Standard Operational Procedure (SOP) for High Dependency Care within the Maternity Unit

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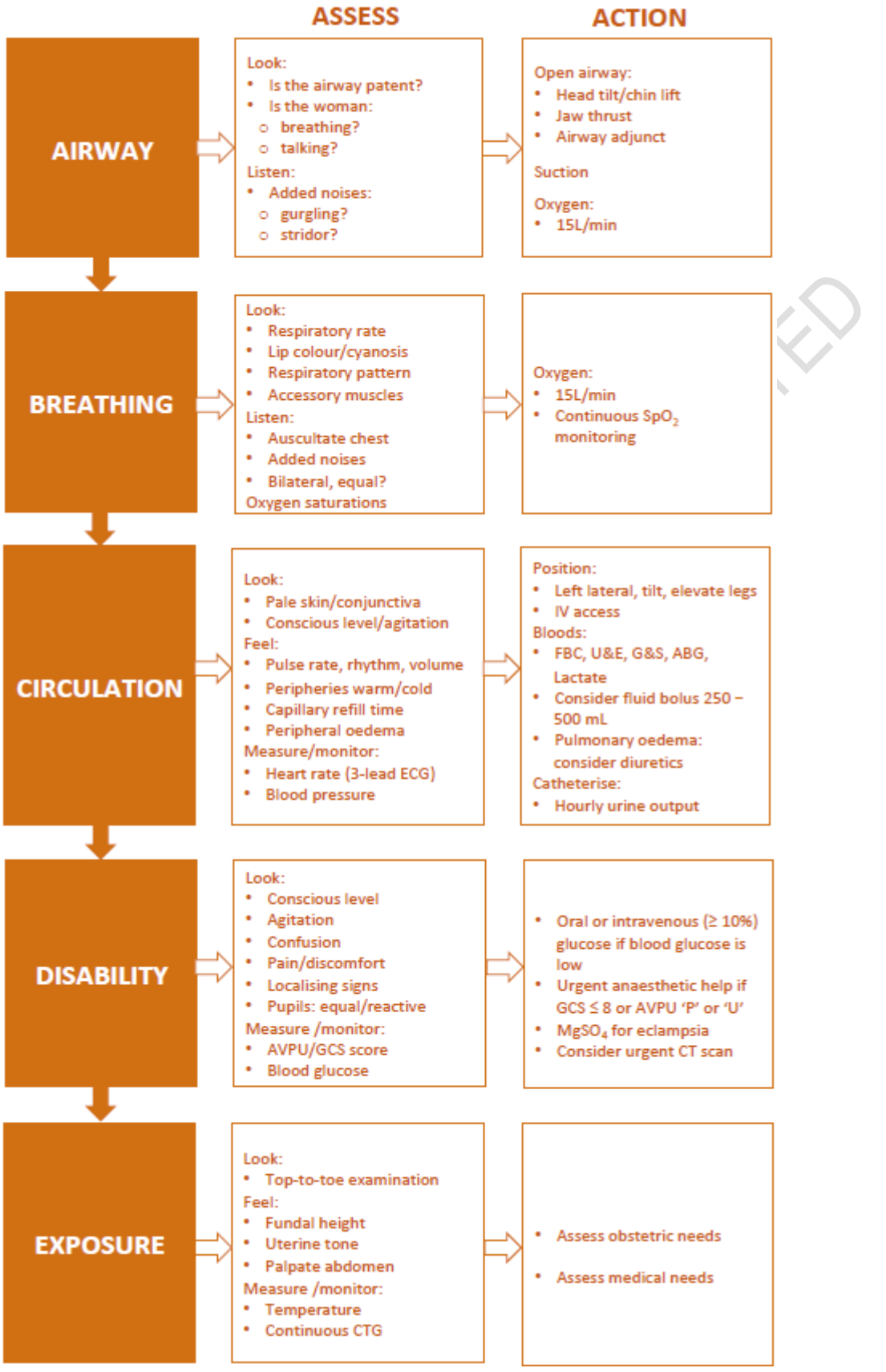
ASSESS
ACTION
AIRWAY
Look:
• Is the airway patent?
• Is the woman:
○ breathing?
○ talking?
Listen:
• Added noises:
○ gurgling?
○ stridor?
Open airway:
• Head tilt/chin lift
• Jaw thrust
• Airway adjunct
Suction
Oxygen:
• 15L/min
BREATHING
Look:
• Respiratory rate
• Lip colour/cyanosis
• Respiratory pattern
• Accessory muscles
Listen:
• Auscultate chest
• Added noises
• Bilateral, equal?
Oxygen saturations
Oxygen:
• 15L/min
• Continuous SpO2 monitoring
CIRCULATION
Look:
• Pale skin/conjunctiva
• Conscious level/agitation
Feel:
• Pulse rate, rhythm, volume
• Peripheries warm/cold
• Capillary refill time
• Peripheral oedema
Measure/monitor:
• Heart rate (3-lead ECG)
• Blood pressure
Position:
• Left lateral, tilt, elevate legs
• IV access
Bloods:
• FBC, U&E, G&S, ABG, Lactate
• Consider fluid bolus 250 – 500 mL
• Pulmonary oedema: consider diuretics
Catheterise:
• Hourly urine output
DISABILITY
Look:
• Conscious level
• Agitation
• Confusion
• Pain/discomfort
• Localising signs
• Pupils: equal/reactive
Measure /monitor:
• AVPU/GCS score
• Blood glucose
• Oral or intravenous (≥ 10%) glucose if blood glucose is low
• Urgent anaesthetic help if GCS ≤ 8 or AVPU 'P' or 'U'
• MgSO4 for eclampsia
• Consider urgent CT scan
EXPOSURE
Look:
• Top-to-toe examination
Feel:
• Fundal height
• Uterine tone
• Palpate abdomen
Measure /monitor:
• Temperature
• Continuous CTG
• Assess obstetric needs
• Assess medical needs

1. Purpose/Background:

High Dependency care is required for those pregnant and postnatal women with complex medical and obstetric problems and should be provided within the Labour ward environment. It requires the involvement of a multi-professional team of midwives, obstetricians, neonatologists, anaesthetists, and intensive care specialists, and that consultants are involved in all management decisions.

2. Scope:

To offer guidance on the identification, admission criteria and management of women requiring high dependency and/or intensive care.

This document is for use by all midwives and it applies to all women cared for by the Maternity Services at St Mary's Hospital.

3. Responsibilities

This SOP is for all members of the multidisciplinary team and the women cared for by the St Mary's Hospital Maternity Services. It is their responsibility to:

- Access, read, understand and apply this guideline to practice.
- Attend mandatory training pertaining to High Dependency care.

4. Procedure

Maternity High Dependency Unit (HDU) Admission Criteria

HDU is a model of care, and ideally should take place in the labour ward recovery area, but can be undertaken in a high risk labour ward room if recovery is in use and appropriate monitoring is available to ensure close observation.

The criteria to admit for HDU or ITU care follows the national definitions of levels of care described by the Intensive Care Society (2013).

Levels of care for adult patients

Level 0 Normal ward care.

Level 1 (HDU) Requiring more frequent observation:

- Mild Antepartum Haemorrhage

- Postpartum Haemorrhage
- Severe Sepsis
- Returning from ITU, but still requiring close observation.

Level 2 (HDU)

- Requiring basic respiratory support (>50% 02 to maintain saturations).
- Requires basic cardiovascular support (IV Labetalol/Hydralazine to control blood pressure) or CVP/Arterial line for monitoring or access.
- Magnesium Sulphate infusion for Severe Pre-eclampsia/Eclampsia
- Magnesium Sulphate infusion for Preterm Labour.

Level 3 (ITU)

- Requiring advanced respiratory support or support of two or more organs.

Roles and responsibilities of staff when admitting and caring for women in HDU

Midwife

- Always work within knowledge base and scope of practice
- Provide one to one care to mother and baby as required
- Contemporaneously document all aspects of care
- Maintain MEOWS HDU chart, fluid balance, investigations and results
- Waterlow and VTE assessment
- Timely escalate any concerns to the labour ward coordinator and medical team in accordance with local and national guidance
- Clear SBAR documentation of handover of care

Obstetric team

- Work collaboratively with the anaesthetic team and decide appropriate location for the woman and the level of care to be provided

- Document a clear plan of care and accepted parameters, see Appendix A, **Maternal Critical Care Structured review**
- Medicines management in line with national and local guidance
- Frequency of observations required
- Timing of reviews (at least twice daily by consultant obstetrician)
- Liase with other specialities where appropriate
- Parameters for discharge from HDU to normal ward care
- Prompt response to midwife concerns

Anaesthetic team

- Work collaboratively with the obstetric team and midwives giving care
- Medicines management as indicated
- Respond to any concerns regarding changing status and deterioration of the patient
- Arrange admission and transfer to ITU if required

Operating department practitioner

- Provide support as required to the multidisciplinary team

Labour ward technicians and health care assistants

- Provide support as required to the multidisciplinary team
- Ensure all equipment is checked and in working order in accordance with local guidance and procedures, and refer any concerns to the labour ward coordinator

Intensive care admission

Early escalation of the possibility of requiring admission to ITU is essential. The decision and transfer to ITU should include:

- Multidisciplinary discussion and agreement between obstetric, anaesthetic and ITU consultants
- Availability of medical notes/documentation of care given

- Discussion with family regarding condition of mother and rationale for transfer
- Portable monitoring for invasive monitoring to facilitate safe transfer
- Completion of the ITU transfer proforma by the labour ward coordinator
- Completion of datix incident form

5 Implementation/training/awareness

- This is a review of a current document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.
- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter

6. Auditable Standards

What aspects of compliance with the document will be monitored	What will be reviewed to evidence this	How and how often will this be done	Detail sample size (if applicable)	Who will coordinate findings	Which group or report will receive findings
Maternal Critical care review completed at each review	Maternal Notes	Yearly	10 sets of notes	Audit Midwife	LW Forum

7. Related Documents:

8. References:

Core Standards for Intensive Care Units (2013). Edition 1.
RCOG (2007) Safer Childbirth**.** Minimum standards for the Organisation and Delivery of Care in Labour.

9 DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

Version:	Date:	Author:	Status	Comment:	Review Date:
0.1	Dec 09	Y Harris	Draft	Replaces • Care of Severely ill pregnant woman • High dependency care	
1.0	Feb 2010	Y Harris	Ratified	Maternity CSG	Feb 2012
1.1	Feb 2011	Y Harris	Updated	for consultation	
2.0	April 2011	Y Harris	Ratified	Maternity CSG	April 2014
3.0	1st December 2011	Y Harris	Ratified	Agreed within the department	1st December 2014
4.0	23rd April 2012	Y Harris	Ratified	Amendments made to monitoring box to reflect CNST recommendations. Approved at Maternity CSG	23rd April 2015
4.0	1st August 2012	Y Harris	Ratified	Updated proforma	23rd April 2015
5.0	5th July 2016	Y Harris / N Dawkins	Ratified	updated	5th July 2019
1(SOP)	25th July 2019	J Alger	Ratified	Converted to SOP- Reviewed and updated	July 2022

Maternal Critical Care Structured review

This is designed to be used during the multi-professional review of a critically ill pregnant or postpartum woman.
It does not replace, nor should repeat the observations and information recorded on the Maternal Critical Care chart.
Relevant notes can be made as each item is considered either directly into the woman's notes or by annotating the work sheet which should be dated, signed and filed in the woman's maternity notes at the end of the review.

Patient ID (addressograph)

Date..... Time.....

	Items to be considered	Notes:
A	**Airway**	
B	**Breathing** (Respiratory Rate, SpO_2, FiO_2, chest examination findings)	
C	**Circulation** (Heart rate, BP, capillary refill time, vasopressors)	
D	**Disability** (level of consciousness, pain, epidural or spinal block)	
E	**Electrolytes** (Mg^{2+}, Na^+, K^+ levels and eGFR/creatinine)	
F	**Fluids** – Review of fluid balance (input, output, blood loss, drains)	
G	**GI & glucose control** (bowel function and gastro-protection measures)	
H	**Haematology** (FBC, clotting profile, VTE prophylaxis)	
I	**Infection** (temperature, Sepsis Six, inflammatory markers, cultures, antibiotics)	
L	**Lines** (cannulae, arterial line, central line, urinary catheter, wound drains)	
M	**Maternal Co-Morbidities** (diabetes, hypertension, asthma, epilepsy)	
N	**Neonatal considerations**	
O	**Obstetric**: antenatal, intrapartum/postpartum related	
P	**Pharmacology** (review drug chart)	
Q	**Questions**	
R	**Recommendations**	
S	**Summary**	
	Signature..... **Print**..... **Date**.....	