Guideline for Admission to the Maternity Assessment Unit

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Table of Contents

1.0 Introduction

The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant.

The Maternity Assessment Unit (MAU) facilitates safe and timely assessment of maternal and fetal condition in the antepartum, intrapartum and postpartum periods.
Appropriate treatment can be initiated, including if required, admission to an appropriate ward.
Some patients will be discharged home from the assessment unit following review.

2.0 Objective

The aim of this guideline is to:

- Provide guidance for midwives who triage women in the Maternity Assessment Unit
- Provide guidance for the care of women admitted to the Maternity Assessment Unit
- Assist in prioritising care at times of high acuity

3.0 Scope

This guideline applies to all medical and midwifery staff working on the maternity unit and midwifery staff in the community.

4.0 Main body of the document

4.1 Telephone Triage

Women are encouraged to contact the Birthing Centre for help, advice and support if they believe they are in labour or they are experiencing any other problems requiring potential admission.

A telephone triage is performed and consideration is given to whether the woman requires a face to face assessment on the Maternity Assessment Unit; or whether to recommend staying at home with a plan to re-evaluate based upon individual need.

Clinical judgment-based information gained during the telephone conversation is used to decide if admission and assessment are required.

Women who are from BAME (Black, Asian and minority ethnic) populations should be offered a face to face assessment.

The following women will always require a face to face assessment on the MAU:

- Third contact with the labour ward requesting advice

- Unable to cope at home with contractions
- Requesting admission and assessment
- Abdominal pain not consistent with contractions
- Bleeding PV
- Spontaneous rupture of the membranes
- Reduced fetal movements
- Evidence of, or investigations or risk factors for, small for gestational age (SGA) or Fetal growth restriction (FGR)
- Signs of premature labour
- Multiple pregnancy
- Reports feeling unwell including signs of maternal sepsis

In the event of an obstetric emergency an assessment will be made whether an ambulance is required and the woman will attend Barnsley Birthing Centre for review and ongoing management. The Midwife will make a clinical judgment as to whether to phone the ambulance on behalf of the woman.

In the event of an emergency which is not deemed obstetric related an assessment will be made whether an ambulance is required. If unsure this must be escalated to the BBC coorindator and/or senior obstetric team.

In all cases, the telephone triage assessment form should be completed and filed in the woman's hospital records.

If the woman is advised to attend the Maternity Assessment Unit, but they are unable to due to transport/financial issues - discuss with the Birthing Centre coordinator regarding arranging a hospital taxi.

4.2 Referral from the Emergency Department

Ideally women referred to the Birthing Centre from the Emergency Department should be reviewed by a senior obstetrician (ST3 or above).
If the woman is reviewed by a junior member of the team, the case should as a minimum be discussed with the senior obstetrician (ST3 or above) prior to discharge.

4.3 Procedure for admission to the Maternity Assessment Unit

Preparation
In most cases the woman's arrival is expected because of a telephone call prior to admission, therefore:

- The hospital records should be read and prepared and any risk factors noted, including social factors. Relevant staff should be informed
- Laboratory information should be checked on the computer records e.g. FBC results, GBS status
- Prepare the room ensuring that equipment and drinking water are available
- Review safeguarding summary sheet. If applicable, document that a review has occurred and any actions that are required. This must be undertaken at every contact.

On admission

Women will be reviewed by a midwife within 30 minutes of admission.
The midwife should:

- Greet the woman with a personal welcome and establish language needs
- Provide introductions and explain their role in the woman's care
- Record the date and time of arrival and the number of admissions to the MAU on the triage form.
- Explain the admission procedure to the woman if applicable.

The woman's privacy and dignity should be maintained at all times.
To maintain confidentiality:

- The interview room should be utilised for discussions of a sensitive or personal nature
- The Birthing Centre Co-coordinator's office can be used where applicable for telephone conversation.

If a medical review is required this will be completed within one hour of referral.

Assessment

A detailed history should be taken, establish the woman's wishes and expectations
Ask the woman about fetal movements including any changes
Assess for: vaginal loss, oedema, headache, nausea/vomiting, sore throat, pain
Perform a vaginal examination with consent if and when indicated
Perform observations, calculate a MOEWS score, and document on a MOEWS chart
Perform Urinalysis
Auscultate fetal heart rate using a Pinnard or hand-held Doppler
Perform a CTG recording if the woman has risk factors for potential fetal compromise

Record findings on the triage form in the woman's records.
Ensure the triage form is completed in full including a plan of care

Women requiring admission will need to be isolated in a side room if they:

Have had unexplained diarrhoea/vomiting in the last 48 hours
Have previously had MRSA
Have an infectious disease or rash of unknown origin

Summoning help

Ensure the woman and her partner know how to summon help and confirm their ability to do so. If leaving the room make sure the woman is informed when you will return
Summon medical assistance in the following circumstances, or where advice or additional expertise is required:

- A pulse rate of 120bpm on two occasions 30 minutes apart
- A single diastolic reading of ≥ 110mm/Hg or a systolic reading of ≥160mm/Hg
- A raised diastolic reading of ≥ 90mm/Hg or a systolic reading of ≥ 140mm/Hg on two occasions 30 minutes apart
- 2^{+} protein on urinalysis and a single diastolic reading of ≥90mm/Hg or a systolic reading of ≥140mm/Hg
- A temperature of ≥ 38°C on one occasion or ≥ 37.5°C on two readings one hour apart

- Any vaginal blood loss other than a show – these women should not be discharged without discussion with a senior obstetrician (ST3 or above)
- SROM for more than 24 hours before the onset of established labour
- Evidence of significant meconium
- Abdominal pain that is not associated with contractions
- Any abnormal presentation including a cord presentation
- High or free-floating head in a nulliparous woman
- Suspected/known SGA or FGR; or macrosomia
- Suspected/known oligohydramnios or polyhydramnios
- Abnormalities in the fetal heart rate
- Reduced fetal movements

This list is not exhaustive.

4.4 Additional care for women in the latent phase of labour

The midwife should discuss:
All findings with the woman and her partner
Braxton Hicks contractions and the physiology of the latent phase of labour explaining what to expect and how active labour is diagnosed
The significance of any vaginal loss including SROM
The woman's birth plan, and jointly agree a plan of care with the woman and her partner

If the woman is in pain, assess her coping strategies.
Discuss analgesia and provide balanced information to establish the most acceptable care available for her

Low risk women in the latent phase of labour may require repeated admissions to triage for reassurance and discussions around coping strategies.
If these women remain low risk following a midwifery assessment, they can be discharged home with advice and where applicable the latent phase leaflet.
Ensure the woman has contact details for the Birthing Centre and her Community Midwifery Team
Women who have or develop risk factors require referral for obstetric review.

In all circumstance on the third admission:

- The Consultant on call should be informed of the woman's admission and any concerns
- If the consultant cannot see the woman personally, documentary evidence of their involvement in the plan of care should be recorded.
- The woman's own Consultant/team should be informed of admission to facilitate a review of care. This request for review should be documented in the woman's records.

4.5 Provision of further care

If admission is required, transfer the woman to a suitable area for further care e.g. Antenatal Postnatal Ward, Birthing Centre.

The plan of care should be clearly documented and discussed at handover.
Any handover of care should involve the woman and her partner.

Any **high-risk** women who require admission must have an obstetric review prior to transfer, unless there is likely to be a significant delay e.g. obstetrician in theatre. In these circumstances, obstetric review must happen in the inpatient area as soon as the obstetrician is available.

NB Women who are rhesus negative blood group with a potential sensitising event will require a Kleihauer taking.
Anti-D can be administered during the admission without the results of the Kleihauer if blood bank is able to dispatch the Anti-D.
If this is not possible, the woman will require follow up on either the Antenatal Day Unit (Monday – Friday 09.00 – 17.00) or the Antenatal Postnatal Ward (weekend) for Anti-D.

Ensure the woman's details are left for staff in these areas to follow up and arrange attendance. The Kleihauer result will need to be reviewed in case further Anti-D is required.

4.6 Process for prioritising care at times of high activity (see appendix 2)

At times of high activity, the shift leader should be informed, and will:

- Reassign staff
- Inform a senior member of the obstetric team
- Re-direct women to the BBC or ANDU where appropriate
- Assist in prioritisation of midwifery and medical assessment
- Re-direct telephone assessment to the BBC

Care/medical review should be prioritised in accordance with the MAU traffic light system (Appendix 3)
For women categorised as 'red' consider direct admission to the Birthing Centre
Other admissions should be categorised as either amber or green and managed accordingly.
Escalation to the consultant on call is required if there are delays in achieving appropriate medical review in a timely fashion
It should be explained to women that care is prioritised by urgency not by time of arrival to the MAU

5.0 Associated documents and references

National Institute for Health and Care Excellence (NICE). Clinical guideline 190. Intrapartum care: care of healthy women and their babies during childbirth (2014). [Online] https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-andbabies-pdf-35109866447557

6.0 Training and resources

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

7.0 Monitoring and audit

Any adverse incidents relating to admission to the maternity Assessment unit will be monitored via the incident reporting system. Any problems will be actioned via the case

review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for Admission to the Maternity Assessment Unit will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

8.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

8.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1 Glossary of terms

ANDU – Antenatal Day Unit
ANPN – Antenatal Postnatal ward
APH – Antepartum Haemorrhage
BAME – Black Asian and minority ethnic
BBC – Barnsley Birthing Centre
BP – Blood pressure
CMW – Community Midwife
CTG - Cardiotocograph
FBC – Full blood count
FGR – Fetal growth restriction
FM – fetal movements
GBS – Group B haemolytic streptococcus
GP – General practitioner
MAU – Maternity assessment unit
MRSA – Methicillin-resistant staphylococcus aureus
PIH – Pregnancy induced hypertension
PPH – Postpartum haemorrhage
PV – Per vagina
SGA – Small for gestational age
SROM – Spontaneous rupture of the membranes
UTI – Urinary tract infection

Appendix 2

Maternity Assessment Unit Management in periods of high activity

Where increasing admissions and demand lead to unavoidable delays in assessment on the Maternity Assessment Unit it is imperative that the following actions are undertaken.

1. **Inform the shift leader** who will then:
   - Reassign staff
   - Inform a senior member of the obstetric team
   - Re-direct women to the BBC or ANDU where appropriate
   - Assist in prioritisation of midwifery and medical assessment
   - Re-direct telephone assessment to the BBC

2. **Risk Assessment**
   Take a comprehensive history either by telephone or face to face on admission.
   Use the traffic light system below to determine the most appropriate place for the woman to be reviewed.
   For women categorised as 'red' consider direct admission to the BBC
   For women who are admitted to the Maternity assessment unit prioritise care/medical review in accordance with the clinical picture using the list below.
   The list is not exhaustive and clinical judgement should be used when prioritising care

RED	AMBER	GREEN
Significant Active Bleeding APH or PPH	Early Labour – Primigravida or Multigravida	DFM – Consider ANDU
Obvious Established Labour – Multigravida	Known breech – SROM	SROM – not contracting
Significant PIH – known raised BP	Known breech – Contracting	Abdominal Pain – Mild
Admission via A&E with abnormal observations	Previous LSCS – SROM	Vaginal Discharge
Referral from CMW/GP with abnormal observations	Previous LSCS – Contractions	Return visit e.g. for Anti D
BBA where it is anticipated that the woman requires 1:1 midwifery care	Moderate, non-specific abdominal pain	UTI
No fetal movements	PPH	ANDU referrals
Known breech with SROM or in labour	Generally unwell	

Use the colour coded laminates to indicate the order in which women need to be seen; place the laminates on top of the case notes.
Indicate in the case notes the priority rating, the time of assessment, and time of review.
Inform women that care is tailored to their individual needs and they will not always be seen in order of arrival
Maintain privacy and dignity at times of high activity.
Utilise the interview room and the labour Ward Co-ordinators office for confidential interviews and telephone discussion

Appendix 4

Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author
1	02/2011		Maternity guideline group
2	01/2013		Maternity guideline group
3	18/01/2016		Maternity guideline group

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	N/A
Reviewed at Women's Business and Governance meeting	17/03/2023
Approved by CBU 3 overarching Business and Governance Meeting	22/03/2023
Approved at Trust Advancing Practice and Nursing procedures Group	N/A

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Guideline
Document title	Guideline for Admission to the Maternity Assessment Unit
Document author (Job title and team)	Practice Educator Midwife/ BBC lead Midwife/Obstetrician
New or reviewed document	Reviewed
List staff groups/departments consulted with during document development	Maternity guideline group involving obstetric consultants, anaesthetists and midwives
Approval recommended by (meeting and dates):	Women's Business and Governance meeting- 17/03/2023 CBU 3 overarching Business and Governance Meeting- 22/03/2023
Date of next review (maximum 3 years)	23/03/2026
Key words for search criteria on intranet (max 10 words)	Triage Maternity assessment unit
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the <u>FINAL</u> version of this document	Name: Jade Carritt Designation: Governance Midwife

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): CBU3 Governance **Date approved: 22/03/2023** **Date Clinical Governance Administrator informed of approval: 23/03/2023** **Date uploaded to Trust Approved Documents page: 28/03/2023**