Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg Caring for Health / À l'écoute de notre santé **CLINICAL PRACTICE GUIDELINE**	**Practice Guideline:** **Obstetrical Patient in a Critical Care Unit: Management of – Adult**	
	Approval Date: *NEW* March 13, 2023	**Pages:** *1 of 6*
		Supersedes: *N/A*

1. PURPOSE AND INTENT:

1.1. To provide guidance and assist with the obstetrical needs of a pregnant or recently post-partum patient who requires care in an Intensive Care Unit (ICU).

2. DEFINITIONS:

2.1. Core Team: Includes obstetrical and critical care physicians in attendance or on call and the nurses who are involved in the patient's direct care. The Core Team includes:

- Critical care attending physician or delegate
- Critical care nurse assigned to the patient and/or critical care CRN
- Obstetrical physician or delegate
- L&D/LDR / postpartum nurse assigned to the patient and/or WCP CRN
- Neonatologist (if applicable) and the Newborn Team
- Anesthesiology (if applicable)
- Indigenous Health (if applicable)
- Spiritual Health Services

2.2. Newborn Team: includes physicians, respiratory therapists, and nurses from neonatology/Neonatal Intensive Care Unit (NICU) to manage care of the neonatal patient if applicable. The Newborn Team could include:

- Neonatologist on Call for NICU
- Senior newborn physician/Senior Neonatologist Resident
- Neonatal resuscitation nurse 1
- Neonatal resuscitation nurse 2
- Respiratory therapist

3. GUIDELINES

3.1. Critical Care Admission/Transfer: Once the patient has been identified as a candidate for critical care admission or has already been transferred into a critical care bed:

3.1.1. The critical care physician (or designate) will ensure that the patient's primary obstetrician has been notified of the transfer. If there is no primary obstetrician identified, then the in-house obstetrician is to be contacted by the critical care physician (or designate).

3.1.2. The in-house obstetrician will assume the care of the patient admitted under a family practice physician or midwife. They will be notified by the critical care physician.

3.1.3. The obstetrical physician or delegate will notify anesthesia and neonatology services if applicable.

3.1.4. Critical care CRN/charge nurse will notify L&D/LDR CRN/charge nurse of obstetrical patient admission/transfer to ICU. The L&D/LDR CRN/charge nurse will notify the L&D/LDR Manager/hospital supervisor (off hours) of the admission/transfer to facilitate appropriate nursing support.

3.2. Determination of Fetal Viability: Viability of the fetus will be determined by the obstetrical physician or delegate upon discussion with neonatology and communicated to the Core and Newborn Teams.

3.2.1. The obstetrical physician or delegate will notify the neonatologist on call for NICU to determine viability if uncertain.

3.3. Determination of Required Nursing Support: The level of nursing support required will vary based on clinical presentation.

3.3.1. The patient ***is <u>not</u> in active labour and the fetus has been deemed viable****:*
An L&D/LDR nurse is assigned as a resource for the critical care nurse and provides assistance with obstetrical monitoring as required. This person does not need to remain present in the ICU but will check in at least every shift and upon request of the critical care nurse.

3.3.2. The patient ***<u>is</u> in active labour and the fetus has been deemed viable****:*
An L&D/LDR nurse is assigned to assist the critical care bedside nurse and remains present in the ICU.

3.3.3. The ***fetus has been deemed <u>not</u> viable****:*
A nurse from L&D/LDR program is assigned as a resource for the critical care nurse and provides assistance with obstetrical monitoring and social supports as required. This person does not need to remain present in the ICU but will check in periodically and upon request of the critical care nurse.

3.3.4. The patient ***is in postpartum period****:*
A L&D/LDR or Postpartum nurse is assigned as a resource for the critical care nurse and provides assistance with postpartum monitoring and assessments as required while the patient remains in ICU. This person does not need to remain present in the ICU but will check in at least every shift and upon request of the critical care nurse, to perform a postpartum assessment per protocol and provide lactation support as needed.

3.4. Collaborating Daily Management Plan for Obstetrical Patient While in ICU: The Core Team will collaborate on the management plan at least daily, which includes:

3.4.1. Neonatology or anesthesia consult if applicable.

3.4.2. The critical care CRN/charge nurse will call the L&D/LDR CRN/charge nurse at the beginning of each shift to confirm ongoing plan of care while the patient remains in the ICU.

3.4.3. In postpartum period, the critical care CRN/charge nurse will call the postpartum CRN/charge nurse at the beginning of each shift to confirm the ongoing plan of care while the patient remains in the ICU.

3.4.4. If L&D/LDR or postpartum nurse is not present in the ICU, the critical care nurse will call the L&D/LDR or postpartum nurse at the beginning of each shift to provide a nurse-to-nurse report.

3.5. Code Blue Resuscitation: In the event the patient experiences cardiac arrest, pre-arrest signs or symptoms, or is delivering the fetus without the Core Team and Newborn Teams present, a code blue shall be activated in accordance with ***Code Blue Team Resuscitation in Acute Care (Adult) Policy***, and an ***Obstetrical 25 and Neonatal 25*** (if applicable) to alert all team members.

3.6. Delivery of Viable Fetus: If the fetus is considered viable and delivery is anticipated or planned:

3.6.1. The obstetrical physician or delegate will notify the neonatologist on call for NICU and discuss the plan of care.

3.6.2. Neonatologist on call for NICU will notify the Newborn Team.

3.6.3. The obstetrical physician or delegate will notify the anesthesiologist if a cesarean section or their specialty services are required.

3.6.4. The critical care CRN/charge nurse will notify the NICU CRN/charge nurse regarding the potential for delivery.

3.6.5. Prior to active labour, the Newborn Team will prepare for infant resuscitation/management in the adult ICU, including ensuring that Infant resuscitation/management equipment is readily available in the adult ICU and checked daily, such as:

- Radiant warmer bed from NICU
- Emergency resuscitation supplies

- Any additional items listed on the document attached to the neonatal transport equipment (i.e.: a "*Jeep")*
- Newborn respiratory equipment supplied by the registered respiratory therapist (Neonatal Team)
- Neonatal SpO2 monitor

3.6.6. The L&D/LDR nurse and obstetrical physician or delegate will prepare equipment for maternal monitoring, assessment and/or management for potential delivery and is readily available in the adult ICU.
This equipment may include:
- Delivery kit
- Emergency caesarean section bundle
- Electronic fetal monitoring machine or handheld doppler

3.6.7. Fetal monitoring will be performed by the L&D/LDR nurse and/or obstetrical physician or delegate, and may include, but not limited to continuous electronic fetal monitoring or intermittent auscultation as per physician's order.

3.6.8. New signs of labour or changes must be escalated to the Core Team. These might include:
- Tachycardia
- Pain, such lower back ache, pressure sensation in the vagina, pelvis, or rectum
- Sensation to push
- Unexplained escalation to sedation requirement
- New vaginal bleeding
- Vaginal fluid leakage
- Palpable contractions
- Crowning

3.6.9. The Core Team and Newborn Team will respond to the adult ICU when a delivery becomes imminent or occurs.

3.7. Delivery of Non-Viable Fetus: If the fetus is not considered viable:

3.7.1. The obstetrical physician or delegate will notify/update the neonatology and anesthesia physician to relay the plan of care.

3.7.2. The Core Team will consider the need for consulting Palliative Care.

3.7.3. The Core Team will liase with Spiritual Health Services if not already directly involved.

3.7.4. The Core Team will liase with Indigenous Health Services if not already directly involved.

3.7.5. The obstetrical physician or delegate will respond to the ICU when the delivery becomes imminent or occurs to deliver the fetus.

3.7.6. The Core Team will coordinate the maternal and fetal plan of care after delivery, including usual care in accordance with site specific Stillbirth: Care of the Mother & Infant Procedure documents.

3.8. Post Delivery of Viable or Non-Viable Fetus: After delivery in the ICU, the Core Team will continue to collaborate and implement the patients (mother and infant) postpartum care plan:

3.8.1. Disposition and management of the infant will be the responsibility of the L&D and Neonatology teams.

3.8.2. The L&D/LDR CRN/Charge nurse will update the postpartum unit CRN/Charge nurse of the delivery.

3.8.3. The postpartum unit CRN/Charge nurse will notify their unit manager or hospital supervisor (off hours) to facilitate ongoing appropriate nursing support. Peripartum nursing support may be provided by the L&D/LDR, or postpartum nurse based on staffing availability.

3.8.4. At a minimum, the critical care nurse will monitor and support vital signs, hemodynamic parameters, and bleeding.

3.8.5. Post-delivery care is documented by the obstetrical physician or delegate and L&D/LDR or postpartum nurse in collaboration with the critical care nurse.

3.8.6. The L&D/LDR or postpartum nurse will complete assessments and interventions specific to the postpartum plan of care, including but not limited to, fundal checks and vaginal bleeding, and lactation support.

3.8.7. Assessment considerations by the critical care nurse that should be escalated with urgency to the Core Team could include:

- Unexplained changes to vital signs or level of consciousness
- Unexpected escalation in hemodynamic support
- Increased vaginal bleeding, clots, tissues
- Foul smelling discharge

4. RESOURCES:

4.1. Critical Care Educators and Women's Health Educators
4.2. Care of the Labouring Woman; SBH Woman & Child Program; June 2008
4.3. Stillbirth: Care of Mother and Infant; SBH Women and Child Program; Jan 2011