MATERNITY UNIT (AND EMERGENCY DEPARTMENT)

GUIDELINE:

ASSESSMENTS/ADMISSIONS TO THE MATERNITY UNIT

AUTHOR:
Midwifery Educator & Quality Coordinator

SCOPE:
This guideline applies to all midwives, nurses and medical staff working in the maternity unit or emergency department

PURPOSE:
To meet an agreed standard for all assessments/admissions to the maternity unit in order to provide effective care to antenatal, intrapartum and postnatal women.

DEFINITIONS:
Admission: Any woman who stays in the maternity unit for longer than 3 hours must be admitted to the maternity unit in order to be filed on the Inpatient Management System (IPMS), and previous medical notes should be obtained.

LMC = Lead Maternity Carer

GUIDELINE
The patient registration form details must be confirmed as accurate, amendments made, signed and dated

A woman remaining in the maternity unit for over 3 hours must be formally admitted.

From the admission details sheet, ascertain correct contact details, including cell phone/s if available, and emergency contact details.

1/ All admissions are to be entered into the birth register and admitted by the maternity receptionist Monday to Friday 0800hrs to 1630hrs, and via admissions out of normal working hours, as soon as possible following admission:

Phone extension 8215 0800 – 2300 hrs
Phone extension 0 2300 – 0800 hrs

Inform admissions of the woman’s:
- Name (birth name)
- Address (check current)
- Date of birth
- Ethnicity
- LMC
Time of arrival

Please ensure that admissions are notified as to whether the women being admitted is for antenatal, labour and delivery or postnatal care.

2/ Please be aware of the guidelines for prevention, management and control of MRSA at TDH for any woman admitted to TDH, especially if they have previously been hospitalised at an ‘at risk’ facility in New Zealand within the last 6 months.

3/ Information must also be gathered to confirm that the woman is a New Zealand citizen. If she is not, then please check with the woman that the address that we have on her notes is her current address before entering in the register.

4/ Order new labels via the maternity receptionist or through admissions if any of the information has changed, or there is insufficient quantity in her notes. For women who are having a planned caesarean section, at least 30 labels need to be available.

5/ The previous medical notes will be collected by maternity receptionist Monday to Friday in working hours, out of normal hours they will be sent to the ward by admissions.

6/ All women need to be informed at an appropriate time on admission, or preferably prior to admission so that a plan is in place to deal with nicotine withdrawal symptoms, that TDH has a smokefree policy and she should be prepared for this event if she is a woman who smokes. The MCIS should be updated on the ‘Lifestyle’ section of the clinical record stating that a smoke-free intervention has been offered and whether or not it has been accepted – every time the woman is admitted. The woman and her visitors should be informed that smoking is not permitted in the grounds of the hospital. If the woman wishes to smoke and leave the hospital grounds, she should be asked to sign the form ‘intention to leave the hospital grounds’. This only needs to be signed once for recurring episodes of leave (see relevant guideline).

Admission under 20 week’s gestation:

Please note that admissions under 20 weeks gestation are not normally accepted on the maternity unit. These women should be referred via the Emergency Department by the obstetrician to ward 8, unless there are exceptional circumstances and the reasons are verified by the obstetrician and liaison and agreement takes place with the midwife coordinating the shift.

Admission over 20 week’s gestation:

For women over 20 weeks gestation who present to ED, good communication should occur between ED and maternity regarding the appropriate place for the woman’s assessment/admission dependant upon the clinical presentation. This will generally be to the maternity unit when the reason for the presentation is pregnancy related. Women, who present to ED/maternity with a non pregnancy related minor illness or injury, will be assessed by the ED.
doctor who may request the input from a Core Midwife in Maternity, to listen to the fetal heart, or an obstetrician if the illness is thought to be pregnancy related. Once cleared medically (taking into consideration timeliness for clinical assessment and appropriateness of individual cases), the woman may be transferred to the maternity unit for further assessment if appropriate.

In the case of a woman who has significant issues in more than one specialty, please refer to the relevant organisational policy. Medical staff should be made aware of this policy so that the woman receives the appropriate treatment and care in the appropriate place.

**Antenatal assessments/admissions to the maternity unit:**
If the woman is under primary care then the LMC is responsible for the initial assessment, contacting the obstetrician and formulating a plan of care before handing over to DHB staff.

In cases of acute admissions or women under secondary care, the core midwives would provide care as appropriate and refer to the obstetrician.

Initial assessment to include:
- Head to toe examination
- Abdominal palpation – fundal height (in cms from 24 wks gestation and plotted on individualised GROW chart), presentation, position, lie, descent, contractions.
- PV loss:
  - If liquor - ?colour, odour, amount. Time leakage began.
  - If blood - ?amount, colour, length of time of bleeding.
- Fetal heart rate – listen to the fetal heart rate using the Doppler or pinnards and ascertain that this is within normal limits
- Cardiotocograph (CTG).
- Urinalysis
- Note any oedema
- Temperature, pulse, blood pressure
- Vaginal examination if required – *think Partosure first* in all cases of suspected pre-term labour, or AmniSure if possible rupture of membranes and no conclusive clinical picture (see relevant guidelines)
- I.D. bracelet

Be vigilant about seeking the following information and documenting:
- Current medications
- Medical history
- Obstetric risk factors
- Review current antenatal blood/scan results from the computer if not filed in the notes
Call an obstetrician for:

- Ngati Porou Hauora women – the midwife from Te Puia should have contacted the obstetrician prior to the admission and the core staff should have been made aware.
- Unbooked women with secondary care issues.
- Women without an LMC with secondary care issues.
- If you have any concerns regarding the safety of the woman or the baby and her LMC has not arrived then it would be prudent to call the obstetrician.

Admissions to the Delivery Unit:

- If the woman has registered with an LMC, but arrives before the LMC then unit staff will be responsible for her care until the LMC arrives.

- If the woman is admitted for a planned induction of labour (IOL), then a clear plan should have been recorded in the records following a 4 way conversation, whenever possible, between the woman, her LMC, O&G and the core midwife. The LMC will have notified the staff or recorded in the plan what involvement in the woman’s care she wishes to provide i.e. will come in to start the IOL, to handover to secondary care or to be called once the woman has established in labour.

- Unit staff should advise the LMC of admission if they are not already aware.

- Ask the woman when her estimated date of delivery (EDD) is and calculate gestation

- Obtain a brief history of the reason for the admission and events leading up to it, e.g. any bleeding, contractions, spontaneous rupture of membranes, decreased/increased fetal movements, abdominal pain, fever, vaginal discharge.

- If the woman is a current smoker, at a suitable time following admission discuss support available to quit and place a sticker into her clinical records. Advise her that nicotine replacement therapy is recommended and will be prescribed for her to use during her hospital stay.

- Ensure the shift coordinator is aware of this admission.

- Ensure the woman and her whanau/family are comfortable and orientate them to their surroundings including location of bathroom, toilet, kitchen facilities.

- Place name, gravida, gestation and LMC on the whiteboard in the office, and the name card on the birthing suite door as soon as practicable.

- If the birth appears to be imminent, prepare the delivery trolley, obtain syntocinon and syntometrine from the fridge in the medical store room and hold in the room. Warm the room, heat the baby resuscitation table, check that all equipment is available and
working e.g. suction, oxygen, neopuff as applicable. If preterm notify the NNU & consider calling the paediatrician

- If for DHB care, e.g. unbooked (with complications) or secondary care handover, then on admission perform an abdominal palpation, CTG monitoring if risk factors present otherwise listen to fetal heart with the pinnard or sonicaid, baseline recordings of vital signs including a urinalysis if possible, and then contact the Obstetrician on call to negotiate ongoing care if secondary care requirements.

- Te Puia Springs women will be admitted under the obstetrician on call for the day with core midwives providing midwifery care until an LMC is available. These may be an elective admission or arrive as an emergency. Te Puia Midwives (Ngati Porou Hauora) should fax, or send with the admitting woman, all the notes that they have available. If there are any queries they are always contactable through Te Puia Springs Hospital.

Any woman with a history of allergies should have an allergy wrist band attached to her wrist and the appropriate sticker with the allergy documented on all pages of their medication chart.

Postnatal admissions:
Postnatal women are not generally readmitted to the maternity unit due to the risk of infection, but are admitted to another ward of the hospital via the Emergency Department.

However, occasionally a baby is admitted to the NNU (usually a transfer back from Waikato) and the mother may become a ‘boarder’ in the maternity unit if NNU has no space and maternity are able to accommodate the woman – generally into birthing suite 5 as it has it’s own toilet/shower facilities and is close to NNU. The mother would be admitted under the speciality ‘Postnatal early intervention’ (see appendix 1). Her care would continue under the LMC, not maternity core staff. If the woman has been an in-patient at another hospital, the MRSA policy should be followed, the LMC will be responsible for this.

Transfer following planned/unplanned home birth, or baby born before arrival of the midwife (BBA):
The baby would not be counted as a hospital birth for statistic purposes, but should be admitted as a general in-patient on the postnatal ward under the care of the LMC, as should the mother.
ASSOCIATED DOCUMENTS

Appendix 1: Maternity and NNU admissions and transfers

Maternity Unit Guidelines:
- Antenatal/Intrapartum fetal monitoring
- Induction of labour
- Antepartum haemorrhage
- Preterm rupture of the membranes
- Pre-labour rupture of the membranes at term
- Guideline for the Care of Pregnant /Postpartum Women Attending the Emergency Department (see Appendix 2)
- ED Obstetric Pathway (Appendix 3)
- Maternity SBARR Handover Form (Appendix 4)
- Obstetric Emergency Call Form (Appendix 5)

TDH Organisational Policy/Guidelines:
- Allergy wrist band
- Care of people with significant care issues in more than one specialty
- The prevention, management and control of MRSA at TDH
- The management of nicotine dependant patients

REFERENCES:
Maternity Services Notice pursuant to Section 88 of the Public Health & Disability Act 2007
GROW charts information downloaded on 25 February 2010 from:
http://www.gestation.net/fetal_growth/fetal_growth.htm
(accessed14th February 2016)

APPROVED BY:

HOD Obstetrics

Clinical Care Manager, Woman, Child & Youth

Date of Approval: ___/____/____

Next Review Date: ___/____/____
MATERNITY AND NNU
Admissions & Transfers on iPMS

1. Mothers are admitted as: ‘Non Psychiatric Inpatients’ (P70/P60)

2. Babies are admitted as: ‘Birth Events’

3. Maternity can only transfer patients between the delivery unit and postnatal ward 1. If you are sending a patient to another DHB, or to any other ward (i.e. ICU, Day ward etc), these patients must be discharged and readmitted to their new ward.

4. Mothers being admitted for mothercrafting are to be admitted under the speciality of ‘Post Nataal Early Intervention’

5. Patients being admitted to Theatre for e.g. Tubal Ligation, are to be admitted into the day ward under the speciality of ‘Gynaecology’.

6. When patients require admission to theatre, maternity staff are to leave them in delivery unit/DU and the Theatre staff action their own admissions etc. When the patient returns we transfer from delivery unit/DU to postnatal/PN.

7. When admitting a patient to ICU – they need to be admitted under ‘Gynaecology’ and a ‘Clinician’ (not a midwife).

8. When the patient needs to go from Maternity to NNU – you need to discharge the mum and transfer the baby. Then readmit the mum into NNU under mothercrafting/‘Post Nataal Early Intervention’.
Appendix 2

GUIDELINE FOR THE CARE OF PREGNANT / POST PARTUM WOMEN ATTENDING THE EMERGENCY DEPARTMENT

All patients are to be triaged and assessed in the Emergency Department before any referrals are made to the O&G team.
Any pregnant patients with possible infectious conditions e.g. diarrhoea and vomiting [of unknown cause], MRSA, flu symptoms, other infectious risks are to be held in ED and not transferred to maternity unless otherwise advised by maternity / O&G staff.

IN THE EVENT OF AN EMERGENCY PLEASE USE THE ED OBSTETRIC EMERGENCY CALL SHEET AND GIVE TO SWITCHBOARD TO CALL THE REQUIRED PERSONAL VIA THE 777 SYSTEM COMMUNICATION

SBARR: The ED team must use SBARR principles (situation, background, assessment, response and recommendation) when communicating with the maternity unit and / or O&G team as an aid to communication.
As a minimum this should include:
- The woman’s name
- Gestation / EDD
- Clinical presentation
- Vital signs including the highlighting of any abnormal vital signs - TEWS
- Known pregnancy complications – relevant past medical history
- Any known safety concerns
- Name of midwife [if known]
- Reason for referral to maternity
- Any other relevant information

The ED team will manage significant problems whilst assessing the need for additional expertise.
If the problem is pregnancy related it is appropriate for the woman to be seen by the Obstetric or Gynaecology team.
If the on call O&G consultant is needed immediately he / she must be summoned to ED via the switchboard.

PREGNANCY RELATED PROBLEMS
All patients are to be triaged and assessed in ED
Gestation <20 weeks:
These cases should be referred to gynaecology if specialist input required
Contact the on call O&G consultant via switchboard.

Gestation > 20 weeks
- Triage and assess the patient in the ED.
- If a review of the patient by a midwife is requested.
- Contact the maternity unit and discuss the patient with a midwife using the SBARR communication tool. Please indicate clearly if the review is to take place in ED.
- If the situation is critical then the O&G Emergency crash team should be summoned to
the ED Maternity Emergency Call Form (appendix1). Give the call form to the telephonist to action the calls.

**IMPELLING DELIVERIES**

If at any time, birth appears imminent, contact Maternity on 8414. Transfer the patient to the delivery suite – if unable to transfer use the ED Emergency call form to summon assistance to the ED.

**POST-PARTUM PRESENTATIONS**

In the post-natal period up to 6 weeks post-partum the woman should be referred to the On Call Obstetrician if she presents with any post-partum related problem.

**NON PREGNANCY RELATED ILLNESSES**

- If a woman presents in the ED at any time during pregnancy > 20 weeks with symptoms which are not directly attributable to the pregnancy the ED team must refer the woman to the appropriate specialty team for assessment.
- If the specialty team decide to admit the woman to a general ward, please advise the on call O&G. This is to ensure that the proposed admission and plan of care is agreed between the specialties, and so that the O&G on call team is aware of the admission particularly if the admission is likely to have an impact on the pregnancy. The O&G consultant taking the communication must contact the receiving specialty to ensure that there is agreement on the care plan [Figure 1].

**Figure1: Pathway for in-patient admissions of pregnant patients for non-pregnancy related admissions**

- Admit to specialty with O&G input [if applicable]
- Discuss with O&G consultant on call – determine if obstetric consultation required for any follow up specific to pregnancy
- Discharge with advice of discharge to O&G consultant

**DOCUMENTATION AND HANDOVER OF CARE OF PREGNANT WOMEN BEING DISCHARGED HOME FROM THE ED**

Documentation and Handover of Care If the woman is seen in ED and discharged home the consultation is recorded on the ‘iSOFT’ computer data base and also recorded in the maternity hand held maternity notes booklet [if brought to the ED by patients]. If there are known safety concerns, then the ED staff must inform the VIP team for follow up. This is to be documented correctly and reports of concern or family violence reports should be done in these instances.
EMERGENCY OBSTETRIC / POST PARTUM [up to 6 weeks] PRESENTATIONS

- ALL PREGNANT WOMEN PRESENTING TO THE ED VIA AMBULANCE / HELICOPTER OR AS SELF PRESENTATIONS ARE TO BE TRIAGED AND ASSESSED IN ED.

- UNSTABLE / CRITICAL / UNSAFE PRESENTATIONS ARE TO REMAIN IN THE ED FOR REVIEW AND ASSESSMENT BY THE ON CALL O&G CONSULTANT [AND OTHER MEMBERS OF THE MATERNAL EMERGENCY TEAM]

- ALL UNSTABLE / CRITICAL PREGNANT WOMEN ARE TO HAVE A PLAN OF CARE AND AGREED DESTINATION BEFORE TRANSFER

- THE DNM IS TO BE ADVISED OF ALL UNSTABLE / CRITICAL PREGNANT WOMEN IN THE ED

ED ATTENDANCE BY PREGNANT WOMEN NOTIFICATION SYSTEM

Please place a copy of the discharge summary of all pregnant women OVER 20 WEEKS PREGNANT attending ED in the O&G tray located beside the ACC tray in ED. ED receptionist to send discharge summary(s) in this tray to maternity reception each morning. If patients have no LMC they will be followed up by the maternity department
**ED OBSTETRIC PATHWAY**

ALL PREGNANT WOMEN OR WOMEN PRESENTING UP TO 6 WEEKS POST PARTUM ARE TO BE TRIAGED AND ASSESSED IN ED ACCESS BADGERNET FOR OBSTETRIC HISTORY

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**YES**

MAIN REASON FOR ED PRESENTATION RELATED TO OBSTETRIC ISSUE

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**IF < 20 WEEKS GESTATION**
ASSESS IN ED WITH GYNECOLOGICAL CONSULTATION
**IF > 20 WEEKS GESTATION AND**
PREGNANCY RELATED PRESENTATION REFER TO MATERNITY & NOTIFY O&G CONSULTANT ON CALL

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**NO**

ADMIT TO SPECIALTY WITH O&G INPUT [IF APPLICABLE]

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DISCUSS WITH ON CALL O&G

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DETERMINE IF PATIENT NEEDS AN OBSTETRIC REVIEW ADVISE IF ANY FOLLOW UP IS REQUIRED SPECIFIC TO PREGNANCY

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DISCHARGE WITH ADVICE OF DISCHARGE TO O&G CONSULTANT / LMC ANTE NATAL / POST NATAL FOLLOW UP AS PER OBSTETRIC ADVICE [IF NO PLAN IN PLACE]

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**MANDATORY CRITERIA FOR PREGNANT WOMEN**

ALL PREGNANT WOMEN PRESENTING TO THE ED VIA AMBULANCE / HELICOPTER OR AS A SELF PRESENTATION ARE TO BE TRIAGED AND ASSESSED IN ED

UNSTABLE / CRITICAL / UNSAFE PRESENTATIONS ARE TO REMAIN IN THE ED FOR REVIEW AND ASSESSMENT BY THE ON CALL O&G CONSULTANT [AND OTHER MEMBERS OF THE MATERNAL EMERGENCY TEAM]

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THE DNM IS TO BE ADVISED OF ALL UNSTABLE / CRITICAL PREGNANT WOMEN IN THE ED

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Facilitator: Core Midwife Kim Kernan
Authorised By: Clinical Care Manager WCY
HOD Obstetrics

Date of first approval: April 2003
Date last review completed: Feb 2016
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## Appendix 4 Maternity SBARR Handover Form

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<td>Midwife Giving Handover:</td>
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<td>MRSA: Has patient been in another hospital in last 6 months</td>
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<td>Facilitator: Core Midwife Kim Kernan</td>
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Appendix 5  Obstetric Emergency Call Form

Name: 
DOB: 
NHI: 

Date: ____________  Time: ____________________  ETA: ____________ 

Gestation of patient: ____________/ 40 weeks [if known] 

Type of emergency: 
☐ Ante-partum haemorrhage  ☐ Post-partum haemorrhage 
☐ Pre-eclampsia / seizures  ☐ Traumatic event please use trauma call form if appropriate 
☐ Impending delivery – unsafe to transfer to maternity 
☐ Other [please specify if known] ____________________________________ 

PLEASE CONTACT THE FOLLOWING PERSONNEL FOR ALL OBSTETRIC EMERGENCY CALLS 

☐ Obstetrician [on call] 
☐ Laboratory Scientist 
☐ House surgeon 

☐ Midwife 
☐ Duty Nurse Manager 

Additional personnel to be called in as requested 

☐ Anaesthetist 
☐ Operating Theatre Team 
☐ Sonographer 

☐ Anaesthetic Technician 
☐ Paediatrician 
☐ Other [please identify] ____________________ 

Please return this form to the Emergency Department. Please ensure there is a patient name / label on this form. All Obstetric Emergency forms to be collected by the ED CNM for clinical review and audit purposes.