Transfers by Ambulance (Maternal)

Classification :	Guideline
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Authors Division:	Women and Children's Health
Departments/Group this Document applies to:	All Obstetric, midwifery and NNU staff

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Guideline to be followed by (target staff): This guideline applies to all obstetric staff and Midwives providing care within the Maternity Unit. There are no implications for training. This guideline aims to provide a standardised process for the safe and appropriate transfer of the woman.

To be read in conjunction with the following documents:

- Milton Keynes University Hospital NHS Foundation Trust. *Maternity health records and recordkeeping guideline.* MIDW/GL/140.
- Milton Keynes University Hospital NHS Foundation Trust. *Multi-professional handover of care (Maternity).* MIDW/GL/100
- Milton Keynes University Hospital NHS Foundation Trust. *NNU escalation plan.* DOC85. Version
- Milton Keynes University Hospital NHS Foundation Trust *Preterm pre-labour rupture of membranes and birth* MIDW/GL/51
- Milton Keynes University Hospital NHS Foundation Trust *homebirth and intrapartum care in the community*

Are there any eCARE implications? No

CQC Fundamental standards:
Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 18 – Staffing

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

This document refers to the management of maternal transfer by ambulance. It does not deal with elective transfer of care or the on-going management following the routine detection of fetal anomalies.

The management of women regarding transfer by ambulance should include Consultant Obstetric and senior neonatal staff in addition to the most senior Midwife available, at both the referring and (potential) receiving units. This must include an assessment of the relative benefits and risks of transfer to both maternal and fetal health.

Communication between all parties at both hospitals, including the mother, is critical. There must be clear and agreed delineation as to who is responsible for maternal care at each stage of the transfer process.

Objectives

- Standardise process for transferring and handing over care.
- Safe delivery of woman
- Reducing risk to mother and baby
- Reducing the need to separate mothers and babies during the postnatal period

Executive Summary

- Indications for maternal transfer
- Contradictions for maternal transfer
- Process for inter utero transfers
- Postnatal transfer of mother

1.0 Roles and Responsibilities:

1.1 The Obstetric team are responsible for identifying service users who may require transfer to another hospital. This would be decided by the Obstetric Consultant on-call following discussion with consultant on-call for the NNU.

1.2 The Maternity Bleep Holder/Shift Co-ordinator will contact all known hospitals to identify available cots.

1.3 The bed manager is responsible for liaising with Thames Valley Emergency Access (TVEA) and feeding information back to the Maternity Bleep Holder/Shift Co-ordinator.

1.4 The transferring Midwife is responsible for providing all care to the woman during the transfer including an accurate and safe handover of care to the receiving unit. This should include copies of all eCare drug, observation charts, blood and other screening tests and relevant medical/midwifery documentation.

1.5 The Obstetrician/Paediatrician must provide an explanation to the woman, partner/family, reasons for referral and which hospital has accepted the service user to be transferred in.

2.0 Implementation and dissemination of document

This guideline is available on the Trust intranet and has followed the full guideline review process prior to publication.

There are no implications for training.

3.0 Processes and procedures - In-utero transfer

3.1 Indications for transfer

- Severe prematurity <27 weeks (singleton), <28 weeks for multiple or <800g
- Medical/Obstetric / Neonatal requirement for enhanced care for service user or unborn baby
- Neonatal Unit (NNU) at capacity. (Please see Paediatric/NNU Escalation policy).
- Lack of availability of neonatal cot of the appropriate level
- Neonatal team request due to staffing / workload ratio
- Labour Ward capacity – staffing / workload ratio

3.2 Contraindications for transfer

- Receiving Obstetric unit or NNU unable to accept transfer
- Service user declining transfer
- Significant risk of birth occurring during transfer, for example those with strong or regular contractions
- Active labour where the cervix is more than three centimetres dilated.
- Known fetal compromise requiring immediate delivery
- Unstable maternal condition likely to require medical intervention during transfer (e.g. active antepartum haemorrhage, uncontrolled hypertension)
- Any other unstable maternal condition
- Potentially lethal fetal condition where active intervention of the fetus was not being considered even if live born. (In cases of fetal abnormalities it is useful to discuss these cases with fetal medicine specialists.)

3.3 Other clinical Considerations

3.3.1 Preterm Labour

Fewer than 50% of women presenting with suspected preterm labour will give birth during the current episode. The following tests and examinations will support decision making to transfer service users out.

Fetal Fibronectin Testing

The National Institute of Health and Care Excellence (NICE) recommend the diagnostic test Fetal fibronectin (fFN) for detecting the likelihood of pre-term labour.

fFN is a protein produced during pregnancy, which functions as a 'glue' attaching the fetal sac to the uterine lining. The presence of fFN during weeks 22-36 of a high-risk pregnancy, along with symptoms of labour suggests that the 'glue' is disintegrating ahead of schedule and raises the possibility of preterm delivery.

When there are supply chain issues affecting the availability of Fetal Fibronectin, alternative tests are available. Please see the Preterm Labour and Birth Guideline Preterm Pre-labour Rupture of Membranes and Birth Guideline .pdf

QUIPP app

The QUIPP app is free to download on Apple and Android– search 'QUiPP'. The app gives individualised scores for risk of having a spontaneous preterm delivery using medical history, quantitative Fetal Fibronectin result and/or cervical length. There are 3 separate algorithms [a) fFN only, b) cx length only, c) fFN and cx length combined. For more information please see the preterm pre-labour rupture of membranes and birth guideline using the link above.

Cervical Dilation

Assessment of cervical dilatation by Speculum examination (digital exam only if cervix not visible on speculum) or by Transvaginal Ultrasound can assist in the prediction of preterm birth.

The decision to transfer must be reconsidered in the following:

- High Risk of Delivery during transfer
- Negative Fetal Fibronectin test
- There is no cervical change
- Cervical length >25mm

3.3.2 Pre-labour Preterm Rupture of Membranes (PPROM)

The median latency between rupture of membranes at 25-31 weeks' gestation and birth is 10 days and 30% of women will not have given birth by 20 days.

Transfer following PPROM should NOT be considered if there is evidence of uterine activity or clinical chorioamnionitis (1 or more of following signs):

- Maternal pyrexia
- Maternal/fetal tachycardia
- Uterine tenderness
- Offensive liquor

Uterine contractions following PPROM are associated with a shorter interval to birth than with intact membranes.

Tocolysis – can be used to delay birth to ensure safe transfer. It is not required unless there is clinical evidence of uterine activity. If used the efficacy of tocolysis must be assessed before transfer i.e.

evidence of a complete cessation of uterine activity for at least 1 hour and no cervical change over this time.

Cervical assessment should be performed immediately prior to transfer using speculum (digital exam only if cervix not visible on speculum) or transvaginal ultrasound.

3.3.3 Service user consent

Service user agreement needs to be obtained prior to transfer and this should be documented appropriately. This will usually require joint counselling by obstetric and neonatal staff.

Counselling should be supplemented with written information whenever possible. It is important to explain that the baby or babies may be transferred back to their home hospital or a hospital nearer to home, at a later stage.

Where a service user is declining transfer to another unit, she should be given the opportunity to explore her concerns. The family need to understand that, in the event of an intra-uterine transfer being declined, the baby will be assessed after birth and if still indicated, ex-utero transfer may need to be arranged if this is in the baby's best interest.

Where an intra-uterine transfer has been declined by the service user, there needs to be clear documentation that the risks and benefits both to her and subsequently to her baby have been explained and understood.

Receiving hospital address and telephone number should be given to the partner in order to minimise any anxiety.

Decisions regarding appropriateness of transfer and interventions at the edges of viability are important. Counselling and decision making should be made with the family using the BAPM Perinatal Management of Extreme Preterm Birth Before 27 weeks of Gestation (2019)). It is advisable to discuss these cases with the tertiary Centre.

In cases where, the woman has communication limitations/barriers the maternity unit would need to work within local policy to ensure the women understands the proposed plan and can give informed consent, usually by the way of an interpreter for example using language line.

4.0 Process for in utero transfer from Milton Keynes Maternity Unit to another hospital

(see Appendix 1)

Please refer to Appendix 1 regarding in utero transfer to OUH (John Radcliffe).

4.1 The Obstetric team is responsible for identifying service users who need transfer to another hospital requiring specialist clinical care.

1.All cases should be discussed with a consultant prior to arranging transfer

Where possible consultant to consultant handover will occur

It is recognised that there are circumstances (e.g. out of hours) where the registrar will have all the relevant information to hand compared to the non-resident consultant. It is accepted that the

registrar can then discuss the transfer with the receiving unit provided they have first discussed it with their own consultant

If any problems are perceived with the transfer there should be a consultant to consultant discussion

It is essential that both transferring and receiving consultants are fully aware of the transfer

4.2 The Maternity Unit Manager/Shift Co-ordinator will contact all known hospitals to identify available cots, if no cots are available from the Transfer Out List held on labour ward, then the bleep holder should liaise with the Clinical Site Manager and Bed Manager to request that he/she contact Thames Valley Emergency Access (TVEA) who will identify the location of cots or beds in other parts of the country.

The on call Obstetric Consultant/Registrar is responsible for communicating the background history, risk assessment and recommended management plans to the obstetric team of the receiving hospital or department. This should be clearly documented within the maternity records and include a covering letter to the receiving unit or department.

The Midwife or Obstetrician will then liaise with the nursing/midwifery staff of unit where capacity has been identified by TVEA to confirm availability and acceptance of the transfer. In Utero Transfer Form (Appendix 3) needs to be commenced

4.3 The receiving unit should be contacted by the on-call Registrar / Consultant, caring midwife or Shift Co-ordinator/Maternity Bleep Holder to provide a telephone summary of the background history, risks and recommended management plans using SBAR (Situation, Background, Assessment and Recommendation). Ensure the ward or department can accommodate the woman and is aware of the approximate transfer times.

4.4 The Maternity Bleep Holder should contact ambulance control to arrange an ambulance for the transfer giving details of the dependency and priority required. Contact number: 0300 1239826

4.5 The name of the doctor agreeing to accept the case and the Consultant to whom the woman will be transferred should be clearly documented in the maternity records.

4.6 A Midwife must accompany a service user being transferred. In all cases consideration should be given to providing a medical escort. The medical escort may include one or more of the following:

- Obstetrician
- Paediatrician
- Anaesthetist

Women being transferred should be escorted by a midwife but there is no requirement for medical staff either obstetric or paediatric. If there is sufficient concern for a doctor to be required for transfer then the condition of mother or fetus is such that delivery should occur locally and a postnatal ex-utero transfer arranged.

The number of qualified staff required to escort women with a multiple pregnancy should be individualised depending on the clinical situation.

It is recommended that a basic neonatal resuscitation kit is taken on the transfer.

4.7 The Midwife is to ensure in-utero transfer equipment is taken with the mother. This includes a sonicaid to monitor fetal well-being where appropriate and delivery pack, instruments and syntometrine/oxytocin. If specialist equipment is required for transfer this must be identified by the appropriate speciality.

If maternity in-utero transfer is not undertaken due to safety reasons/unstable for transfer, this decision should be reviewed, and risk assessed on a regular basis at least every 4 hours, and transfer should be completed if the clinical condition changes to allow a safe transfer. There is an element of risk with all in-utero transfers, therefore regular risk assessment will be vital during the transfer. In cases where there is uncertainty about whether a transfer is appropriate i.e. complex maternal or fetal cases, discussion with both obstetric and neonatal senior teams should take place. Ensure that all discussions both internally and with external teams are documented in the medical and women's records. A maternal/birthing person's health should always take a priority.

5.0 Process for transfer from home to Milton Keynes Maternity Unit

5.1 When the Community Midwife has made a decision to transfer a service user from home to hospital then she should contact the Labour Ward Co-ordinator advising of the transfer and giving the background history, current assessment and recommendations using SBAR. The transfer should be expedited in line with the home birth and intrapartum care SOP. Home Birth and Intrapartum Care in the Community.pdf

5.2 The Community Midwife dials 999 for an ambulance and travels in with the service user. The second on call Midwife should ensure that all equipment is collected, ensures that the birthing partner is informed of where to go on arrival at the hospital and returns to the hospital with equipment and any clinical waste. For all women in established labour, transfer to hospital should be by ambulance accompanied by a midwife. Ambulance transfer is arranged via 999. Where transfer is time critical, the midwife should advise the call handler that they are a midwife and that it is an 'Obstetric Emergency' which will trigger a rapid 'blue light' response. The midwife may delegate the request for an ambulance to another person, e.g., the 2 nd midwife present, student midwife, or the woman's partner but where possible, the call should be made by the midwife.

Reasons for transfer following risk assessment:

- Malpresentation/unstable lie.
- Fetal heart rate abnormalities heard on auscultation in first or second stage.
- Intrapartum haemorrhage.
- Significant meconium stained liquor.
- Cord prolapse/cord presentation
- The woman requests an epidural.
- The woman requests to be transferred.
- Hypertension in labour BP ≥150/100 on 2 or more occasions (recorded 15
- minutes apart) or if the woman is symptomatic of PET.
- Maternal Pyrexia of 37.5°C or greater on two occasions, two hours apart or
- 38°C on one occasion.
- Lack of progress in the first or second stage of labour see Trust Guideline for
- the Management of: Intrapartum Care in All Settings Trustdocs Id: 850.
- Retained placenta.

- Suspected 3rd / 4th degree perineal tear.
- Postpartum haemorrhage of 500 – 1000mL if woman clinically unstable or >
- 1000mL.
- Maternal collapse.
- Any deviation from the norm which concerns the midwife.
- Clinical judgement remains paramount in all situations and this list is not exhaustive. Timings should be recorded for:
    - time of decision to transfer and time transport called
    - time of arrival of transport at home
    - time left home
    - time of arrival at obstetric unit/neonatal unit
    - time seen by medical staff

6.0 Postnatal transfer of mother

Where possible, we aim to keep families together to develops relationships, which improves breastfeeding outcomes and may reduce the risk of postnatal depression.

When mother and baby cannot be transferred together arrangements to transfer mother separately should be made as soon as possible

Postnatal transfer may also be required for maternal reason only

The pathway in Appendix 4 should be used when considering postnatal transfers.

7.0 Handover of Care

This must occur between all members of the multidisciplinary team when shifts change. When women are transferred to a different location to receive care handover of plans of care should take place. It should always be clearly documented who is responsible for the care of the service user at that time. There should be clear concise communication and handover of information at all times between the multidisciplinary team using SBAR, especially where there are specific concerns in relation to child protection issues, mental health, obstetric and medical issues.

Midwives have a duty to communicate fully and effectively with colleagues, ensuring that they have all the information they need about the service users in their care. (NMC, 2015; Updated 2018)

8.0 Record Keeping

8.1 In utero transfer

- **Before transfer a duplicate copy of any hand-held maternity records must remain within the maternity unit. The original maternity records must go with the service user to the receiving unit and a print out of eCare records such as drugs and observation charts, blood and other antenatal screening results.** Please refer to Maternity Health Records and Record Keeping policy.

- The on-call Registrar/Consultant should write a letter to the receiving hospital with a summary of the past medical history, present identified problems, interventions, treatment and any recommended management plans within a SBAR format.

- The Midwife will document assessments, plans of care, treatments and intervention any discussion undertaken and all observations taken during transfer. Documentation of handover at receiving unit following the principles of SBAR should also be made.

8.2 Transfer to hospital from community during the intrapartum period

- If transferred to the hospital from a home birth it is required the Midwife should document:
  - Reason for transfer
  - Actions taken
  - All clinical observations undertaken during transfer**.**

  A RADAR form and In Utero Transfer Form (Appendix 3) should be completed for all transfers

8.3 Postnatal transfer

- A record of all midwifery and medical assessments and plans of care should be documented

- Midwives will document all care provided, including that provided during transfer

9.0 Statement of evidence/references

Adams, E., Puddy, V. and Outram, G.; Thames Valley & Wessex Neonatal Operational Delivery Network (2014; Last updated 2018) *Policy for exception reporting of neonates who meet criteria for transfer to NICU/LNU.* [Online]. Available from: https://southodns.nhs.uk/wp-content/uploads/2020/01/Exception-Reporting-Policy-Final.pdf [Accessed 18 November 2020]

Adams, E., Puddy, V. and Outram, G.; Thames Valley & Wessex Neonatal Operational Delivery Network (2014; Last updated 2018) *Policy for transfer of infants to a NICU/LNU.*[Online]. Available from: https://southodns.nhs.uk/wp-content/uploads/2018/11/Transfer-Policy-for-LNU-SCU-2018-Final-Version-ratified-Sept-2018.pdf [Accessed 18 November 2020]

British Association of Perinatal Medicine (2019) *Perinatal management of extreme preterm birth before 27 weeks of gestation: a framework for practice.* [Online]. Available from:https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 [Accessed 17 November 2020]

Edwards, K. and Impey, L. (2020) Extreme preterm birth in the right place: a quality improvement project. [Online]. *Archives of Disease in Childhood - Fetal and Neonatal Edition*,105:445-448. Available from: http://dx.doi.org/10.1136/archdischild-2019-317741 [Accessed 17 November 2020]

Fenton, A., Peebles, D. and Ahluwalia, J. for British Association of Perinatal Medicine (2008)*Management of acute in-utero transfers: a framework for practice*. [Online]. Available from:https://hubble-live-assets.s3.amazonaws.com/bapm/attachment/file/35/IUTs_Jun08_final.pdf[Accessed 18 November 2020]

Marlow, N. et al. (2014) Perinatal outcomes for extremely preterm babies in relation to place of birth in England: the EPICure 2 study. [Online]. *Arch Dis Child Fetal Neonatal Ed,* 99:F181– F188. Available from: http://dx.doi.org/10.1136/archdischild-2013-305555 [Accessed 17 November 2020]

National Institute for Health and Care Excellence (2018) Biomarker tests to help diagnose preterm labour in women with intact membranes. [Diagnostics guidance DG33]. [Online]. Available from: https://www.nice.org.uk/guidance/dg33/ [Accessed 18 November 2020]

NHS Improvement [2018] *SBAR communication tool – situation, background, assessment, recommendation.* [ACT Academy Online library of Quality, Service Improvement and Redesign Tools]. [Online]. Available from: https://improvement.nhs.uk/documents/2162/sbar-communication-tool.pdf [Accessed 18 November 2020]

Nursing & Midwifery Council (2015; Updated 2018) *The code: professional standards of practice and behaviour for nurses, midwives and nursing associates*. [Online]. January 2015; Updated 10 October 2018. London: NMC. Available from:https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf [Accessed 18 November 2020]

Oxford AHSN Maternity Network (2016) *Place of birth of extremely premature babies in the Thames Valley network area – an update.* [Online]. Available from:http://www.oxfordahsn.org/wp-content/uploads/2015/05/FINAL-Place-of-Birth-A-Year-On-July-2016.pdf [Accessed 17 November 2020]

10.0 Governance

10.1 Document review history

Version number	Review date	Reviewed by	Changes made
5.2	**11/2023**	**S Betts**	
5	01/2021	N Payne/E Patton	Reviewed and updated.
5.1	December 2018	L. Stratton-Fry/K.Smith	Appendix 3 information added about steroids and magnesium in relation to PRecept study
6.0	December 2020		Reviewed and updated
6.1			
7.0	December 2023	Sophie Betts Erum Khan Faryal Nizami	Reviewed and updated

10.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
FOR CONSULTATIONS ON PREVIOUS VERSIONS, SEE RELEVENT VERSION NUMBER.					
Sent to all maternity staff for comment	Maternity	09/11/2023	27/11/2023	Changes to appendix 1	Yes
Women's Health Guideline Review Group	Women's Health	06/12/2023	-	Approved	Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
a)Number of in utero transfer to other maternity unit b) Number of postnatal transfers for maternal reasons c)) Number of women transferred in labour from home to hospital d) The outcomes following transfer (where appropriate) - the timing of birth, hospital where eventually delivered,	Radar/ Audit	a) Preterm birth specialist midwife b) Governance team c) Community midwifery team d) Governance team	a)Case by case b) Case by Case c) Quarterly d) case by case	Labour Ward Forum, Perinatal M & M Maternal and Neonatal Quality Improvement Group, LMNS, CSU

neonatal outcome, maternal outcome				

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women and children	Department	Maternity
Person completing the EqIA	Alex Fry	Contact No.	Ex 87153
Others involved:		Date of assessment:	12/2023
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*All staff*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
Emails , maternity guideline group and maternity CIG
How are the changes/amendments to the policies/services communicated?
Emails. Guideline group, maternity CIG
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA	23/12/2026		

Appendix 1Useful contacts

Useful contacts

Hospital name	Level of Neonatal Unit	Labour Ward number	Neonatal Unit number
John Radcliffe, Oxford	3	01865223203	01865221987
Royal Berkshire (Reading)	2	01183227340	01183225111
Wexham Park (Slough)	2	0300 6154521	03006154533
Stoke Mandeville (Aylesbury)	2	01296316107	01296316115
Luton and Dunstable	3	01582797135	01582718097
Bedford	2	01234792072	01234795805
Northampton	2	01604545520	01604545898
Kettering	1	01536492281	01536492878
Addenbrookes (Cambridge)	3	01223217648	01223256937
Hinchingbrooke (Huntingdon)	1	01733678000 ext 6250	01733678000 ext 8599
Leicester General	3	01162584800	01162584807
Leicester Royal Infirmary	2	01162586451	01162586451
Warwick	3	01926495321 ext 4548	01926495321 ext 4552
Birmingham City Hospital	3	01215075100	01215874184
Birmingham Women's Hospital	3	01213358190	01214723032
Queen Charlotte's (London)	3	02033133474	02033136390
Royal Free (London)	2	0203758200 ext 33168	02078302721
Guy's and St Thomas' (London)	2	02071884045	02071882968
King's College (London)	3	02032993553	02032999000 / 02032932654
Peterborough (Stamford)	3	01733677236	01733677246 / 01733677247
Coventry University Hospital	3	02476966673	02476967368
Emergency Bed Service	02074077181 (No labour ward or NNU)		

Appendix 2: Maternal Transfer Antenatal

The following neonatal units will accept Neonates in utero 22 + 6 weeks gestation
(Please indicate if able to accept)

Hospital	NNU	Labour Ward
John Radcliffe, Oxford 01865 221059 (NNU) 01865 221651 (LW)		
Royal Berkshire, Reading 01183 227430 (NNU) 01183 227303 (LW)		

The following neonatal units will accept Neonates in utero 26 weeks – 27 + 6 gestation

Hospital	NNU	Labour Ward
John Radcliffe, Oxford 01865 221059 (NNU) 01865 221651 (LW)		
Royal Berkshire, Reading 01183 227430 (NNU) 01183 227303 (LW)		
Wexham Park, Slough 01753 634533 (NNU) 01753 634521 (LW)		

The following neonatal units will accept Neonates in utero 28 weeks or more

Hospital	NNU	Labour Ward
Royal Berkshire, Reading 01183 227430 (NNU) 01183 227303 (LW)		
Wexham Park, Slough 01753 634533 (NNU) 01753 634521 (LW)		
Stoke Mandeville, Aylesbury 01296 316115 (NNU) 01296 316756 (LW)		

John Radcliffe will not accept infants at 28 weeks or more unless there is specific maternal or infant reasons which mean the mother/infant cannot be looked after elsewhere

Hospital	NNU	Labour Ward
Luton and Dunstable 01582 491166		
Bedford 01234 355122		
Northampton 01604 634700		
Kettering 01536 492000		
Addenbrooks 01223 245151		
Hitchingbrook 01480 416416		
Leicester General 03003 031573		
Leicester Royal Infirmary 03003 031573		
Warwick 01926 495321		
Birmingham City Hospital 01214 242000		
Birmingham Women's 0121 4721377		
Royal Berkshire Reading 01183 225111		
Queen Charlottes London 0208 3831111		
Wexham Park Slough 01753 633000		
Royal Free London 02077 940500		
Guys and St Thomas London 02071 887188		
Horton Hospital Banbury 01865 741166 (32 single, 34 twins)		
Kings College London 02032 999000		
Peterborough 01733 874000		
Walgrave Coventry 0247 6964000		

RADAR

Emergency Bed Service London 0207 4077181		

Appendix 3: Preterm Intra-utero and Extra-utero transfer and Optimisation Record

Service user information:			
Name:	**DOB:**	**NHS no:**	**Pro-nouns:**
Interpreter required? (Y/N)	**If yes, which language?**		

Clinical Background:	
Gestation: **Parity:** **EDD:** **Singleton or Multiple:**	**Blood group:** **Antibodies:** **GBS status:** **Any hospital admission indicating CPE/ MRSA swabs? (Y/N)**
Current obstetric history:	**Medical/surgical history:**
Previous obstetric history:	**Current medications:**
Mental health/ communication barriers / safeguarding issues: **CC yes no to print**	**Allergies:**

Clinical Situation:	
☐ Threatened preterm labour	☐ Rescue cerclage
☐ Established preterm labour	☐ Service capacity (for IUT >27/40)
☐ PPROM	☐ Maternal concerns (detail below)
☐ Fetal concerns (detail below)	☐ Other (detail below)
☐ Details:	

Maternal Assessment:					
	MOEWS score	**Uterine activity**	**PV loss / liquor colour**	**FH auscultated and present**	**Clinical signs of infection (Y/N)**
Prior to transfer					
Indwelling devices					
Date & time inserted	**Type of device**		**Comments (e.g. gauge, site, VIP score)**		

	□ Urinary catheter	
	□ IV cannula	

Blood results				
Were these bloods taken BEFORE the administration of AN steroids?			Yes	No
Date & time	**Hb**	**WCC**	**CRP**	**Platelets**

PV assessment				
Date & time	**Dilation**	**Effacement**	**Membranes**	**SROM date, time & colour**

Point of care assessment				
Date & time	**Fetal presentation (USS)**	**Cervical length (USS)**	**Fibronectin/ Partosure / Actim Partus / Amnisure / Actim-Prom**	**QUiPP app score**

Preterm Optimisation Medication:				
	Date & time	**Drug name**	**Route**	**Dose**
1st steroid				
2nd steroid				
MgSO4				
Antibiotics				
Tocolytics				
Analgesia				

Antenatal counselling

Obstetric Team discussion with parents:

Labour and birth:

- **Active management** □
- **Palliative management** □
- **Vaginal birth** □
- **C-section** □
- **In Utero Transfer**
- **Fetal monitoring**

Optimisation:

- **Steroids**
- **MgSO4**
- **IV antibiotics**
- **Tocolysis**

Neonatal team to discuss with parents:

Respiratory support □

Thermal care □

Delayed cord clamping □

Birthday cuddles □

Milk as medicine and

Expressing discussed and kit given □

Research studies □

Transfer In Utero Communication:	
Referring consultant	
Accepting consultant	
Name of accompanying Midwife	

Timing:	
Date & time of decision to transfer	
Date & time of departure from Level 2	
Date & time ambulance contacted	
Ambulance reference number	

Birth details

Mode of Birth from assessment and fluid balance	Neonatal Management:
Delayed cord clamping (mins/secs):	**Use of plastic bag**
If no DCC, why?	**First temperature (<1hr, pre transfer)**
Umbilical cord milking? (ONLY IF >28/40): Yes/No	**Use of transwarmer**
cord blood samples taken Placental swabs taken and sent	Apgars @ 1- 5 -10 min
Placenta sent to histology	Resuscitation from assessment and fluid
Measured blood loss **from assessment and fluid balance**	**Nasal high flow with…** Intact cord □
Postnatal VTE :	After cord C+C □
Maternal Postnatal Care Plan:	

Postnatal Neonatal Care

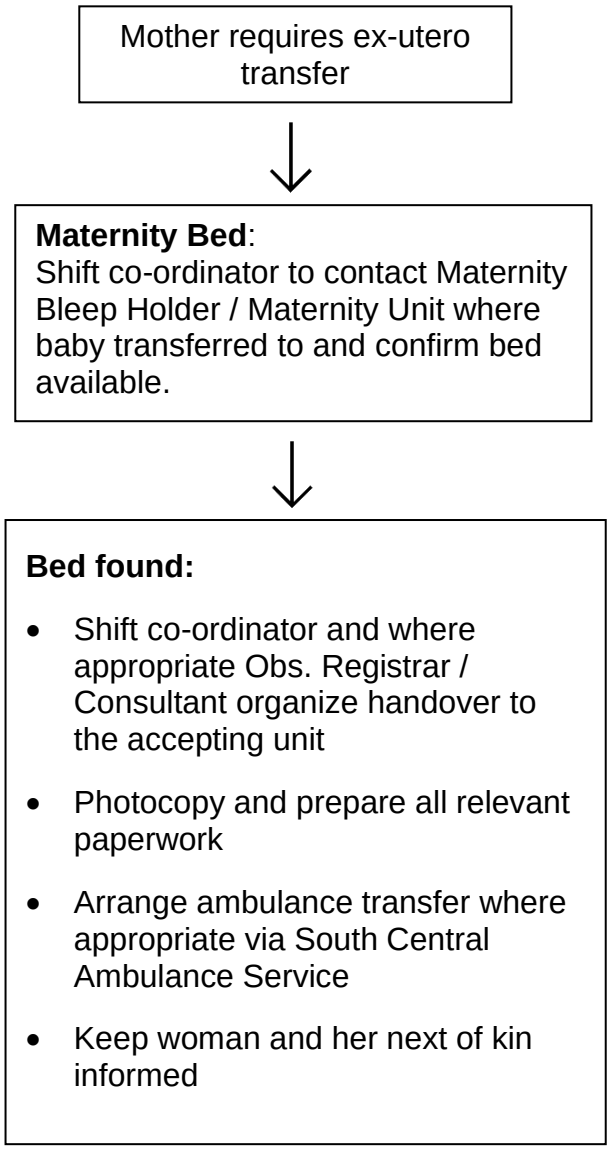
Arrival to unit temperature □
Parents/baby has a Birthday Cuddle □
Colostrum to be expressed within 2 hours and given to neonatal nurse □ First breast milk time
Caffeine Use of VGV Indwelling device for baby Parents updated by neonatal team □ Call sonnet time

Transfer Ex-Utero Communication:	
Date & time SONNET contacted	
Referring consultant	
Accepting consultant	
Timing:	
Date & time of decision to transfer	

Date & time of departure from Level 2	

Transfer checklist:	
Parents	☐ Parents aware of destination & provided with address and contact information of receiving unit.
Paperwork required. (to be printed)	☐ Booking history ☐ Handheld AN record (if applicable) ☐ Blood results (Booking & recent) ☐ USS reports and CTGs (if applicable) ☐ Drug chart ☐ Safeguarding support plan / confidential communique (if applicable) ☐ This form completed

Appendix 4: Maternal Transfer Postnatal



Remember:

- to document everything in woman's notes
- keep woman and her next of kin informed
- Ensure that she is clinically stable to be transferred
- all transfers need to be reported via Radar