

BTHFT Maternal Critical Care: Admission Checklist

>22 weeks pregnant / postpartum admission to critical care

On admission (within 1 hour)

	Completed	N/A
• Display maternal critical care alert poster at patient's bedside	<input type="checkbox"/>	<input type="checkbox"/>
• Inform on-call obstetric consultant of admission	<input type="checkbox"/>	<input type="checkbox"/>
• Inform on-call obstetric anaesthetist of admission	<input type="checkbox"/>	<input type="checkbox"/>
• Inform midwife in charge on labour ward of admission	<input type="checkbox"/>	<input type="checkbox"/>
• If antenatal, ensure resuscitaire present on critical care + checked	<input type="checkbox"/>	<input type="checkbox"/>
• If antenatal, consider presence/location of hysterotomy kit/guide and delivery pack	<input type="checkbox"/>	<input type="checkbox"/>
• Ensure emergency obstetric medications available - including oxytocin, ergometrine, carboprost and misoprostol.	<input type="checkbox"/>	<input type="checkbox"/>
• Complete maternal VTE assessment + prescribe appropriate LMWH dosing	<input type="checkbox"/>	<input type="checkbox"/>
• Consider need for large bore IV access	<input type="checkbox"/>	<input type="checkbox"/>
• Ensure valid group + save sample and clarify requirement for anti-D (NB Group and save sample only valid for 72 hours in pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>
• Clarify presence of any safeguarding alerts + actions required	<input type="checkbox"/>	<input type="checkbox"/>
• If post-natal, clarify location + condition of the baby to update patient/family	<input type="checkbox"/>	<input type="checkbox"/>

Clinical handover

	Completed	N/A
• If antenatal - ensure emergency delivery plan clearly documented by MDT	<input type="checkbox"/>	<input type="checkbox"/>
• Document target physiological parameters, including BP and urine output in pre-eclampsia	<input type="checkbox"/>	<input type="checkbox"/>
• Detail any obstetric specific infusions (eg. oxytocin/magnesium/hydralazine) and ensure documented plan for these on EPR	<input type="checkbox"/>	<input type="checkbox"/>
• Ensure aware of any obstetric procedures and post operative instructions	<input type="checkbox"/>	<input type="checkbox"/>
• In PPH - ensure EBL and ongoing management plan documented, including any devices in situ.	<input type="checkbox"/>	<input type="checkbox"/>

Within 12 hours of admission

	Completed	N/A
• Document MDT review on EPR (to include consultants in ICM, obstetrics, obstetric anaesthesia, midwife +/- any other relevant medical/surgical specialists)	<input type="checkbox"/>	<input type="checkbox"/>
• MDT review to include documented assessment of fetal compromise, need for fetal monitoring + risk of labour/delivery	<input type="checkbox"/>	<input type="checkbox"/>
• If high risk of labour/delivery - ensure Neonatal team aware	<input type="checkbox"/>	<input type="checkbox"/>
• Inform relevant medical / surgical teams of admission to critical care	<input type="checkbox"/>	<input type="checkbox"/>
• Consider medication safety in pregnancy + need for critical care pharmacy review	<input type="checkbox"/>	<input type="checkbox"/>
• Consider requirement for critical care dietetic review +/- input	<input type="checkbox"/>	<input type="checkbox"/>
• Perform urine dipstick for proteinuria +/- send PCR (protein:creatinine ratio)	<input type="checkbox"/>	<input type="checkbox"/>
• If antenatal, discuss + document preferred feeding wishes	<input type="checkbox"/>	<input type="checkbox"/>
• If postnatal, establish feeding wishes + contact infant feeding team (see over)	<input type="checkbox"/>	<input type="checkbox"/>
• If postnatal, encourage (where appropriate) infant visiting, photos of newborn, clothing/muslin swaps	<input type="checkbox"/>	<input type="checkbox"/>

Useful contacts

MATERNAL CARDIAC ARREST: 2222 - ask for OBSTETRIC TEAM+/- NEONATAL TEAM

- Obstetric consultant on call: via switchboard
- Obstetric anaesthesia consultant: via switchboard
- Delivery suite co-ordinator: 4157
- ICU consultant on call: via switchboard
- ICU SpR: 606
- Transfusion: 4204
- Haematology: 4205
- Obstetric SpR: 980
- Obstetric SHO: 975
- Obstetric anaesthetic trainee: 976
- Neonatal ward: 4523
- Infant feeding team: 4583

Clinical Resources

RCP: Acute Care Toolkit 2019: Managing acute medical problems in pregnancy



Resuscitation Council UK / OAA : Obstetric Cardiac Arrest Algorithm



MOMs Guidelines: Collection of national links and obstetric guidelines



BUMPS website: Best use of medicines in pregnancy



Normal blood results in pregnancy

U+Es	Non-pregnant	Pregnant	Trimester 1	Trimester 2	Trimester 3
Urea (mmol/L)	2.5-7.5		2.8-4.2	2.5-4.1	2.4-3.8
Creat (umol/L)	65-101		52-68	44-64	55-73
K+ (mmol/L)	3.5-5.0	3.3-4.1			
Na+ (mmol/L)	135-145	130-140			
24hr protein (g)	<0.15	<0.3			
PCR (mg/mmol)		<30			

FBC	Non-pregnant	Pregnant
Hb (g/dL)	12-15	11-14
WCC x 10 ⁹ /L	4-11	6-16
Platelets x 10 ⁹ /L	150-400	150-400

LFTs	Non-pregnant	Pregnant	Trimester 1	Trimester 2	Trimester 3
Bilirubin (mol/L)	0-17		4-16	3-13	3-14
ALT (IU/L)	0-40	6-32			
ALP (IU/L)	30-130		32-100	43-135	133-418
GGT (IU/L)	11-50		5-37	5-43	3-41
Albumin (g/l)	36-46		33-43	29-37	28-36

BTHFT Maternal Critical Care: Daily Checklist

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During critical care stay

	Completed	N/A
• Document daily MDT review by relevant teams on EPR	<input type="checkbox"/>	<input type="checkbox"/>
• Start critical care diary + consider referral to clinical psychology	<input type="checkbox"/>	<input type="checkbox"/>
• If postnatal, promote regular contact + interaction between mother/baby	<input type="checkbox"/>	<input type="checkbox"/>
• Any intra/inter-hospital transfers should occur as per ICS/FICM transfer guidelines for obstetric patients	<input type="checkbox"/>	<input type="checkbox"/>

If antenatal:

	Completed	N/A
• Daily MDT review to include need for fetal monitoring + risk of labour/delivery	<input type="checkbox"/>	<input type="checkbox"/>
• Ensure maternal alert form present at bed space	<input type="checkbox"/>	<input type="checkbox"/>
• Consider need for valid group and save sample (only valid for 72 hours in pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>
• Ensure appropriate VTE prophylaxis prescribed, as per trust guidance	<input type="checkbox"/>	<input type="checkbox"/>
• Ensure daily Maternal Critical Care Safety checks completed including:		
1. Presence of neonatal resuscitaire	<input type="checkbox"/>	<input type="checkbox"/>
2. Presence of peri-mortem C-section equipment	<input type="checkbox"/>	<input type="checkbox"/>

If postnatal:

	Completed	N/A
• Ensure daily midwifery input for first 28 days	<input type="checkbox"/>	<input type="checkbox"/>
• Promote regular contact + interaction between mother/baby	<input type="checkbox"/>	<input type="checkbox"/>
• Support partner +/- baby's presence on critical care, where possible	<input type="checkbox"/>	<input type="checkbox"/>
• Contact infant feeding team to arrange infant feeding review (see useful contacts)	<input type="checkbox"/>	<input type="checkbox"/>

At discharge from critical care:

	Completed	N/A
• Complete critical care medical discharge summary on EPR	<input type="checkbox"/>	<input type="checkbox"/>
• Review medications, including LMWH, as per RCOG guidance	<input type="checkbox"/>	<input type="checkbox"/>
• Complete critical care medical handover to obstetric registrar on call	<input type="checkbox"/>	<input type="checkbox"/>
• Complete critical care medical handover to obstetric anaesthetist on call	<input type="checkbox"/>	<input type="checkbox"/>
• Inform neonatal team of mother's transfer location if baby on neonatal unit	<input type="checkbox"/>	<input type="checkbox"/>
• Inform CCOT of discharge	<input type="checkbox"/>	<input type="checkbox"/>
• Consider need for staff debrief +/- case review	<input type="checkbox"/>	<input type="checkbox"/>

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