Referral, Handover of Care and Transfer UHL Obstetric guideline

NHS
University Hospitals of Leicester
NHS Trust

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Contents

1. Introduction and Who Guideline applies to 1
Related documents: 2
Associated patient information leaflet: 2
What's new? 2
2. RESPONSIBLE CLINICIAN: 2
2.1 Antenatal care: 2
2.2 Intrapartum care: 3
2.3 Postnatal care: 3
2.4 Ward rounds: 4
2.5 Referrals 5
2.6 Handovers 7
2.7 Transfers 10
2.8 Communication: 12
2.9 Personnel: 13
2.10 Ambulances: 13
2.11 In-Utero Transfer in - intrapartum from community /birth centre / alongside birth centres: 13
2.12 Maternal postnatal transfer in: 14
2.13 Postnatal transfers out: 14
3. Education and Training 15
4. Monitoring Compliance 15
5. Supporting References 15
6. Key Words 15
Contact and review details 16
APPENDIX 1: SBAR Form 17
Appendix 2: Emergency equipment SBAR sticker 18
APPENDIX 3: Handover Sheet (LRI) 19
Appendix 4: Handover sheet (LGH) 22
Appendix 5: In-utero transfer flowchart 24
Appendix 6: In-utero transfer record 25

1. Introduction and Who Guideline applies to

These guidelines are intended for the use of all staff involved in the care of pregnant women and people in the antenatal period, during labour or postnatally. This includes midwives and obstetricians.

Background

The Francis Report made a number of recommendations on the need for there to be a named clinician who is accountable for a patient's care whilst they are in hospital. The Academy of Medical Royal Colleges was asked how this could be taken forward and they produced "Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients" (2014) This guidance only relates to a patients stay in hospital. It was recognised that this is only part of the overall pathway and that the principle should also apply to a community or primary care setting but implementation of this would be complex.
The guidance in this document aims to ensure that the Maternity Service can meet those recommendations where possible.

Related documents:
Intrapartum Care UHL Obstetric Guideline Trust ref: C60/2019
Booking Process and Risk Assessment UHL Obstetric Guideline Trust ref: C16/2011

Associated patient information leaflet:
Listening to your baby's heart beat in labour

What's new?

- Midwife to midwife handover on delivery suite - Equipment should be checked and the second SBAR sticker in Appendix 1 completed

2. RESPONSIBLE CLINICIAN:

- The responsible clinician (RC) is the clinician with overarching responsibility for the patient's care. The RC may not be involved in the day to day clinical care during all care episodes, but should assume overarching responsibility and be a point of contact for the patient and their family.

- In the Maternity Service, all women book with the community midwife. On receipt of the booking information at the consultant units a risk assessment is made. Where the woman or pregnant person is assessed as "midwifery led" the community midwife is the responsible clinician. Where consultant care is required this will be allocated by the antenatal core midwives or by the clinic coordinators where a specialist clinic appointment is not required.

- The responsible clinicians name should be documented in the health record and the pregnant person should be informed.

2.1 Antenatal care:

- At every point where care is transferred to another clinician this should also be documented and dated and the pregnant person informed.

- Low risk women and pregnant people who are admitted to an antenatal ward, and cannot be allocated to a specialist team, but have some complex issues and therefore require continuity of care. A General obstetric consultant will be allocated for the care.

- At LGH, this will be the consultant on whose clinic day the patient has been admitted from Monday till Friday. Those patients admitted on Saturday will be under care of consultant whose clinic was on Friday and those admitted on Sunday will be under care of consultant who will have clinic on Monday (covering all 7 days).

- For LRI, General obstetric consultant for Tuesday clinic will be responsible for all patients admitted from Monday till Wednesday and General Obstetric consultants for clinic on Thursday-will be responsible consultants for patients admitting from Thursday till Sunday.

- A formal risk assessment should be completed at around 36 weeks gestation and documented on the specific form within the health records. The RC should be reviewed and reconfirmed at the same time, and this should be documented.

- Where the community midwife requires obstetric advice; contact should be made via MAU

2.2 Intrapartum care:

- The midwife coordinator is responsible and accountable for the day to day running of the delivery suite and should ensure that quality care is given at all times.

- The midwife coordinator should provide leadership, direction and support to midwives, student midwives, maternity care assistants and junior doctors. The Lead Midwife needs to be visible, accessible and responsive to the needs of women.

- The midwife in charge of ward areas, maternity assessment units and the midwife in charge of the birth centre have the same responsibilities for their area as the midwife coordinators on delivery suite.

- High risk people who already have a responsible clinician allocated in the antenatal period should remain under that clinician's overarching care. Women and pregnant people who are high risk or become high risk intrapartum, will be allocated a consultant obstetrician as their responsible clinician. This will usually be the consultant on Hot Week on that day or under care of specialist clinic depending on the medical problem or complication.

2.3 Postnatal care:

- High risk people who already have a responsible clinician allocated in the antenatal period or intrapartum period should remain under that clinician's overarching care. People who had a low risk pregnancy and delivery but who become high risk postnatally will be allocated a consultant obstetrician as their responsible clinician. This will usually be the consultant on Hot Week on that day.

- Low risk people who are admitted to a postnatal ward, cannot be allocated to a specialist team, but have some complex issues and therefore require continuity of care. A General obstetric consultant will be allocated for the care.

  - At LGH, the consultant on whose clinic day the patient has been admitted. (Each day there is a general obstetric clinic from Monday until Friday). Those patients admitted on Saturday will be under care of consultant whose clinic was on Friday and those admitted on Sunday will be under care of consultant who will have clinic on Monday (covering all 7 days).

  - For LRI General obstetric consultant for Tuesday clinic will be responsible for all patients admitted from Monday till Wednesday and General Obstetric consultants for clinic on Thursday-will be responsible consultants for patients admitted from Thursday till Sunday.

2.4 Ward rounds:

- Whilst the person is an inpatient on a ward, the name of the responsible clinician should be written on the white board above the bed and also on the board by the midwives station. The named midwife should also be displayed on the white board.

- Monday to Friday, daily Ward rounds will be carried out on each site as per agreed timetable.

  - At the LRI this will be the MAU consultant, assisted by the designated SPR where appropriate.
  - At the LGH antenatal ward patients and complicated postnatal patients will be seen by the designated Consultant. If the responsible consultant is on leave, the labour ward consultant (aided by the on call SpR) is responsible for the ward round.

- Where there are postnatal people with complex needs a review by an SPR or above should be requested.

- At the weekend cover may vary according to the rota.

- On weekends and bank holidays the resident consultant (8 am till 5pm) carries overall responsibility for the care of all inpatients and also for completion of ward rounds along with the on call team. This means that the on call consultant is expected to review all antenatal and complex postnatal ward patients. Depending on activity, this may not be feasible, particularly at LRI (two wards), in which case as a minimum a board round with the registrar (ST4 or above) should take place for those patients the Consultants could not see (At the LRI the consultant should start the ward round on ward 5 where usually most high risk patients are placed).

- In people with highly complex problems where it is felt that continuity of care is crucial, the responsible clinician may need to be personally involved in decision making as far as possible, individually or as a member of a multidisciplinary team, or liaise closely with clinicians performing daily ward rounds.

- In times of special emergencies when out of hours Consultant cover is altered/ increased e.g. a labour ward consultant and MAU consultant both on site, the two consultants must communicate and agree who does the ward round. All antenatal patients must be reviewed by a consultant and there has to be communication about particularly high risk patients as the labour ward on call consultant has ultimate responsibility for all inpatients.

2.5 Referrals

Consultant Referral by the Obstetric Team

The referral guide below lists specific circumstances where a consultant MUST be informed, but consultant advice should be sought whenever the SpR is uncertain about any aspect of a patient's care.

Postnatal –
Midwives can refer and admit people to delivery suite if needed up to 28 days postpartum. Most postnatal complications can be referred to the GP, who can then refer people up to 6 weeks postnatal to maternity assessment unit/delivery suite, if indicated. In exceptional circumstances; the consultant's input can be sought.
Midwives should use SBAR handover to escalate/refer women or birthing people who have been discharged to midwifery led care but present with concerns that require referral back to obstetric led care.

After contacting the consultant it is important to document the consultation fully in the patient's notes.

Contacting senior medical staff:

Consultant and the registrar on call must be informed in accordance with the following guidance and this should be documented in the case notes.

The consultant must be informed and attend in cases of:

- Caesarean Section for major Placenta Praevia
- Major APH / PPH where bleeding is ongoing
- Severe pre eclampsia / Eclampsia
- Maternal collapse (massive abruption, massive obstetric haemorrhage where massive haemorrhage protocol has been instigated, septic shock, uterine rupture etc)
- Caesarean section with large uterine fibroids
- American Heart Association Class III & IV cardiac disease
- DIC
- Maternal death
- Return to theatre for laparotomy
- Morbid obesity BMI>40
- Intrapartum stillbirth
- Trial of instrumental delivery or full dilatation section if SpR <ST6
- For other emergency cases when the registrar(s) on call is/are already busy or in gynae theatre
- Intensive workload on the delivery suite where closure of both units is contemplated

The consultant must be informed and may need to attend in cases of:

- Patient requiring transfer to ITU
- Patient requires Pre-eclampsia protocol
- Stillbirth or neonatal death on ward / delivery suite
- Major sepsis suspected
- Chorioamnionitis undergoing caesarean section
- Caesarean section for the 2nd twin
- Caesarean section for a pre-term pregnancy under 34/40
- Closure of one unit is contemplated because of midwifery staffing shortages
- Intensive workload on the delivery suite where closure of one unit is contemplated
- The woman or birthing person declines the recommended mode of delivery

If the level of complex activity is high and further skilled medical presence is required then the consultant obstetrician and the delivery suite coordinator will make the decision to contact the consultant obstetrician on the other site in the first instance and they will be required to attend. If this is not possible, the on call manager will contact off duty Consultant Obstetricians to identify who is available to come in.

Situations where an experienced obstetrician must attend (Consultant or ST6-7 or above):

- Major APH / PPH / DIC
- Eclampsia/severe pre-eclampsia protocol
- Caesarean section for pre-term baby (under 34 weeks)
- Caesarean section for placenta praevia
- Caesarean section at full dilatation
- Caesarean section for transverse lie
- Caesarean section where adhesions might be present i.e. Crohn's, previous myomectomy, bowel surgery, etc.
- Caesarean section after 2 previous sections
- Caesarean section with large uterine fibroids
- Caesarean section with BBI
- Severe cardiac, renal, respiratory or haematological disease
- Patient returning to theatre following surgery
- Severe chorioamnionitis undergoing caesarean section
- Keillands forceps (only individuals competent at Keillands may supervise)
- Postpartum collapse
- Trial of instrumental delivery in theatre
- Multiple pregnancy delivery
- Vaginal breech delivery
- Repair of third or fourth degree tear (unless and ST3-5 is signed off as competent)

Situations where an ST6-7 or above must be involved in the assessment and decision-making process (if there is only a ST4 / 5 in residence they should discuss the case / management with the consultant:

- Preterm labour for intrauterine transfer
- Maternal pyrexia (Temp above 38°0C)
- DVT / PE
- Suspected chorioamnionitis
- Severe cardiac disease
- Pre-term labour <34 weeks
- Pre-term ruptured membranes <34 weeks
- Breech in labour
- Failed attempt at fetal blood sampling
- Admission of a woman or birthing person with a complex fetal/maternal problem

These lists are not exhaustive and clearly, if a junior SpR is uncertain about any aspect of patient management then they should consult the senior SpR/consultant. If the junior SpR requests senior presence for whatever reason then the senior SpR or consultant must attend.

If a senior SpR is uncertain about any aspect of patient management then they should contact the consultant obstetrician on call for the delivery suite for advice or to request their attendance.

The midwife in charge of the delivery suite has a responsibility to ensure that the consultant obstetrician who is covering or on call is contacted in any situation where she feels that the patients' safety may be compromised.

2.6 Handovers

Midwife/obstetric handovers

Handover between midwives and obstetricians should be face-to-face. At the end of each shift outgoing staff should make sure that time is taken to hand over all relevant information.

Midwife coordinating shift to midwife coordinating shift on delivery suite

The midwife handing over to the oncoming midwife gives a face to face handover of all aspects of care of the women and birthing people on delivery suite using the SBAR handover form (Appendix 1 or 2).

The form is also used during the multidisciplinary ward round to document relevant information about the woman or birthing person's care on delivery suite at the LRI.

Changes that occur during the shift will be documented on the white boards on the delivery suites.

At the end of the shift these forms are signed and filed in a designated folder on delivery suite.

Midwife to midwife on delivery suite

A face to face verbal handover is given between the midwife handing over the care and the midwife receiving care. This includes all relevant aspects of care following the principles of SBAR.

The midwife handing over care documents that care has been passed to the oncoming midwife using the SBAR sticker (Appendix 1).

Equipment should be checked and the second SBAR sticker in Appendix 2 completed

The midwife receiving care should also document in the patient health care records using the SBAR sticker (Appendix 1), acknowledging receipt of care and introductions made to the woman, birthing person and their family.

A plan of care is then formulated based on the information received and documented in the patient health care records.

Obstetrician to obstetrician

The obstetrician transferring responsibility for cover must give an up to date report of relevant patient information to the obstetrician and their team taking over cover with a face to face handover in a designated area using the SBAR handover form (Appendix 3 or 4), ensuring they handover all aspects of patient care when finishing their shift

Delivery Suite to ward:

Midwife assesses woman, or birthing person, and baby's suitability for transfer to antenatal/postnatal ward.

Telephones ward to check bed availability and give brief verbal overview of case.

Completes documentation electronically and in hand written notes.

Ensures woman or birthing person is accompanied to ward by a midwife unless circumstances dictate otherwise.

Verbal handover to ward midwife is at the bedside following the principles of SBAR.

Confidential information may be given in a designated private area if required.

Ward midwife to document receipt of handover in health care records by completing the relevant SBAR page in postnatal notes

Antenatal / Postnatal Ward Handovers:

On the antenatal/postnatal ward a face to face verbal handover of all patients is given in a designated area for all members of staff on duty.

Handover details of each patient are held electronically on E3 and NerveCentre and updated when required.

Handover to community midwife:

Antenatal:
- Assessment by appropriate practitioner of woman or pregnant persons suitability for transfer/discharge home
- Completion of hand written notes
- Completion of E3 discharge summary
- Copy of discharge summary will be forwarded to the GP via the community office.

Postnatal:
- Assessment of physical suitability of woman or birthing persons and baby for transfer home by appropriate practitioner
- Completion of hand written notes
- Completion of hand written discharge check list, which is filed in case notes
- Midwife completes E3 discharge summary and gives woman or birthing person postnatal notes for mother and baby (except in cases of fetal/neonatal loss) to hand to community midwife
- Midwife provides child health record book
- Provision of bar coded labels for the baby
- Details of midwifery visits and emergency contact numbers are provided
- Details provided of breastfeeding support via local support groups, websites or telephone contact.
- Bounty bag is provided
- Information entered on E3 discharge is sent electronically to community midwifery office
- Community midwifery administration staff check system throughout the day at regular intervals in order to pass discharge information to community midwife
- Community midwifery office telephones community midwife leads with details of all discharges once a day
- A designated health professional or team member allocates care
- Hard copy of E3 discharge summary sent to GP and health visitor
- Ward clerk / maternity care assistant to discharge woman (and baby) on electronic database, tracking the hospital notes

Antenatal services to maternity assessment unit / delivery suite / ward:

Woman or pregnant person assessed for suitability to be transferred.

Ward is telephoned to check bed availability and give brief verbal overview of case.

Completion of relevant documentation, including a written plan for ongoing treatment.

.
Woman or birthing person is accompanied by member of staff to MAU / delivery suite/ ward.

Verbal handover to midwife to include:
- Verbal summary of antenatal care
- Written documentation of handover passed to MAU/ delivery suite/ward midwife following the principles of SBAR using the SBAR handover sticker

Ward to delivery suite/birth centre / alongside birth centres:

Woman or birthing person assessed for suitability to be transferred.

Ward staff confirms bed availability by telephone and gives a brief verbal overview of case to midwife in charge.

Woman or birthing person accompanied to delivery suite/ birth centre by midwife.

Verbal and written documentation of handover to labour ward midwife to include:
- Verbal summary of antenatal care
- SBAR sticker to be placed in health record, signed by both transferring and receiving midwife, as written documentation of handover.

2.7 Transfers

Transfer between hospitals / trusts

The transfer of a woman or pregnant person to another trust can occur for a number of reasons:
- Woman's or pregnant person's choice
- For specialist treatment available/ not available at this hospital for mother or baby
- In cases of preterm labour, or a high risk preterm delivery, or delivery of a baby known to require neonatal care and requiring a NNU cot when the onsite NNU cannot accommodate the baby
- Woman or birthing person transferred postnatally to follow their baby who has already been transferred to another unit
- In cases where transfer is required during the intrapartum period from community/birth centre
- Transferred postnatally from the community/birth centre with complications following birth
- Thames Ambulance Services Ltd (TASL) should transfer pregnant people between hospital sites.
- If there are any difficulties in requesting ambulance transfer, the duty manager for the hospital should be contacted.

Contact numbers:
- TASL 0116 3666770
- Duty Manager 07921 545532

In-utero transfer in from other hospital:

A request received from another hospital to transfer a woman or birthing person to UHL prior to delivery may be made for a number of reasons, the most frequent being for the delivery of a baby known to require neonatal care. To ensure that appropriate care can be provided for both mother and baby without compromising the care of women or birthing people already in the directorate a number of steps must be followed.

- All requests for in-utero transfer should be directed to the most senior obstetrician on delivery suite.

- It is this obstetrician's responsibility to speak to all relevant members of staff.

- Minimum details required to act on a request for in-utero transfer in include:
    1. SBAR (if possible)
    2. Patient's name, address and date of birth
    3. Parity
    4. Gestation
    5. Reason for transfer
    6. Specific pregnancy details (e.g. diabetes, past caesarean section)
    7. Confirm consultant involvement with decision for in-utero transfer

The obstetrician will then discuss the appropriateness of the transfer with:

- Consultant obstetrician on call
- Neonatologist on call
- Nurse in charge on the neonatal unit to confirm cot availability
- Midwife coordinating shift on delivery suite to confirm ability of delivery suite to accept transfer
- Maternity bleep holder

Acceptance of transfer must not take place until all listed staff have been contacted and have agreed transfer may take place.

Once transfer has been accepted, a midwife should be allocated to care for the woman or pregnant person, and preparation made to receive the patient.

Maternity reception when manned should be informed that in-utero transfer is expected and patient information details given.

When the woman or birthing person arrives, maternity reception can then admit them onto the hospital computer database, generating a hospital number for UHL and a set of patient records.

In-utero transfer out (not temporary transfer of admissions**):**

The decision to transfer a patient 'in utero' must be made by the most senior obstetrician on delivery suite, in consultation with the following clinicians:

- Consultant obstetrician on call
- Resident neonatologist on call & senior nurse in charge on the neonatal unit
- Midwife coordinating the shift on delivery suite
- Maternity bleep holder
- The woman or birthing person and her family

It is important that consultation with these individuals be made prior to any arrangements for transportation to another hospital.

The procedure to follow for in-utero transfer out:

No: Item:	Responsibility:
Identify reason for transfer (In consultation with the above clinicians)	Senior obstetrician on delivery suite
Find suitable receiving hospital	Obstetrician on delivery suite (See appendix 5 for options and telephone numbers)
Inform patient and family	Senior obstetrician on Delivery Suite
Ensure patient is stable prior to transfer	Senior Obstetrician on Delivery Suite / Midwife in Charge of case
Gather relevant equipment needed for transfer (will vary depending on reason for transfer)	Midwife in Charge of case
Book Ambulance	Midwife in charge of case / midwife in charge of delivery suite / maternity bleep holder
Reassess reason for transfer – "Is transfer still appropriate?"	Senior obstetrician on delivery suite
Phone receiving hospital to inform them you are leaving	Midwife in charge of delivery suite / maternity bleep holder
Record details transfer of in-utero transfer as part of E3 antenatal discharge summary.	Midwife in charge of case
Complete Datix incident form	Midwife in charge of case

2.8 Communication:

After a suitable receiving hospital is found, the referring obstetrician must discuss the case with the receiving obstetrician and document details on in utero transfer record (form) (Appendix 6), including:

- Patient name, and date of birth
- Parity and gestation
- Reason for transfer
- Relevant history
- Agreed plan of care (which may change when transfer complete) which must be documented clearly by the obstetrician in the notes
- Referral letter for the receiving hospital

2.9 Personnel:

Women or birthing people transferred from delivery suite must be escorted, as a minimum, by a midwife.

2.10 Ambulances:

When booking the ambulance for transfer it is important to have all relevant information:

- When transfer required (usually immediately)
- Name and date of birth of patient
- Transfer from and to
- How many people will be travelling (may be midwife and obstetrician)
- Urgency of transfer (blue light or routine)
- Stretcher or chair required

Ensure patient, equipment, documentation and personnel are ready for transfer as soon as possible, as emergency ambulances will usually arrive within 30 minutes.

Booking the ambulance:
Ring ambulance control in Nottingham in order to book the ambulance. They will discuss with the delivery suite coordinator the urgency of the case.
An anticipated time of transfer is arranged and will usually be requested to take place within one hour. In the event of the coordinator being unable to contact ambulance control they will telephone 999 and give the required details.

Documentation:
It is the responsibility of the midwife/obstetrician who is arranging and or completing the in utero transfer to ensure that the 'Maternity In-Utero Transfer Record' (appendix 6) is completed and filed in the hospital notes.
The 'Maternity In-Utero Transfer record' should remain within the hospital notes and not accompany the woman to the accepting maternity unit. The woman should be kept informed of all plans.

2.11 In-Utero Transfer in - intrapartum from community /birth centre / alongside birth centres:

- A request received from a community midwife or birth centre midwife to transfer to delivery suite may be made for a number of reasons.
- The most frequent is for delay in the first or second stage of labour, fetal distress or maternal request for epidural.
- All requests must go direct to the midwife coordinator on delivery suite.
- The obstetrician on duty will also be informed by the midwife coordinator. Maternity reception should be informed that the in-utero transfer is expected and patient information details given.
- An appropriate room and equipment will be prepared ready for the woman or birthing persons arrival on delivery suite.
- Ambulance should be booked as per section on page 13

Minimum details required to act on a request for an intrapartum transfer from the community/birth centre will include:

SBAR handover. As a minimum this should include:

a. Reason for transfer
b. Parity
c. Gestation
d. Specific pregnancy details
e. Labour details up until time of transfer request

Once the woman or birthing person has arrived on delivery suite a SBAR handover sticker should be added to their notes as written documentation of handover.
Both the midwife giving the handover and the midwife receiving the handover should sign the sticker.

2.12 Maternal postnatal transfer in:

Direct contact with midwife coordinator/bleep holder should be made.

Minimum details required to act on a request for maternal postnatal; transfer in will include:

- Direct contact with midwife coordinator/bleep holder
- Obstetrician should be informed by midwife coordinator
- Theatre team should be briefed if appropriate
- Nurse in charge of neonatal unit should be informed if appropriate
- Neonatologist should be informed if appropriate
- Maternity reception if manned should be informed that a maternal postnatal transfer is expected and patient information details given.

Once transfer has been accepted a midwife should be allocated to care for the woman or birthing person and neonate and preparations made to receive them.

On arrival at the receiving maternity unit, an SBAR handover sticker should be added to the patients' notes as written documentation of handover.
Both the midwife giving the handover and the midwife receiving the handover should sign the sticker.

2.13 Postnatal transfers out:

These may include transfer of baby to a neonatal unit in another hospital or if specialist treatment is required for the mother such as renal/cardiac investigations.

The obstetrician/ neonatologist will contact the receiving hospital to refer the patient and enquire about availability of a bed.

In case of transfer for maternal reasons the senior obstetrician will liaise with medical staff at the receiving hospital.

In the cases of a woman or birthing person wishing to transfer to accompany their baby, the bleep holder should liaise with the receiving hospital bleep holder to make enquiries re bed availability.

The woman should be reviewed by the obstetrician prior to her transfer where appropriate (e.g. after caesarean section or medical complications).

The Midwife in charge/bleep holder should book the ambulance. An SBAR handover should be given to the ambulance staff.

If a woman is transferred postnatally the obstetrician or midwife should complete the necessary paperwork to accompany her. This will include her referral letter, midwife transfer report. Notes may be copied or originals sent if the transfer is within UHL.

Staff should consider the most appropriate method of transport, and / or escort if required. This should be discussed with the bleep holder, the midwife in charge of the area and the woman's consultant obstetrician.

3. Education and Training

None

4. Monitoring Compliance

None

5. Supporting References

1. CESDI. Project 27/28: An enquiry into quality of care and its effect on the survival of babies born at 27-28 weeks. TSO. London. 2003.
2. Marsh SM, Rennie JM and Groves PA. *Clinical Protocols in Labour.* The Parthenon Publishing Group. London.2002.
3. Marsh SM, Rennie JM and Groves PA. *Clinical Protocols in Labour.* The Parthenon Publishing Group. London.2002.
4. Royal College of Obstetricians and Gynaecologists. *Improving Patient Handover. Good Practice Guideline Number 12.* London 2010

6. Key Words

SBAR, TASL

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Contact and review details

Original Authors: L Payne, L Matthews, C Kendall, J Andrews and D Brooks - Senior Midwives and Ward Managers Guideline lead: L Taylor – Clinical risk & quality standards midwife	**Executive lead:** Chief Nurse

REVIEW RECORD

Date	Issue Number	Reviewed By	Description Of Changes (If Any)
12.06.14	V3	As above	General update of telephones numbers etc. Insertion of guidance in the case of complex activity
November 2017	V4	L Matthews and A Buckley	General update. Some unnecessary information taken out. More reflective of what happens in reality
September 2020	V5	Cornelia Wiesender	General update. Responsible clinician for LRI updated. On call consultant is expected to review all antenatal and complex postnatal ward patients. Consultant to start ward round on ward 5 at LRI.
November 2022	V5.1	J Morrissey L Taylor	Removed clinician's names and made reference to job titles only. Clarified that Community midwives need to contact MAU if they require a Consultants advice Added that referral back to obstetric care should be made using SBAR referral when appropriate In hospital handover documentation now on NerveCentre Updated advice for when contacting TASL and/or Duty manager
December 2023	V6	E Tewley & L Taylor	Added midwife to midwife emergency equipment SBAR handover. Updated format and terminology

APPENDIX 1: SBAR Form

S	**Situation** identify self / site / unit patient name & reason for referral current concerns
B	**Background** obstetric history, parity, gestation medical history problems with current pregnancy allergies etc.
A	**Assessment** vital signs – MEOWS score stage of labour, progress colour of liquor bleeding drugs administered clinical impression concerns
R	**Recommendations** - what I need from you is … - be specific about request & time frame - suggestions for tests / treatments - clarify orders & expectations

Appendix 2: Emergency equipment SBAR sticker

HANDOVER GIVEN USING SBAR TOOL

Situation Background Assessment Recommendation

	FROM:	TO:
Name		
Signed		

Room/Location:

O2: ☐ Call Bell: ☐

Suction: ☐ EM buzzer: ☐

Resuscitaire No.:
(if applicable)

Checked/Stocked: ☐

APPENDIX 3: Handover Sheet (LRI)

Date:	Time:	Staff handing over:	Designation:	Staff handing to:	Designation:

Emergency and resuscitation equipment checking completed AM	Coordinator signature:
Emergency and resuscitation equipment checking completed PM	Coordinator signature:

Any other information:

Room	Initials/parity/gestation	Situation (Reason for admission)	Background (Medical/Obstetric history/allergies/ problems in pregnancy)	Assessment (Progress in labour/ liquor/ drugs/ concerns)	Recommendation (Tests/ Treatment/ Plan
Triage					
1					
2					
3					
4					

5					
6					
7					
8					
Room	**Initials/parity/gestation**	**Situation** (Reason for admission)	**Background** (Medical/Obstetric history/allergies/ problems in pregnancy)	**Assessment** (Progress in labour/ liquor/ drugs/ concerns)	**Recommendation** (Tests/ Treatment/ Plan
9					
10					
HDU 1					
HDU 2					
Bracken					

GW A					
GW B					
GW C					
GW D					
Recovery Bay 1					
Recovery Bay 2					
Recovery Bay 3					
Clover					

Appendix 4: Handover sheet (LGH)

Date:	Time:	Staff handing over:	Designation:	Handing over to:	Designation:

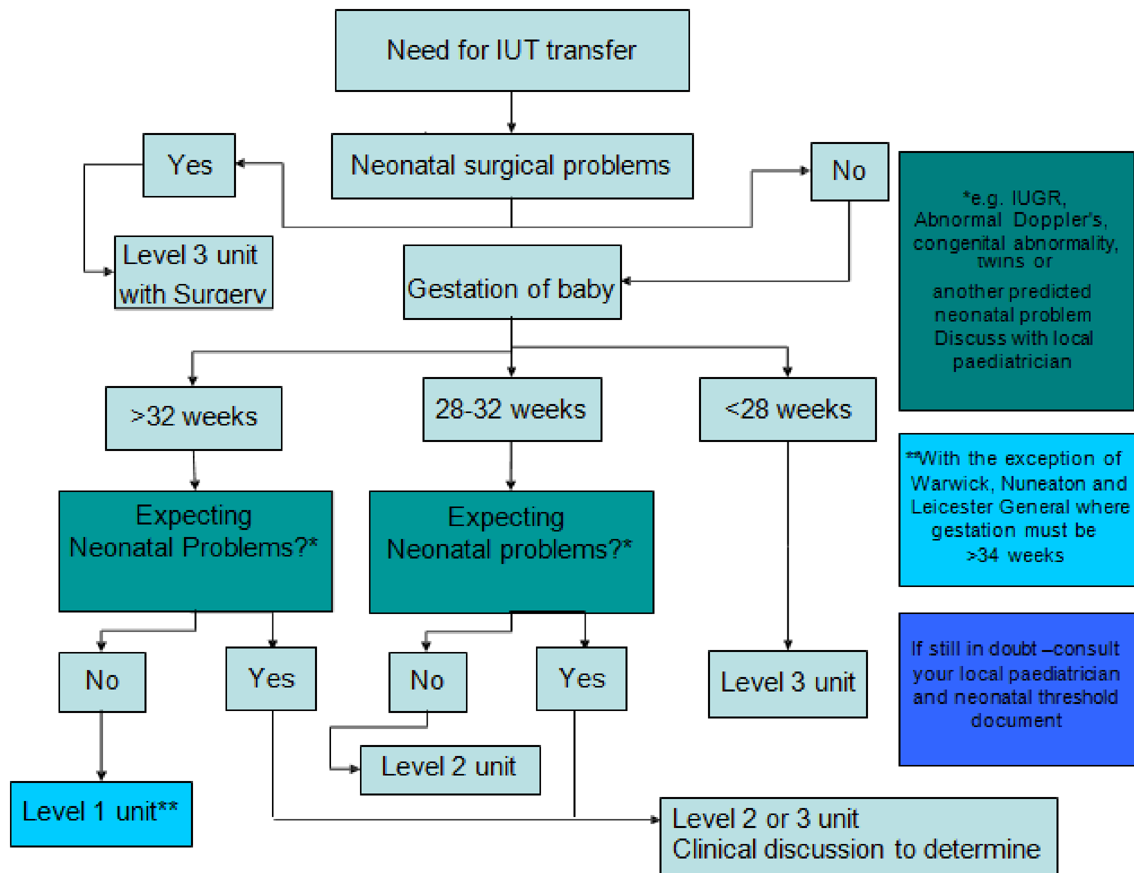
Emergency and resuscitation equipment checking completed AM	Coordinator signature:
Emergency and resuscitation equipment checking completed PM	Coordinator signature:
Any other information:	

D/S Room	Initials / parity/ gestation	Situation (Reason for admission)	Background (Medical/ obstetric history/allergies/ problems in pregnancy)	Assessment Progress in labour/Liqour/Drugs/Concerns	Recommendation (Tests/Treatment/Plan)	Acuity Score
8						
9						
10						
11						
12						
14						
15						
16						

	Initials / parity/ gestation	***Situation*** (Reason for admission)	***Background*** (Medical/ obstetric history/allergies/ problems in pregnancy)	***Assessment*** Progress in labour/Liqour/Drugs/Concerns	***Recommendation*** (Tests/Treatment/Plan)	
Obs room A						
Obs room B						
Obs room C						
Obs room D						
HDU 1						
HDU 2						
Theatre 1						
Theatre 2						
Recovery bay 1						
Recovery bay 2						
Theatre cases pending						
ITU / PACU						
Cases of concern on ward / Meadow						
NNU						

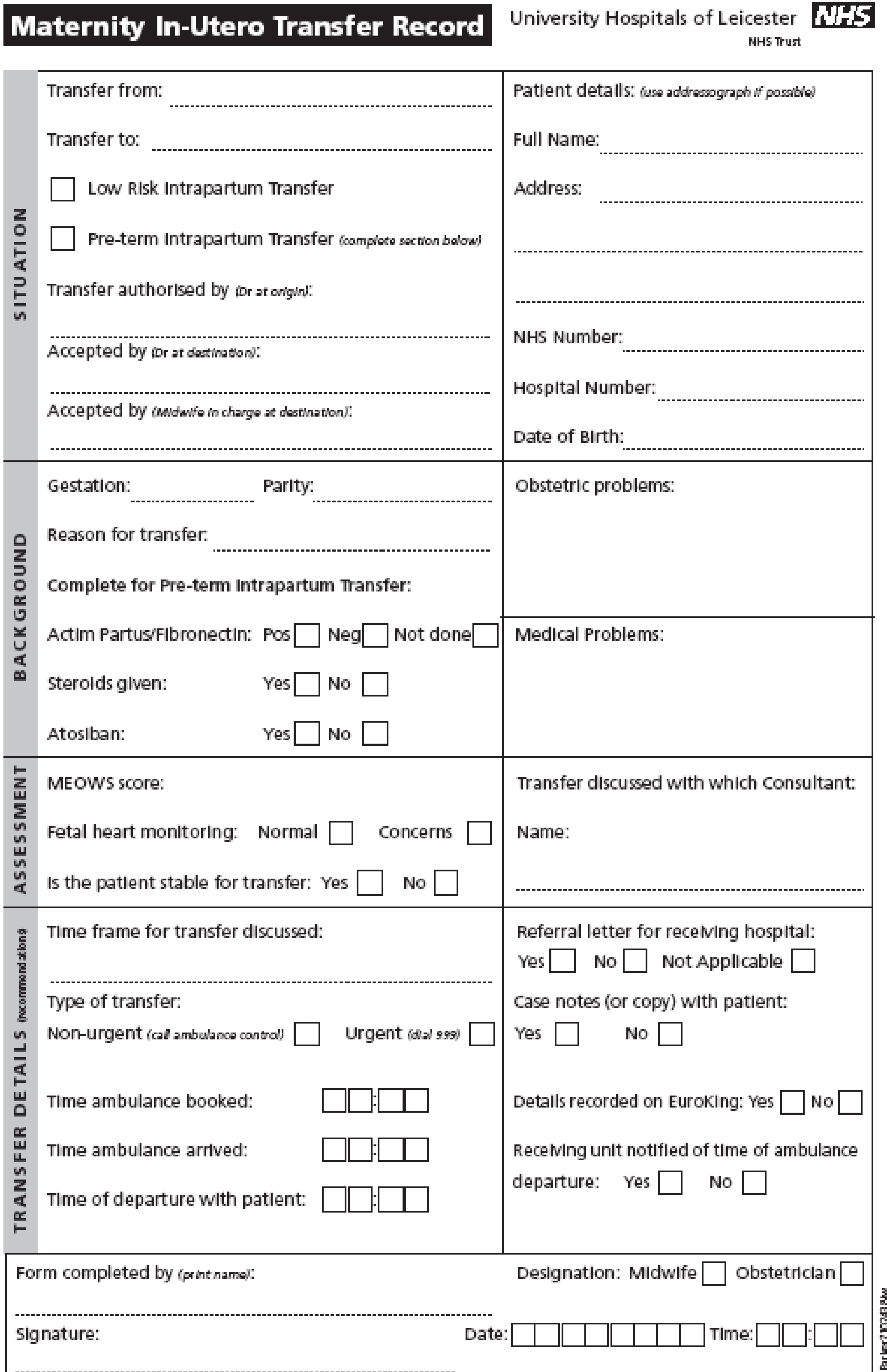
Appendix 5: In-utero transfer flowchart

The following flow chart can be used to determine the most suitable unit for the in-utero transfer



The telephone number for the Central Newborn network is 0300 300 0038

Appendix 6: In-utero transfer record



Maternity In-Utero Transfer Record

University Hospitals of Leicester NHS Trust

SITUATION

Transfer from: ....

Transfer to: ....

☐ Low Risk Intrapartum Transfer

☐ Pre-term Intrapartum Transfer *(complete section below)*

Transfer authorised by *(Dr at origin)*: ....

Accepted by *(Dr at destination)*: ....

Accepted by *(Midwife in charge at destination)*: ....

Patient details: *(use addressograph if possible)*

Full Name: ....

Address: ....

NHS Number: ....

Hospital Number: ....

Date of Birth: ....

BACKGROUND

Gestation: .... Parity: ....

Reason for transfer: ....

Complete for Pre-term Intrapartum Transfer:

Actim Partus/Fibronectin: Pos ☐ Neg ☐ Not done ☐

Steroids given: Yes ☐ No ☐

Atosiban: Yes ☐ No ☐

Obstetric problems:

Medical Problems:

ASSESSMENT

MEOWS score:

Fetal heart monitoring: Normal ☐ Concerns ☐

Is the patient stable for transfer: Yes ☐ No ☐

Transfer discussed with which Consultant:

Name: ....

TRANSFER DETAILS *(recommendations)*

Time frame for transfer discussed: ....

Type of transfer:

Non-urgent *(call ambulance control)* ☐ Urgent *(dial 999)* ☐

Time ambulance booked: ☐☐:☐☐

Time ambulance arrived: ☐☐:☐☐

Time of departure with patient: ☐☐:☐☐

Referral letter for receiving hospital: Yes ☐ No ☐ Not Applicable ☐

Case notes (or copy) with patient: Yes ☐ No ☐

Details recorded on EuroKing: Yes ☐ No ☐

Receiving unit notified of time of ambulance departure: Yes ☐ No ☐

Form completed by *(print name)*: ....

Designation: Midwife ☐ Obstetrician ☐

Signature: .... Date: ☐☐☐☐☐☐☐☐ Time: ☐☐:☐☐

Parker7103438jw