in Pregnancy and the Puerperium*.
4. BSPS lead transfusion practitioner (2021) *Blood Transfusion Policy for Adult patients with related guidelines*.
5. Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBRRACE-UK) (2019) *Saving Lives, Improving Mothers' Care: lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-1*. Available at: https://www.npeu.ox.ac.uk/mbrrace-uk/reports
6. Royal College of Physicians (2019) *Acute care toolkit 15: Managing acute medical problems in pregnancy*. Available at: https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-15-managing-acute-medical-problems-pregnancy
7. Frimley Health NHS Foundation Trust (2020) *Sepsis in Maternity*

APPENDIX 1: FLOWCHART FOR ANTENATAL AND POSTNATAL WOMEN WHO ATTEND THE EMERGENCY DEPARTMENT OR ELSEWHERE IN THE HOSPITAL



All pregnant or recently delivered women presenting with any of the following:
ABDOMINAL PAIN, SEVERE HEADACHE, PROTEINUREA, BREATHLESSNESS, PYREXIA OR CHEST PAIN
must be reviewed by an obstetric registrar or consultant.

For full guidance please refer to the guideline 'Antenatal and postnatal women who attend the Emergency Department or are admitted outside the maternity Department
(MEOWS stands for Modified Early Obstetric Warning System)