Complex Care

Complex Antenatal

Examples of important information	Example of how to document
I- Identification	
Name UR DOB	CJ UR checked and correct DOB checked and correct 3 identifiers must be checked but do not document confidential information
S- Situation	
• Presenting complexity/ concern • Gestation • Gravida/Parity • Where was this presentation? e.g. antenatal clinic, women's assessment, A&G ward, Birthing suite.	CJ presents to woman's assessment with decreased FM. Has not felt the baby move for 24 hours. 32+4 G5P0
B- Background	
Relevant background may include: • Medical, surgical, family and obstetric history • Current pregnancy history • Serology • Investigations and screening in the pregnancy • Risk factors • Interventions	Past hx: 4 spontaneous miscarriages in the first trimester. 2 previous presentations for decreased fetal movements in this pregnancy. Last presentation at 28 weeks. Discharged after CTG monitoring and education. Low lying placenta (3cm from OS) and fetal growth <8th centile as per last scan at 28 weeks Serology negative, 28-week screening for GDM negative.
A- Assessment	
• Vital signs • Physical examinations • Investigations • Blood results • CTG results	• BP 120/80, HR 90, Temperature: 36.7, RR: 20 • Reports nil PV loss • Abdo assessment: Long, lie, ROA, 3/5 above brim • CTG insitu: Baseline 155, nil accelerations, reduced variability (3-5bpm), no decelerations, nil contractions
R- Recommendation	
• What is the plan of action? • Consultation and referral. • Consider who you have liaised with to create the plan (consider the multidisciplinary team)	• CTG discussed with RMO and Team leader. Plan: Continue monitoring the CTG until it meets normal criteria. • USS booked (next available): to assess fetal wellbeing and current position of the placenta • Encourage oral intake of fluid. If no improvement in variability, reassess and consider IV Hartmann's

Signature and designation of the supervising midwife or doctor. Date of signature and date of the episode of care must match *(retrospectively signed records will not be counted).*

Complex Intrapartum – example of emergency caesarean section

<table>
<tr><th>Examples of important information</th><th>Example of how to document</th></tr>
<tr><td colspan="2">I- Identification</td></tr>
<tr><td>Name
UR
DOB</td><td>CJ
UR checked and correct
DOB checked and correct
3 identifiers must be checked but do not document confidential information</td></tr>
<tr><td colspan="2">S- Situation</td></tr>
<tr><td>• Presenting complexity/ concern
• Gestation
• Gravida/Parity
• Where was this presentation? eg Antenatal Clinic, Women's Assessment, A&G ward, Birthing suite.</td><td>G1P0, Induction of labour at 39 weeks for IUGR (<1st centile) and 3 episodes of reduced FM

Actively pushing for 1.5 hours with minimal descent

CTG:
• Baseline, rising (5bpm) over the past hour. 150bpm, now 155bpm.
• Variability: reduced 3-5 bpm
• Decelerations: Late decelerations, taking longer to recover with each contraction
• No accelerations
Registrar present to review and create plan</td></tr>
<tr><td colspan="2">B- Background</td></tr>
<tr><td>Relevant background may include:
• Medical, surgical, family and obstetric history
• Current pregnancy history
• Serology
• Investigations and screening in the pregnancy
• Risk factors
• Interventions</td><td>Pregnancy:
• G1: P0 / presented to woman's assessment with reduced FM at 28, 37 and then at 39 weeks.
• A positive blood group
• Negative serology. GDM negative
• Latest USS: fetal weight estimate XXXX (provide specific values). = less than 1st centile. Fundal heigh 35cm.
• Poor antenatal attendance to clinic appts. Failure to attend 32-week ultrasound.
• GBS negative

Labour:
• ARM: 0900
• Oxytocin infusion commenced: 0930
• Fully dilated at 1600
• CTG met criteria within antenatal phase (provide generalised breakdown from first stage)
• 4:10 strong contractions, 1 min of resting tone. Oxytocin at 96mls/hour</td></tr>
<tr><td colspan="2">A- Assessment</td></tr>
<tr><td>• Vital signs
• Physical examinations
• Investigations
• Blood results
• CTG results</td><td>• Vaginal Examination (undertaken by the registrar at time of review): Fully dilated, -1 station, LOT, Moulding ++, Caput +++
• CTG: as stated in the situation (repeat again here, can discuss the change over the labour or in second stage)
• Observations: BP 100/60, HR 70, Temp 37.1, RR 18</td></tr>
<tr><td colspan="2">R- Recommendation</td></tr>
<tr><td>• What is the plan of action?
• Consultation and referral.
• Consider who you have liaised with to create the plan (consider the multidisciplinary team)
• Suggested ongoing follow-up</td><td>• Due to fetal distress and prolonged second stage with a high fetal head, registrar recommended emergency LSCS.
• Woman consented and prepped for theatre
• Live Male born 10:07, APGARS 5:5 and 7 (please see complex neonatal XX for the management of the neonate at the time of birth).
• Cord Gasses (value stated)
• Transfer to the postnatal ward, liaise with SCN for mother to see the baby before admission to the unit</td></tr>
</table>

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Complex Intrapartum – example of elective caesarean section

I- Identification	
Name UR DOB	CJ DOB checked and correct UR checked and correct 3 identifiers must be checked but do not document confidential information
S- Situation	
• Presenting complexity/ concern • Gestation • Gravida/Parity • Where was this presentation? e.g., antenatal clinic, women's assessment, A&G ward, Birthing suite.	39 weeks gestation, 2: 1 EL LSCS for previous 3C tear *(state the mode of the complex birth and the indication)* Live male born at XXXX on the XX/XX/XXX via an elective LSCS. (now G2:P2)
B- Background	
Relevant background may include: • Medical, surgical, family and obstetric history • Current pregnancy history • Serology • Investigations and screening in the pregnancy • Risk factors • Interventions	• *(year)* Forceps birth of a live male. Episiotomy + 3C tear. Counselled in antenatal clinic, Informed consent for an EL LSCS. Paperwork signed in preadmission pack. • A positive blood group • Negative serology • GDM negative, first trimester screening: low risk, Morphology did not display any abnormalities • History of endometriosis and laparoscopy in 2017
A- Assessment	
• Vital signs • Physical examinations • Investigations • Blood results • CTG results	**Pre LSCS:** • BP 120/80, HR 100, Temp 36.2 RR 20. • Weight 90 kg • IDC inserted on the ward prior to LSCS with consent. Draining clear urine • Fasting since 2000 (the day before) • Pre-operation checklist completed. CJ dressed for theatre **During Theatre:** • EBL 1000mls. *State the management and medication for this.* • Cord Gasses (values if taken) and *state the indication* (routine, neonates' condition at birth) • BP 120/80, HR 105, Temp 36.4 RR 20. • Placenta: complete, Membranes: Complete
R- Recommendation	
• What is the plan of action? • Consultation and referral. • Consider who you have liaised with to create the plan (consider the multidisciplinary team) • Suggested ongoing follow-up	• For a CBE at 6 hours postnatal • Hourly observations for 12 hours due to spinal morphine at birth • Mother and baby to remain together • Liaise with the Postnatal ward for transfer • Manage pain with oral medication. Tramadol and oxycodone charted. • Assistance with breastfeeding required.
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