Notification of NEW and UPDATED Guidelines February 2018

Clinical Midwifery/Nurse Specialist – Guidelines and Quality

Obstetrics and Gynaecology

Consultant Responsibilities [procedure]

- Amalgamated content from WNHS Policy (On-Call Responsibilities of WNHS Obstetric and Gynaecological Consultants) and KEMH Obstetric & Gynaecology guideline (ASCU Consultant Responsibility) together into same document: Procedure

Falls: Risks, Prevention & Management

- For patients identified at risk of falls, to include risk in iSoBAR handover
- Post fall management section: A full physical examination of the patient should be undertaken by the medical team to assess if intracranial, intrathoracic or intra-abdominal bleeding has occurred
- Baby fall prevention section: Provide parent education that includes: Address the safety issues of placing the baby on the bed unattended as all babies have the potential to roll off the bed

Transfer of a Patient to Agnes Walsh Lodge / House

- Description about difference between AWH and AWL added.
- Key points 1-4 added: women from regional areas no longer routinely offered accommodation at AWL; VMS does not provide care to AWL; bed requests through Discharge Coordinator; AWL used as last resort
- Exclusion criteria reviewed. Major placenta praevia and recurrent APH are not excluded. Added SROM and TPL to not be transferred prior to 48hours following review and condition to be stable prior to transfer.
- The process of contacting, and contact details of, Discharge Coordinator have been updated

Obstetrics and Midwifery

Cord blood collection / analysis

- RCA recommendation: Section about abnormal blood gases added (number 11)

Breech Presentation

- A woman whose only indication for CS is breech presentation, should not be transferred to the theatre suite until the presentation has been confirmed with bedside ultrasound

Breech (Uncomplicated term) Vaginal Birth Quick Reference Guide

- In flowchart- requires ultrasound prior to transfer to theatre

Cardiac Disease

- RCA recommendation- updated guideline.
- Maternal echocardiogram at 13 weeks and physician review of echocardiogram result
- Women with valvular disease, including Rheumatic Heart Disease are seen by physician in early pregnancy and again at 28-32 weeks (at minimum) AND to ensure a plan regarding management in labour is documented on MR 004.
- Mitral valve stenosis is the most common lesion in Rheumatic Heart disease and the one that carries the highest risk. This may be a difficult clinical diagnosis and there should be a low threshold for maternal echocardiography
- Observations section- added: Auscultate lung fields if there is any change in respiratory status. Report any deterioration in clinical status to Senior Registrar. Consider oxygen, invasive haemodynamic monitoring and pulse oximetry if indicated, chest xray, arterial blood gas, nebuliser if indicated.
- Management of VTE in women with cardiac conditions in pregnancy & puerperium: gestation for therapeutic anticoagulation changed when transferring from warfarin to heparin- now 36 weeks

Corticosteroids: Antenatal use of

- Recent CIMS- joined two guidelines into one so all corticosteroid information in one guideline

Adolescent Clinic [procedure]

- Referral: <18 years at the time of birth with first baby. If don't meet criteria but require special consideration, discuss with CMN Manager (Outpatients).
- Pap smear removed as national cervical screening guidelines and age range for screening have changed- see separate cervical screening guidance
- If STI- proof of cure changed from 6 weeks to 1 month after treatment
- Blood tests/ anaemia management section revised- now refer to Anaemia in Pregnancy guideline
- Home visiting and parent education section added (read section)
- Follow-up home visits changed from six months to up to four months postnatally
- Postnatal check-up section expanded.
  - EWC booking clerks can be emailed a request for post-natal appt ensuring mailing address is included.
  - If implanon inserted prior to discharge- offer follow-up with KEMH or own GP; if implanon required but not inserted prior to discharge, give four week appt; If mirena required then give a six week appt.

Amnioinfusion

Caesarean: Pre-Admission Clinic for Births by Elective Caesarean

- Palpation in PAC by midwife, and if unsure of position (or if the woman's only reason for elective caesarean is breech presentation and fetus is now cephalic), discuss with the PAC RMO, and the woman is sent to MFAU or scanned in clinic depending on the RMO in PAC.
- Document list removed- refer to current PAC checklist that accompanies PAC packs
- Added: Explain to the woman about enhanced recovery after surgery (ERAS) principles (e.g. encourage mobilisation, eating and drinking as soon as possible)

Caesarean Birth: Midwives Attending Theatre

- Moved to Perioperative Services (access via Healthpoint)

Caesarean Section: Post-Operative Care

- Equipment for admission of post-op woman no longer includes sanitary pads, bath wipes or nappies
- ERAS principles added. Provide patient checklist- section 1.4 added. Encourage early mobilisation within six hours of returning to ward.
- Monitor PIVAS on all IV sites for their duration and 48 hours after removal
- If post-op obs not stable- more frequent observations and medical review recommended- see Recognising & responding to clinical deterioration guideline
- Non-adhesive pad dressings to be removed at least 48hrs after caesarean. Remove post shower. Read section 6.2 for changes
- Monitor for fever, assess for signs of infection, separation and dehiscence. Encourage loose clothing, cotton underwear, and the patient to gently clean and dry the wound daily. Plan removal of clips/staples if required.
- Can be discharged from 24 hours after caesarean if medically cleared.

Cervical Suture: Removal

- One hour post removal of suture if the CTG is reactive and there are no other clinical concerns the woman may be discharged with planned follow-up

Family Domestic Violence- Screening for

- Screen women at first contact (any area- no longer limited to EC or LBS)

Hypertension in Pregnancy

- Diazoxide removed
- CMP section added (p.2)

Hypertension in Pregnancy – midwifery care

- Diazoxide removed
- CMP section added (p.20)

MFAU: Referral to

- Clarified: Doctor responsible for reviewing the woman: in hours is team doctor, after hours is MFAU doctor.
- Sending woman for blood tests in pathology: Consider severity of symptoms: there are times when pathology referral is unsuitable/ unsafe. In these cases, refer directly to MFAU.
- Phlebotomy staff available on weekdays/ weekends if difficult bleed
- If a bedside USS is required this can be performed in the Antenatal clinic. If not possible, a clinical handover must occur to the practitioner responsible for the ultrasound
- Process reviewed- see section: 'Arranging an ultrasound scan as part of MFAU assessment'
- Medical review of planned attendances- when contacting doctor- if no reply within 15 minutes, repeat pager.
- Code blue medical may be considered if situation demands. See clinical deterioration guideline.
- If requiring External cephalic version (ECV) attempts do not require advanced ultrasound booking- arrangement done on the day

Community Midwifery Program (CMP)

Gynaecology

Emergency Centre

- Reviewed by guideline pod- read guideline

Stoma Care

- Links to SCGH

Intercostal Catheter (Chest drains)

- Links to SCGH

Perioperative Services [Access through Healthpoint- intranet only]

Caesarean- Roles of staff attending

- Ratified by MSMSC & PSMSC - moved to Perioperative as now covers more than midwifery roles

HSSD [Access through Healthpoint- intranet only]

Anaesthetics

Imaging [Access through Healthpoint- intranet only]

Provision of CT Services to KEMH Patients

- See guideline

WITHDRAWN-

Obstetrics & Gynaecology

1. **Interpreter use of** [refer to policy]
2. **Venepuncture (adult)**
3. **Volumetric Infusion Pumps/syringe drivers: Electronic Infusion Devices**
4. **Demand management and diversion at KEMH flow chart** [content moved to Patient flow hub page]
5. **ASCU: Consultant responsibilities flowchart** [guideline flowchart and policy content merged to create new procedure]
6. **Management of B12 deficiency**- already in section B- removed duplicate

Obstetrics & Midwifery:

1. **Visiting Midwifery Service Antenatal Care**
2. **Folic Acid Supplementation**
3. **Genetics Service – Referral to**
4. **Childbirth and Parenting Courses**
5. **Vaginal Examination - performing**
6. **Oxytocin for the Third Stage of Labour in the FBC**
7. **Ergometrine for Primary Postpartum Haemorrhage in the FBC**
8. **Syntometrine for the Third Stage of Labour in the FBC**
9. **Episiotomy in the FBC: Lignocaine Prior to**
10. **Perineal Repair in the FBC: Lignocaine for**
11. **Corticosteroids: Management in Pregnancy with Diabetes** – [content amalgamated into "Corticosteroids: Antenatal use of (in section Obstetrics & Midwifery above)]
12. **IUGR MFAU QRG**- removed from website as content moved into SGA/IUGR guideline Oct 2016

CMP: Withdrawn- instead refer to KEMH guideline

1. **Abdominal pain [CMP]**
2. **Decreased Fetal Movements [CMP]**
3. **Shoulder dystocia [CMP]**