Admission to Women's Assessment Unit (WAU)

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1. Purpose of policy

The purpose of this policy is to provide a pathway for admission to Women's Assessment Unit (WAU) at Auckland City Hospital.

The aims of this policy are to:

- Provide a safe and effective assessment unit
- Ensure a prompt assessment of women who require urgent gynaecological or obstetric opinion
- Enable staff to provide appropriate management for gynaecological or obstetric conditions in a timely manner
- Ensure women are supplied with discharge information to be able to access follow up care
- Clarify the midwifery, nursing, medical and clerical roles and responsibility for both elective and acute admissions to WAU.

2. Definitions

Antenatal woman	A pregnant woman who is ≥ 20 weeks gestation
Postnatal woman	A woman who has given birth in the last 42 days.
Gynaecology woman	A woman who is either < 20 weeks pregnant or has a gynaecological condition
Team of the day	Medical team rostered on to provide obstetric and gynaecological services for a 24-hour period.

3. General principles for managing an admission to WAU

Maternity referral may include:

- Reduced fetal movements for all women ≥ 26 weeks gestation
- Suspected ruptured membranes pre-labour
- Preterm labour check less than 37 weeks gestation
- Raised blood pressure and/or proteinuria
- Suspected obstetric cholestasis
- Antepartum haemorrhage
- Non-specific abdominal pain
- Any condition identified as requiring urgent review under the New Zealand (NZ) Maternity referral guidelines (refer Supporting evidence).

Gynaecology referrals may include:

- Stable ectopic pregnancy
- Stable with incomplete, inevitable, missed or threatened miscarriage
- Ovarian cyst
- Mild to moderate Ovarian Hyper Stimulation Syndrome (OHSS)
- Pelvic inflammatory disease (PID)
- Hydrosalpingectomy
- Per Vaginam (PV) bleeding

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- Urinary tract infection/ pyelonephritis
- Abdominal pain (score <5)
- Stable with Retained Products of Conception (RPOC)
- Dysmenorrhea
- Menorrhagia
- Bartholins/ labial abscess
- Post-operative complications following gynaecology surgery
- Medical management of miscarriage
- Repeat Blood Human chorionic gonadotropin (BHcG)
- Repeat ultra sound scan (USS) for further diagnosis
- Medical abortion 20 weeks and over (arranged admission with assigned Senior Medical Officer (SMO) and team)

The WAU environment is available to Lead Maternity Carers (LMCs) to undertake a primary assessment and consultation with the WAU obstetric or gynaecological team. If the plan includes admission, then the LMC needs to discuss handover of midwifery care with the WAU Clinical Charge Midwife (CCM).

Maternity consultations must be undertaken following the principles within the referral guidelines including a three-way consultation to plan for care including the woman, LMC and obstetric team.

When antenatal women require admission, there is a 'transfer of clinical responsibility' to Auckland DHB obstetric team. The woman's LMC remains the same.

All admissions are under the team of the day. However, if recently admitted under another team, or are under another team in clinic, transfer to that team should occur upon warding.

All inductions of labour must have the name of the approving obstetrician and clear documentation of who is responsible for their care during the induction process.

4. Referral to Women's Assessment Unit

Antenatal women and postnatal women ≥ 42 days:

- These women may be referred by their LMC, General Practitioner (GP), Adult Emergency Department (AED), a medical centre, another hospital or the woman may self-present.
- Referrals should be made by phoning the WAU on-call SMO phone (this is held by the WAU registrar after hours)
- A follow up call should then be made to the CCM /midwife in charge for WAU
- The CCM or midwife in charge will notify the ward clerk of the impending arrival.

Non-gynaecology/ Non-obstetric Illness:

- If a patient should present directly to WAU without being accepted by the Obstetrics & Gynaecology (O&G) team, and clearly has a non-gynaecological or non-obstetric condition, the woman must be assessed by a nurse or midwife as stable to be redirected to AED. If the woman is < 20 weeks pregnant, this assessment can be made by either a nurse or a midwife.

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Refer to the Non Obstetric Illness ED pathway see Associated documents).

Gynaecology patients:

- Prior to the transfer of a gynaecology patient from AED to WAU a phone call must be made to the on-call WAU SMO/registrar, followed by a phone call to WAU gynaecology nurse to arrange timing of transfer. If a transfer cannot occur due to bed or staffing shortages, the WAU CCM should escalate to the Midwifery Unit Manager during working hours and the CNM after hours.

5. Documentation of telephone advice

- Details of telephone calls/contacts will be documented in the maternity electronic record. They should include who is making the call, the reason for the call, the advice given and a plan for follow up or on-going concern.
- The entry should be completed as close to the phone call as possible and verified so the LMC is notified of the call.
- Phone conversations for gynaecology women are documented on the National Women's Maternity Service Telephone Advice Record (CR3000) which is sent to Clinical Records within one week after the conversation.

6. CCM/ midwife in charge responsibilities

- Allocate a space either in an ambulatory area (if possible) or in a bedded room (if needed).
- To triage women (see Appendix 1 - Gynaecology triage tool) presenting to WAU to ensure that the women are seen in a timely manner and within order or clinical priority.
- Allocate staff as required to ensure clinical safety.
- Provide midwifery advice to both pregnant women and colleagues as requested.

7. Midwife responsibilities

- Perform a midwifery assessment on all women who present to WAU.
- Commence a Maternity Early Warning Score (MEWS) chart for all pregnant/postnatal women and escalate care in line with the score.
- Commence a Maternal Sepsis Screening and Action tool (CR3170) if criteria met.
- Undertake further investigations as indicated following the initial assessment.
- Make a plan with the woman and document in her clinical records.
- Decide, following assessment, whether the women is suitable for discharge home or whether an obstetric review or transfer to Labour and Birthing Suite is required.
- Refer to WAU registrar according to clinical need and priority.
- Once plan is in place, ensure it is implemented in a timely fashion.
- Complete the maternity electronic record discharge summary before the woman is discharged as this ensures the LMC and GP are informed.
- Give the woman a printed copy of her assessment, which will include a follow up plan and advice if condition returns or deteriorates.

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- Notify LMC of admission/assessment and admission/discharge including any plan made.

8. Gynaecology nurses responsibility

- According to triage category (see Appendix 1 - Gynaecology triage tool), assess the woman and fulfil all observational and immediate intervention procedures, and document in A-D planner.
- Commence a MEWS chart for all pregnant women (regardless of gestation) and an early warning score (EWS) for all non-pregnant women, care is escalated in line with the score.
- Commence Maternal Sepsis Screening and Action tool (CR3170) if criteria is met.
- Inform WAU registrar of admission.
- Notify LMC of admission/assessment/discharge if women are pregnant.
- Regular two-hourly observations or more frequent when required.
- Intentional rounding is completed hourly which involves pain assessment, bleeding assessment when indicated, re-positioning and toileting (see Associated documents).
- Patient and family to be kept informed of plan of care and approximate waiting times.
- Clear and detailed nursing documentation is completed.

9. Medical team responsibilities

- WAU O&G team to assess and stabilize condition, then formulate and document plan of care/treatment and update the electronic whiteboard accordingly, including Clinician Sign On when first seeing the patient.
- Ensure the maternity electronic record is completed before the woman is discharged as this should ensure the LMC and GP are informed of assessment details.
- If there is a plan to admit the patient to the ward, the O&G team must confirm which team the patient will be under and identify from Medirota the duty Ward SMO for that team. The Case Manager on CMS must be changed by the ward clerk to the correct Ward Team SMO upon warding. The RMO or SMO should ensure they communicate the correct details to the ward clerk. This is important so that the right SMO/Team is identified on the clinical management system (CMS) as clinically responsible once the patient is on the ward, and all laboratory and radiology results will then go to the right person. Refer to Results (Laboratory and Radiology) Procedure in Women's Health (see Associated documents).
- Appropriate clinical handover to the team should occur as soon as possible, ideally by 08:15 the next day so that morning ward rounds can proceed appropriately.
- Rapid clinical rounds should be completed in front of the WAU whiteboard regularly at least every two hours during the day by the WAU SMO, registrar and CCM (11:00,13:00,15:00).
- Post-acute ward rounds should commence in WAU.

10. Ward clerk responsibilities

- Welcome the women and her support person/s to WAU.
- The ward clerk ensures that the Patient registrations policy (see Associated documents) is followed for all presentations/admissions to WAU. This includes but not limited to:
  - Electronically registered on the Auckland DHB's Patient Master Index on the CMS

- Registered under the correct National Health Index (NHI) number.
- Patient information recorded accurately. Patients must be presented with a registration form each time they present for treatment and have the opportunity to read the information and sign that they understand and agree to the statements.
- Ensure the woman's email address is entered for post-discharge contact.
- Amendments to demographic, contact and GP details must be documented in any hard copy clinical records and also in the maternity electronic record .
- Amendments must be reflected on the patient labels. Any preprinted patient labels will be destroyed if they do not reflect current changes.

- A patient identification band must be attached to all patients as part of the admission process (see Associated documents, Identification of Patients policy).
- The ward clerk will notify the CCM/Midwife in charge in a timely manner when a woman arrives in WAU either expected or self-presenting.
- The ward clerk will ensure that a set of appropriate hard copy clinical records is available as needed.
- The ward clerk will ensure that the correct Case Manager is assigned to the patient on admission (the duty WAU SMO) and upon warding (the duty Ward SMO).

11. Induction of labour admission procedure

Follow process as per Induction of Labour policy (see Associated documents)

12. Supporting evidence

- Ministry of Health. (2012). Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Wellington. Available from: https://www.health.govt.nz/system/files/documents/publications/referral-glines-jan12.pdf

Other

- Royal Cornwall Hospitals, Day Assessment unit Maternity Referral Clinical Guideline V2.3 March 2021

13. Associated documents

- Patient Registration policy
- Identification of Patients (including Newborns) policy
- Auckland DHB Standard Operating Procedure: Intentional Rounding

Women's Health documents

- Admission - Postnatal
- Decreased (Reduced) Fetal Movements
- Admissions & Triage General Gynaecology and Gynae-oncology
- Women's Assessment Unit (WAU) - AED Process for Obstetric Patients over 20 weeks

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- Results (Laboratory and Radiology) Procedure in Women's Health
- Induction of Labour
- Pathway for assessment and care of pregnant women presenting to ED with non-obstetric illness

Forms

- CR3000: National Women's Maternity Service Telephone Advice Record
- CR5825: Maternity Early Warning Score (MEWS)
- CR3170: Maternal Sepsis Screening and Action tool

14. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

15. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.

Appendix 1: Gynaecology triage tool

Triage 1

- **Life threatening – to be seen immediately**
- **If medical team not available promptly call the appropriate Code Red or Blue**
- Collapsed
- Severe Ovarian Hyperstimulation Syndrome (OHSS)
- Respiratory distress
- Vaso Vagal
- Clinically unstable patient for example:
  - Ruptured ectopic pregnancy
  - Acute abdominal pain, torsion, ruptured ovarian cyst
- Cervical shock
- Ectopic with clinical symptoms
- Torted ovarian cyst
- Anaphylaxis
- Cardiac Arrest
  - Seen by nursing and medical team immediately
  - Registrar contacted

Triage 2

- Imminently life threatening – to be seen within **10 minutes**
- Ectopic pregnancy
- Unstable maternal observations
- Severe abdominal pain of unknown cause (pain score >5)
- Heavy prolonged bleeding with clots

Triage 3

- Potentially life threatening – to be seen within **30 minutes**
- Stable ectopic
- Mild to moderate OHSS
- PID
- Pyelonephritis
- Stable with incomplete, inevitable or threatened miscarriage
- Ovarian cyst
- Hydrosalpingectomy
- PV bleeding
- Abdominal pain (score <5)

Triage 4

- Potentially serious – to be seen within **60 minutes**
- RPOC - stable
- Dysmenorrhea
- UTI
- Bartholins/Labial abscess
- Missed miscarriage
- Menorrhagia
- Post-operative complications

Triage 5

- Less Urgent – to be seen within **120 minutes**
- Repeat BHcG
- Medical management of Miscarriage
- Repeat USS for further diagnosis

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