NHS Lanarkshire

Guidance for Initial assessment of pregnant women attending ED and ECU in NHS Lanarkshire

The MBRRACE report in December 2017 highlighted that care for women before, during and after pregnancy must be seamless across the professions, disciplines and agencies that support and work with women during this period of immense vulnerability.

The scope of the guidance is to help identify and manage common medical conditions or potential emergencies outside the immediate area of expertise and improve communication and teamwork.

Pregnant women booked with University Hospital Wishaw will have been advised to contact Maternity Triage or EPAS if they have any concerning symptoms potentially related to pregnancy. However, pregnant or postnatal women may attend or be brought by ambulance to ED or other departments following accident/injury, domestic violence or with a medical/surgical problem.

General guidance

- All pregnant or postpartum women attending the emergency department should be triaged according to clinical priority.
    - If they are more than 12 weeks pregnant with anything other than minor physical injuries (not involving abdominal area) the woman should be advised to contact her midwife to ensure appropriate follow up.
    - Women less than 12 weeks pregnant with mild vaginal bleeding, no pain and are clinically well should be advised to contact Early Pregnancy Assessment Unit or Triage (out of hours).
    - Women < 12 weeks pregnant with anything other than vaginal bleeding should be managed as deemed appropriate.
    - Any woman with a suspected ectopic (abdominal pain, vaginal bleeding and a positive pregnancy test <12 w gestation) should be discussed with the on call team via page 136 at UHW.
    - This list will include women from GGC presenting in early pregnancy complications (ectopic, miscarriage) and any women with a concealed pregnancy.

- Consider contacting the maternity coordinator (dect phone 7890 at UHW) for any pregnant / postpartum woman who presents with otherwise unexplained :-
  - Pelvic or Abdominal pain
  - Severe headache
  - Hypertension
  - Proteinuria
  - Breathlessness
  - Pyrexia
  - Chest pain
  - Heavy vaginal bleeding and who may require obstetric review.

- Contact the maternity coordinator (dect phone 7890 at UHW) for a woman admitted with a medical or surgical condition who requires midwifery or obstetric review during, or follow up after their period of inpatient treatment or investigations.

Specific situations; in all cases

- **Initial ABC assessment, contact Obstetrics team as per chart**

Collapse in pregnant women >24 weeks pregnant

- Consider differential diagnosis of venous thromboembolism (VTE), concealed bleeding, eclampsia, cardiac or respiratory cause or sepsis

Collapse in women of childbearing age

- Perform a pregnancy test, consider possibility of ruptured extrauterine pregnancy; consider cardiac or respiratory cause or sepsis

Bleeding in pregnancy >12 weeks pregnant

- Consider possibility of miscarriage, placenta praevia and placenta abruption. **If postpartum** , perform external uterine massage to improve uterine tone if she has evidence of heavy bleeding and

- **Measure** all blood loss.

- Women haemodynamically compensate until they have lost 30 % of their blood volume (1500 ml for 50 kg woman , 2.1 L for a 70 kg woman) , at which point the rule of 30 applies (fall in systolic by 30 mmhG, heart rate rises by 30 bpm, evidence tachypnoea, and oliguria < 30 ml / hour with drop in haematocrit) . Moderate to severe shock is likely.

Pain in pregnancy un-booked, positive pregnancy test

- Consider as differential diagnosis ectopic pregnancy, surgical pathology (appendicitis)

Pain in pregnancy >12 weeks pregnant

- Consider possibility of miscarriage or labour depending on gestation
- Consider acute surgical pathology (appendicitis, cholecystitis, pancreatitis, biliary colic, renal colic)

Sepsis, presumed Sepsis, SIRS, unexplained symptoms

- Early antibiotic treatment is paramount, multidisciplinary team assessment often necessary including senior obstetrician, senior anaesthetist, senior neonatal team
- Early delivery may be considered, once patient stable

Hypertension

- Any patient presenting with tonic and/or clonic seizures or collapse and not epileptic – consider possibility of eclamptic fit if antenatal/postnatal and > 20 w g gestation
- Intravenous treatment may need to be started in ED. See related guideline.

Trauma

- Consider domestic violence and referral to Maternity Triage

VTE

- VTE causing cardio-vascular compromise should be managed in collaboration with Medical and Anaesthetic team at UHM, UHH or UHW.
- All other instances should be managed on the medical wards after discussion with Obstetric team (via maternity Dose of Enoxaparin is 1mg/kg (booking weight) and should be administered prior to diagnostic investigations (CTPA or VQ scan). Any women presenting with a stable VTE needs to be followed up at the MOT clinic in Maternity Day bed Unit within 7 days (Contact Tracy Smith, ext 6426 at UHW). Any unstable VTE needs MDT input with consultant to consultant discussion.

NHS Lanarkshire

Pregnant Women and Postnatal up to 6 weeks presenting to A&E

With signs and symptoms requiring IMMEDIATE obstetric review and referral	With signs and symptoms requiring URGENT obstetric review and referral	With signs and symptoms requiring PROMPT obstetric review and referral
Fast Page or Crash page Obstetric Registrar on-call, Maternity co-ordinator Anaesthetic and Neonatal team as appropriate	Initial medical assessment in and referral for assessment/advice to Obstetrics team on-call	Initial medical assessment in ED, referral to appropriate medical or surgical specialty OR discharge home AND inform Obstetrics team on-call

Above patients presenting in Hairmyres and Monklands Hospital ED – Obstetrics team in Wishaw can be contacted for advice; patient transfer may not always be appropriate or needed. A senior obstetrician may travel between hospital sites for assistance.

If admitted under medical or surgical specialty care, patient should be discussed with the Obstetrics team prior to admission. Joint care plan should be agreed between medical or surgical and obstetrics team; identification of most appropriate environment should be made based on acute presenting condition and maternal pregnancy complications and co-morbidities.

Immediate – assessment on arrival in unit

Immediate birth, cord prolapse, active seizure or postictal, major trauma, severe respiratory distress, major haemorrhage, acute onset severe abdominal pain, suspected sepsis, ruptured ectopic pregnancy

Urgent – assessment

Uterine contractions <37 weeks pregnant but no imminent birth, PPROM (Premature Prelabour Rupture of Membranes), vaginal bleeding or story of bleeding prior to arrival associated with collapse, severe headache, epigastric pain, visual disturbance, severe hypertension, 1st or 2nd trimester miscarriage with blood loss >500mls and ongoing bleeding

Prompt – assessment

Discomfort in pregnancy not associating uterine contractions, nausea/vomiting and/or diarrhoea, minor trauma (not involving abdomen and pelvis), signs and symptoms of infection with no evidence of sepsis (dysuria, cough, fever), miscarriage suicidal ideation, 1st trimester miscarriage with blood loss <500ml

Have you considered?

- **Contact maternity triage when a woman presents > 12 w with vaginal bleeding or abdominal trauma for a Kleihauer test and administration of Anti D prophylaxis in Rh negative pregnant patients.**

Reduced fetal movements >24 weeks gestation

- Regardless of main presenting complaint, reduced fetal movements warrants referral to Maternity Triage once patient stable

ABC resuscitation should not be delayed in pregnancy, ensure Left lateral tilt

- Emergency Caesarean Delivery may need to be performed in ED if woman in extremis to allow effective resuscitation of mother

Contact numbers

Obstetrics and Gynaecology on-call team

Coordinator midwife – 01698 361100, Dect 7890/Page 017

Registrar Obstetrics – 01698 361100, Page 137

Registrar Gynaecology – 01698 361100, Page 136

Consultant on-call Gynaecology (Mon-Fri 9 – 5pm) – 01698 361100, Page 185

Consultant on-call Obstetrics (also covering Gynaecology out of hours and during weekends –01698 361100, Page 138

Anaesthetist on-call Obstetrics –01698 361100, Page 131

Maternity theatre 01698 361100, ext 7688

CEPOD theatre – UHW, 01698 361100, call coordinator on 022

Ward 24 – Phone 01698 366241

EPAS – Phone 01698 366217

Triage – Phone 01698 36 6005/6217

Related guidelines on Firstport

Clinical Guidelines –Maternity

Bacteraemia in Pregnancy

Chickenpox / Varicella in Pregnancy

Cord Prolapse Guideline

Domestic Abuse in Pregnancy

EPAS Folder

Extreme Prematurity (22-26 weeks

Hypertension in pregnancy

Genital Tract Sepsis

Major Obstetric Haemorrhage

Retained Placenta

Sepsis in Maternity Patients - recognition and immediate management

Thromboprophylaxis in Pregnancy and the Puerperium

Vaginal Breech Delivery

References

MBRRACE-UK. *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15*. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2017.

Smithson, David S. et al. *Implementing an obstetric triage acuity scale: interrater reliability and patient flow analysis*. American Journal of Obstetrics & Gynaecology, Volume 209, Issue 4, 287 - 293

Gratton, Robert J. et al. *Acuity Assessment in Obstetrical Triage*. Journal of Obstetrics and Gynaecology Canada, Volume 38, Issue 2, 125 – 133

Qureshi, H., Massey, E., Kirwan, D., Davies, T., Robson, S., White, J., Jones, J. and Allard, S. (2014), *BCSH guideline for the use of anti-D immunoglobulin for the prevention of haemolytic disease of the fetus and newborn.* Transfusion Med, 24: 8-20. doi:10.1111/tme.12091

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Dr AJ Thomson MRCOG, Dr JE Ramsay MRCOG, Sir S Arulkumaran FRCOG, London; Mr KT Moriarty MRCOG, Northampton; Mr DI Fraser MRCOG, Norwich; Mr AK Ash FRCOG, London; Dr G Kumar FRCOG, BMFMS, RCGP, BCSH on behalf of the Guidelines Committee of the Royal College of Obstetricians and Gynaecologists. *Antepartum Haemorrhage, Green-top Guideline No. 63*, November 2011

Dr TA Johnston FRCOG, Birmingham and Dr K Grady BSc FRCA FFPMRCA on behalf of the Guidelines Committee of the Royal College of Obstetricians and Gynaecologists. *Maternal Collapse in Pregnancy and Puerperium. Green-top guideline No. 56*, January 2011

Hypertension in pregnancy: diagnosis and management, NICE guideline [NG133] Published date: June 2019

Sepsis: recognition, diagnosis and early management, NICE guideline [NG51] Published date: July 2016. Last updated: September 2017

Originator: **Dr C Willocks**

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