Guideline

Admission assessment and general principles for the care of high risk women in labour

Audit standards

All high risk women in labour should undergo, or receive, the following:

1. An identity label applied on admission to hospital.

2. Observations performed, with at least the following frequency:
   - 2-4 hourly temperature
   - hourly pulse (or more frequently if clinically needed)
   - blood pressure (BP) – as determined by clinical condition (usually at least four hourly)
   - 4 hourly MEWS scores
   - urinalysis with each urine passed
   - half-hourly documentation of quality and frequency of uterine contractions (with quality recorded at intervals in the labour progress notes).

3. Involvement of obstetric staff in care-planning and decision-making.

4. A partogram commenced after admission when labour is diagnosed, or syntocinon is commenced if used for induction of labour.

1 Scope

Local: for use in Maternity Services only.

2 Purpose

This guideline provides general principles for the initial assessment and care of women in high risk situations and should be read in conjunction with all other guidelines on aspects of high risk labour. It is applicable to all staff including midwives and obstetricians.

3 Recommendations

Admission of high risk women should follow the same general procedure as outlined in low risk intrapartum guideline 2.2: admission assessment and general principles for the care of low risk women in labour.

An electronic patient identification bracelet should be applied with the following information:

- full name
- hospital number
- date of birth.

Check the 'alert notice/ special risk' page inside the notes. Complete if applicable.

Following a baseline set of admission observations, high risk women should have the following **minimum** frequency of observations, which should be recorded on the partogram during labour. Where relevant, other charts may be used for recording observations, for example, for women with pre-eclamptic toxaemia (PET):

- blood pressure (BP) – at a minimum of four-hourly, or as determined by clinical condition or related clinical guideline
- 2-4 hourly temperature
- hourly pulse (or more frequently if clinically needed)
- 4 hourly MEWS score (modified early warning score (see HR 2.26 *Use of MEWS (Modified early warning score) within Maternity Services)*
- urinalysis – on admission and with each urine passed
- half-hourly assessment of the frequency of uterine contractions (this may be on the partogram but quality should also be recorded at intervals in the labour notes). C

Any deviation from normal parameters should be followed by re-assessment and review. Observations may need to be more frequent than this and must therefore be tailored according to clinical need.

Labour is diagnosed as described in:

- low risk intrapartum guideline 2.7: diagnosing labour onset and assessing progress in labour for low risk women and
- high risk intrapartum guideline 2.14: delay in labour.

Assessment of progress in labour should similarly follow the latter guideline (2.14).

Obstetric medical staff, and, where applicable, anaesthetic medical staff, should be made aware of all women where high risk factors are present. There should be evidence of joint care planning and decision-making in high-risk labours. ✓

It must be clear from the notes who is the current lead professional at all times (see low risk antenatal guideline 1.1: responsibility for care).

Birth-plans should be discussed and reviewed as part of the admission procedure. Even if the woman has not previously documented a plan, her wishes for labour should be explored or options presented. A woman's hopes and plans for labour should be documented on the admission assessment sheet. ✓

Privacy and dignity should be maintained at all times.

Women should be actively involved in all aspects of the decision-making about their care in labour. Verbal consent should be sought at all times and documented prior to invasive or intimate procedures such as a vaginal examination. C

A partogram should be commenced for all women in active labour, when labour is first diagnosed, or when syntocinon is initiated for induction. B

Continuity of midwife should be maintained if possible. Handing over of care should occur, preferably, only at a shift change. B

One-to-one care in labour should be recognised and valued as an important aspect of labour care. Trials have shown that women who have continuous intrapartum support in labour are less likely to have intrapartum analgesia, operative birth, or to report dissatisfaction with their childbirth experiences. A

4 Monitoring compliance with and the effectiveness of the guideline

The use and effectiveness of this guideline, in particular, the key audit standards, will be monitored through the following processes:

- Risk management process – the Obstetric Risk Manager will collect incident forms relating to any adverse birth outcomes which may involve failure to follow the recommendations contained within this guideline, in particular, the frequency of observations followed by appropriate action. (See: perinatal services incident reporting and investigation policy and procedure). The Obstetric Risk Manager will report to the Perinatal Governance Committee; any agreed action at this meeting will be taken by the nominated person(s) within midwifery, and/ or Obstetrics.
- Clinical Audit - compliance with these recommendations and the audit standards will be monitored on an ad-hoc basis as part of the agreed annual audit plan for obstetrics. Any deficiency in practice will be

reported to senior clinicians within maternity services and an agreed effectiveness trail will be written and actioned by the nominated leads and reported back to the audit department of the Patient Safety department to ensure the recommendations from the audit are implemented within the agreed time frame.

- Patient complaints – patient views will be reviewed using the complaints process if any complaint involves failure to follow this guidance.
- Individual patient case reviews, user/ clinician feedback and staff meetings will also contribute to this monitoring and compliance process.

Any changes to this guideline will be initiated by any nominated person(s) within midwifery, and/ or Obstetrics/ Anaesthetics and facilitated by the Research and Development Midwife and taken through the guideline review process.

5 Associated documents

- LR 1.1: responsibility for care guideline
- LR 2.2: admission assessment and general principles for the care of low risk women in labour guideline
- LR 2.7: diagnosing labour onset and assessing progress in labour for low risk women guideline
- HR 2.14: delay in labour guideline
- HR 2.26: Use of MEWS (Modified early warning score) within Maternity Services)
- perinatal services incident reporting and investigation policy and procedure

Equality and diversity statement

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Document management

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