NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Intrapartum care: existing medical conditions and obstetric complications

NICE quality standard

Draft for consultation

August 2019

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| **This quality standard covers** care during labour and birth for women who need extra support because they have a medical condition or complications in their current or previous pregnancy. It also covers women who have had no antenatal care. It describes high-quality care in priority areas for improvement. It does not cover hypertension in pregnancy, diabetes in pregnancy, or the organisation of care for pregnant women with complex social factors.  **It is for** commissioners, service providers, health practitioners, and the public.  This is the draft quality standard for consultation (from 22 August 2019 to 23 September 2019). The final quality standard is expected to publish in February 2020. |

# Quality statements

[Statement 1](#_Quality_statement_1:) Women with an existing medical condition develop their individualised intrapartum care plan with a multidisciplinary team that includes a member with expertise in manging the medical condition during pregnancy.

[Statement 2](#_Quality_statement_2:) Women with an existing medical condition are involved in reviewing their intrapartum care plan with the multidisciplinary team.

[Statement 3](#_Quality_statement_X) Pregnant women with heart disease have intrapartum risk regularly assessed.

[Statement 4](#_Quality_statement_[X]) Women who have had a previous caesarean section and are in labour know about the potential benefits and risks of different modes of birth.

[Statement 5](#_Quality_statement_[X]) Women in labour with sepsis or suspected sepsis have observations carried out by a multidisciplinary team at a frequency based on the level of clinical concern.

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| NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE pathway on [patient experience in adult NHS services](http://pathways.nice.org.uk/pathways/patient-experience-in-adult-nhs-services)) which should be considered alongside these quality statements.  Other quality standards that should be considered when commissioning or providing intrapartum care for women with existing medical conditions or obstetric complications and their babies include:   * [Preterm labour and birth](https://www.nice.org.uk/guidance/qs135) (2016) NICE quality standard 135 * [Contraception](https://www.nice.org.uk/guidance/qs129) (2016) NICE quality standard 129 * [Antenatal and postnatal mental health](https://www.nice.org.uk/guidance/qs115) (2016) NICE quality standard 115 * [Diabetes in pregnancy](https://www.nice.org.uk/guidance/qs109) (2016) NICE quality standard 109 * [Intrapartum care](https://www.nice.org.uk/guidance/qs105) (2017) NICE quality standard 105 * [Neonatal infection](https://www.nice.org.uk/guidance/qs75) (2014) NICE quality standard 75 * [Inducing labour](https://www.nice.org.uk/guidance/qs60) (2014) NICE quality standard 60 * [Multiple pregnancy: twin and triplet pregnancies](https://www.nice.org.uk/guidance/qs46/) (2013) NICE quality standard 46 * [Postnatal care](https://www.nice.org.uk/guidance/qs37) (2015) NICE quality standard 37 * [Hypertension in pregnancy](https://www.nice.org.uk/guidance/qs35) (2019) NICE quality standard 35 * [Caesarean section](https://www.nice.org.uk/guidance/qs32) (2013) NICE quality standard 32   A full list of NICE quality standards is available from the [quality standards topic library](http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards-/Quality-standards-topic-library). |
| Questions for consultationQuestions about the quality standard **Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?  **Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  **Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. Questions about the individual quality statements **Question 4** For draft quality statement 1 and 2: Could these statements be combined into a single statement which focuses on women developing and reviewing their individualised care plan with the multidisciplinary team? If so, would it be clear from the definitions section that the multidisciplinary team should include a clinician with expertise in the medical condition during pregnancy?  **Question 5** For draft quality statement 3: For measurement and quality improvement purposes, at which key contacts should intrapartum risk be reassessed in women with heart disease? Local practice case studies **Question 6** Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please provide details on the comments form. |

# Quality statement 1: Developing care plans

## Quality statement

Women with an existing medical condition develop their individualised intrapartum care plan with a multidisciplinary team that includes a member with expertise in managing the medical condition in pregnancy.

## Rationale

Specialist advice is important to ensure the best intrapartum care for a woman with an existing medical condition. Having a multidisciplinary team that includes a member with expertise in managing the medical condition during pregnancy means this advice is readily available. More than 1 expert may be involved if a woman has more than 1 medical condition. Personalised, holistic care during labour and birth can be planned to help reduce the risk of adverse outcomes for the woman and her baby, such as maternal morbidity and still birth.

## Quality measures

### Structure

Evidence that multidisciplinary teams planning individualised intrapartum care for women with an existing medical condition include a member with expertise in managing the medical condition in pregnancy.

***Data source:*** Local data collection, for example, service protocols or local network agreements.

### Process

Proportion of women with an existing medical condition who planned their individualised intrapartum care with a multidisciplinary team that included a member with expertise in managing the medical condition in pregnancy.

Numerator – the number in the denominator who had a multidisciplinary team that included a member with expertise in managing the medical condition in pregnancy.

Denominator – the number of women with an existing medical condition who planned their individualised intrapartum care with a multidisciplinary team.

***Data source:*** Local data collection, for example, audit of patient records, emails and records of phone calls demonstrating the inclusion of a member with expertise in managing existing medical conditions during pregnancy in the multidisciplinary team.

### Outcomes

a) Incidence of maternal morbidity associated with an existing medical condition.

***Data source:*** Local data collection, for example, audit of patient records. The [MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) reports on maternal morbidity.

b) Incidence of maternal mortality associated with an existing medical condition.

***Data source***: Local data collection, for example, audit of patient records. The [MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) reports on maternal mortality.

c) Incidence of neonatal mortality in babies of women with existing medical conditions.

***Data source:*** Local data collection. [The MBRRACE-UK perinatal mortality surveillance report](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) presents data on perinatal deaths.

## What the quality statement means for different audiences

**Service providers** (NHS hospital trusts) ensure that protocols are in place for women with an existing medical condition to develop individualised intrapartum care plans with a multidisciplinary team that includes a member with expertise in managing the medical condition in pregnancy. Input into the multidisciplinary team can be at face-to-face meetings or by phone or email.

**Healthcare professionals** (obstetric physicians and clinicians with expertise in managing medical conditions during pregnancy) take part in multidisciplinary meetings for intrapartum care planning for women with existing medical conditions, in person or by phone or email.

**Commissioners** (clinical commissioning groups) have clinical protocols in place to ensure that multidisciplinary teams planning intrapartum care for women with an existing medical condition include an obstetric physician or a clinician with expertise in managing the medical condition during pregnancy. Specialist input at multidisciplinary meetings may be in person, or by phone or email, and is monitored.

**Women with a medical condition** plan their care during labour and birth with a team that includes a healthcare professional who has experience of managing their medical condition during pregnancy. The team works with the woman to plan holistic care tailored to support the best possible outcomes for mother and baby.

## Source guidance

[Intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121/) (2019) NICE guideline NG121, recommendations 1.2.1 and 1.2.2.

## Definitions of terms used in this quality statement

### Existing medical condition

An existing medical condition associated with a higher risk of adverse outcomes in labour and birth, including:

* heart disease
* subarachnoid haemorrhage
* arteriovenous malformation of the brain
* acute or chronic kidney disease
* haemostatic disorders

[Adapted from NICE’s guideline on [intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121) evidence review B]

### Multidisciplinary team

For pregnant women with a medical condition, the multidisciplinary team should include an obstetric physician or clinician with expertise in caring for pregnant women with the medical condition and may include, as appropriate:

* a midwife
* an obstetrician
* an obstetric anaesthetist
* a clinician with expertise in the medical condition
* a specialty surgeon
* a neonatologist
* a critical care specialist
* the woman’s GP
* allied health professionals.

The team is led by a named healthcare professional.   
  
[NICE’s guideline on [intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121/), recommendations 1.2.1 and 1.2.2]

## Equality and diversity considerations

Pregnant women with existing medical conditions should be provided with information to support intrapartum care planning that they can easily read and understand themselves, or with support, so they can communicate effectively with the multidisciplinary team. It should be accessible to women who do not speak or read English and it should be culturally appropriate. Women should have access to an interpreter, link worker or advocate if needed. They should not be a member of the woman’s family, her legal guardian or her partner, and they should communicate with the woman in her preferred language.

For women with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's [Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/).

## Question for consultation

Could these statements be combined into a single statement which focuses on women developing and reviewing their individualised care plan with the multidisciplinary team? If so, would it be clear from the definitions section that the multidisciplinary team should include a clinician with expertise in the medical condition during pregnancy?

# Quality statement 2: Reviewing care plans

## Quality statement

Women with an existing medical condition are involved in reviewing their intrapartum care plan with the multidisciplinary team.

## Rationale

Involving a woman in reviewing their intrapartum care plan with the multidisciplinary team enables them to discuss their care plan with the appropriate specialists. The team may give the woman information to aid discussions and support shared decision making. Involvement of the woman allows the care plan to be tailored to her condition, her experience of the condition, and her preferences for labour and birth. The woman should be involved in updating the plan to reflect changes in her condition during pregnancy and on admission for birth.

## Quality measures

### Structure

a) Evidence of local processes to provide opportunities for women with an existing medical condition to discuss the intrapartum management of their condition with the multidisciplinary team.

***Data source:*** Local data collection, for example, documented procedures, service specifications and staff training on communication skills.

b) Evidence of local arrangements to ensure that women with an existing medical condition are supported to review their intrapartum care plan throughout pregnancy, including when their condition changes, and on admission for birth.

***Data source:*** Local data collection, for example, service protocols, records for training in communication skills, multidisciplinary working and shared decision making.

### Process

a) Proportion of reviews during pregnancy of the intrapartum care plan for a woman with an existing medical condition, which involved the woman.

Numerator – the number in the denominator which involved the woman.

Denominator – the number of reviews during pregnancy of the intrapartum care plan for a woman with an existing medical condition.

***Data source:*** Local data collection, for example, audit of patient records, minutes of multidisciplinary team meetings.

b) Proportion of updates following a review of an intrapartum care plan for a woman with an existing medical condition, which involved the woman.

Numerator – the number in the denominator which involved the woman.

Denominator – the number of updates following a review of an intrapartum care plan for a woman with an existing medical condition.

***Data source:*** Local data collection, for example, audit of patient records, minutes of multidisciplinary team meetings.

### Outcome

The proportion of women with an existing medical condition who felt that they were involved in preparing and reviewing their intrapartum care plan with the multidisciplinary team.

Numerator – the number in the denominator who felt that they were involved in preparing and reviewing their intrapartum care plan with the multidisciplinary team.

Denominator – the number of women with an existing medical condition and an intrapartum care plan.

***Data source:***Local data collection, for example, a patient experience survey. [Care Quality Commission Maternity Services Survey](https://www.cqc.org.uk/publications/surveys/maternity-services-survey-2017) question: Thinking about your care during labour and birth, were you involved enough in decisions about your care?

## What the quality statement means for different audiences

**Service providers** (NHS hospital trusts) ensure that systems are in place for women with an existing medical condition to be involved in reviewing their intrapartum care plan during pregnancy. The plan should be updated in response to any changes in the woman’s medical condition and reviewed on admission for birth. The multidisciplinary team should include the woman as a member of the team and support her involvement, ensuring they give her opportunities to discuss how her condition may affect intrapartum care.

**Healthcare professionals** (such as obstetricians, midwives, clinicians with expertise in managing the medical condition during pregnancy and obstetric anaesthetists) ensure that women with existing medical conditions are involved in reviewing their intrapartum care plan during pregnancy. The plan should be updated in response to any changes in the woman’s medical condition and reviewed on admission for birth. To help support involvement, the multidisciplinary team should provide information about, and opportunities to discuss, the woman’s medical condition and its potential impact on intrapartum care for the woman and her baby.

**Commissioners** (clinical commissioning groups) ensure they commission services that involve women with an existing medical condition in reviewing their intrapartum care plan during pregnancy. The plan should be updated in response to any changes in the woman’s medical condition and reviewed on admission for birth. Multidisciplinary teams within commissioned services should provide opportunities for discussion to support the woman’s involvement, and regard her as a member of the team.

**Pregnant women with a medical condition** are involved with the care team in updating plans for care during labour and birth. They are given opportunities to discuss how their medical condition may affect their care and the care of their baby.

## Source guidance

[Intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121/) (2019) NICE guideline NG121, recommendation 1.2.1.

## Definitions of terms used in this quality statement

### Existing medical condition

An existing medical condition associated with a higher risk of adverse outcomes in labour and birth, including:

* heart disease
* subarachnoid haemorrhage
* arteriovenous malformation of the brain
* acute and chronic kidney disease
* haemostatic disorders

[Adapted from NICE’s guideline on [intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121), evidence review B]

### Involved in reviewing their intrapartum care plan

Involvement in care planning may be supported by giving women information supplementary to that given as part of routine antenatal care. This additional information should cover:

* how a woman’s medical condition may affect her care
* how labour and birth may affect a woman’s medical condition
* how a woman’s medical condition and its management may affect her baby.

To help ensure her goals, expectations of labour and birth, and how she views her condition are reflected in her intrapartum care plan, the multidisciplinary team should regard the woman as a member of the team and provide her with opportunities for discussing her care. This involvement should help ensure that the woman has an intrapartum care plan that is based on informed and shared decision making.

[NICE’s guideline on [intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121), recommendations 1.1.2 and 1.1.4, and evidence reviews A and B]

## Equality and diversity considerations

Information provided to a woman during a review of care planning should be in a format they can easily read and understand themselves, or with support, so they can communicate effectively with healthcare professionals. It should be accessible to women who do not speak or read English and it should be culturally appropriate. Women should have access to an interpreter, link worker or advocate if needed. They should not be a member of the woman’s family, her legal guardian or her partner, and they should communicate with the woman in her preferred language.

For women with existing conditions who have additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's [Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/).

## Question for consultation

Could these statements be combined into a single statement which focuses on women developing and reviewing their individualised care plan with the multidisciplinary team? If so, would it be clear from the definitions section that the multidisciplinary team should include a clinician with expertise in the medical condition during pregnancy?

# Quality statement 3: Heart disease and intrapartum risk

## Quality statement

Pregnant women with heart disease have intrapartum risk regularly assessed.

## Rationale

Changes to the heart and circulation occur during pregnancy, so regular intrapartum risk assessment is needed for pregnant women with heart disease. The results of this assessment allow for planning for any additional management needs during labour and birth. Risk assessment is based on a combination of clinical, diagnostic and functional assessment involving a cardiologist with expertise in managing heart disease in pregnancy.

## Quality measures

### Structure

Evidence of local arrangements for pregnant women with heart disease to have regular intrapartum risk assessments by a multidisciplinary team that includes a cardiologist with expertise in managing heart disease in pregnancy as part of their intrapartum care planning.

***Data source:*** Local data collection, for example, service protocols and local network agreements for referral.

### Process

Proportion of pregnant women with heart disease who have regular intrapartum risk assessments by a multidisciplinary team that includes a cardiologist with expertise in managing heart disease in pregnancy.

Numerator – the number in the denominator who had regular intrapartum risk assessment during pregnancy by a multidisciplinary team that included a cardiologist with expertise in managing heart disease in pregnancy.

Denominator – the number of pregnant women with heart disease.

### Outcomes

Rates of mortality during labour, birth and the early postnatal period for women with heart disease.

**Data source:** Local data collection. The [MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) reports on the number of maternal deaths attributed to heart disease.

## What the quality statement means for different audiences

**Service providers** (NHS hospital trusts) ensure that local protocols and referral pathways are in place so that pregnant women with heart disease have regular intrapartum risk assessments by a multidisciplinary team that includes a cardiologist with expertise in managing heart disease in pregnancy.

**Healthcare professionals** (cardiologists with experience of managing heart disease in pregnancy) participate in intrapartum risk assessment for women with heart disease as part of multidisciplinary intrapartum care planning. They use their knowledge and experience to advise the multidisciplinary team on specialist aspects of intrapartum care for women with heart disease, which is tailored to the woman’s individual level of risk.

**Commissioners** (clinical commissioning groups) ensure that they commission services with capacity for a cardiologist with expertise in managing heart disease in pregnancy to be involved in intrapartum risk assessment for pregnant women with heart disease as part of a multidisciplinary team.

**Pregnant women with heart disease** have a regular check of their heart condition by a team that includes a specialist cardiologist. This will help them and the team to plan the care needed during labour and birth.

## Source guidance

[Intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121/) (2019) NICE guideline NG121, recommendations 1.3.1 and 1.3.4.

## Definitions of terms used in this quality statement

### Multidisciplinary team

For pregnant women with heart disease, the multidisciplinary team should include a cardiologist with expertise in managing for pregnant women with heart disease, and may include, as appropriate:

* midwife
* an obstetrician
* an obstetric anaesthetist
* a specialty surgeon
* a neonatologist
* a critical care specialist
* the women’s GP
* allied health professionals.

[NICE’s guideline on [intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121/), recommendations 1.2.2 and 1.3.1]

### Intrapartum risk assessment

The assessment includes diagnostic classification, cardiac functional capacity and clinical assessment.

The following should be used:

* comprehensive clinical assessment, including history and physical examination
* the modified World Health Organization (WHO) classification of risk – defined according to the [modified WHO classification of maternal cardiovascular risk](https://academic.oup.com/eurheartj/article/39/34/3165/5078465#123895150) [(European Society of Cardiology)](https://academic.oup.com/eurheartj/article/39/34/3165/5078465#123895150)
* New York Heart Association ([NYHA) functional class](https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure) – see American Heart Association's [information about classes of heart failure](https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure).

[Adapted from NICE’s guideline on [intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121), recommendation 1.3.4 and evidence review C]

## Equality and diversity considerations

Pregnant women with heart disease should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with the multidisciplinary team as part of their risk assessment. It should be accessible to women who do not speak or read English and it should be culturally appropriate. Women should have access to an interpreter, link worker or advocate if needed. They should not be a member of the woman’s family, her legal guardian or her partner, and they should communicate with the woman in her preferred language.

For women with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's [Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/).

## Question for consultation

For measurement and quality improvement purposes, at which key contacts should intrapartum risk be reassessed in women with heart disease?

# Quality statement 4: Informed birth choices for women in labour with previous caesarean section

## Statement

### Women who have had a previous caesarean section and are in labour know about the potential benefits and risks of different modes of birth.

## Rationale

Women who have had a previous caesarean section will have discussed the benefits and risks associated with different modes of birth as part of their antenatal care. Reiterating these benefits and risks during labour and explaining any new benefits and risk factors that may have occurred due to a change in clinical circumstances allows a woman to make an informed decision about mode of birth. The woman can then make an informed choice between continuing with labour or having an emergency caesarean section.

## Quality measures

### Structure

Evidence of local processes to ensure that women who have had a previous caesarean section and are in labour know about the potential benefits and risks of different modes of birth.

***Data source:*** Local data collection, for example, service specifications, records of communication skills training.

### Process

Proportion of women who have had a previous caesarean section and are in labour who are reminded of the benefits and risks of different modes of birth.

Numerator – the number in the denominator who were reminded of the benefits and risks of different modes of birth.

Denominator – the number of women in labour who had a previous caesarean section.

***Data source:*** Local data collection, for example, audit of patient records. The [National Maternity & Perinatal Audit](http://www.maternityaudit.org.uk/pages/home) reports the proportion of women who had a vaginal birth for their second baby after a caesarean section for the first baby.

### Outcomes

The proportion of women with a previous caesarean section who were satisfied with the explanation of the benefits and risks of different modes of birth they were given in labour.

Numerator – the number in the denominator who were satisfied with the explanation of the benefits and risks of different modes of birth they were given in labour.

Denominator – the number of women in labour with a previous caesarean section.

***Data source:*** Local data collection, for example, a patient survey.

## What the quality statement means for different audiences

**Service providers** (NHS hospital trusts) ensure that systems are in place for women with a previous caesarean section who are in labour to discuss the benefits and risks of different modes of birth, including any new benefits and risks.

**Healthcare professionals** (such as midwives and obstetric physicians) ensure that they have discussed the benefits and risks of different modes of birth with women with a previous caesarean section during the intrapartum period. They confirm a woman’s understanding of these discussions during labour, including any new risks that have arisen since the birth plan was made.

**Commissioners** (clinical commissioning groups) ensure that they commission services that have systems in place for discussion of the benefits and risks of different modes of birth with women with a previous caesarean section during intrapartum care planning. They commission services that discuss any new benefits and risks that have arisen while they are in labour.

**Women who have had a caesarean section for an earlier pregnancy** take part in a discussion of the benefits and risks of the different options for birth while they are in labour. This helps them to decide how they want to give birth.

## Source guidance

[Intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121/) (2019) NICE guideline NG121, recommendations 1.19.2, 1.19.3 and 1.19.4.

## Definitions of terms used in this quality statement

### Benefits and risks of different modes of birth

These include:

* a vaginal birth is associated with a small chance of uterine rupture
* an emergency caesarean section may mean a higher chance of:
  + heavy bleeding needing a blood transfusion
  + infection, for example, intrauterine infection
  + a longer hospital stay
  + complications for a future pregnancy, which include placenta praevia and placenta accreta
* similar outcomes for the baby with a vaginal birth and another caesarean section
* a lower chance of complications in labour for women who have had a previous caesarean section and a previous vaginal birth.

[NICE’s guideline on [intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121), recommendations 1.19.2, 1.19.3 and 1.19.4]

### Mode of birth

Vaginal birth or an emergency (unplanned) caesarean section.

[NICE’s guideline on [intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121), recommendation 1.19.2]

## Equality and diversity considerations

Women should have access to an interpreter, link worker or advocate if needed. They should not be a member of the woman’s family, her legal guardian or her partner, and they should communicate with the woman in her preferred language.

For women with existing condition who have additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's [Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/).

# Quality statement 5: Observations for sepsis or suspected sepsis

## Statement

Women in labour with sepsis or suspected sepsis have observations carried out by a multidisciplinary team at a frequency based on the level of clinical concern.

## Rationale

## Women in labour with sepsis or suspected sepsis need monitoring to assess changes in their condition. Physiological changes can occur during labour that may mask the early signs of sepsis. Sepsis is associated with maternal and neonatal mortality. The frequency of observations and the composition of the multidisciplinary team depends on the severity of the condition.

## Quality measures

### Structure

Evidence of local processes to ensure that women in labour with sepsis or suspected sepsis have observations carried out by a multidisciplinary team at a frequency based on the level of clinical concern. There are systems in place to make staff aware of the approach.

***Data source:*** Local data collection, for example, audit of patient records, written protocols, staff communications and training records.

### Process

Proportion of women in labour with suspected sepsis or sepsis had observations carried out by a multidisciplinary team at a frequency based on the level of clinical concern.

Numerator – the number in the denominator who had observations carried out by a multidisciplinary team at a frequency based on the level of clinical concern

Denominator – the number of women in labour with suspected sepsis or sepsis.

***Data source:*** Local data collection, for example, audit of patient records.

## What the quality statement means for different audiences

**Service providers** (NHS hospital trusts) ensure that systems are in place for a multidisciplinary team to carry out observations women in labour with sepsis or suspected sepsis at a frequency based on the clinical concern. The composition of the multidisciplinary team is determined by whether sepsis is suspected or confirmed and whether there are signs of organ dysfunction.

**Healthcare professionals** (such as senior midwives and obstetricians) ensure that they carry out observations for women with sepsis or suspected sepsis in labour as part of a multidisciplinary team. The frequency of the observations and composition of the multidisciplinary team are determined by the level of clinical concern.

**Commissioners** (clinical commissioning groups) ensure that they commission services that have capacity for senior healthcare professionals to monitor observations for women with sepsis or suspected sepsis as part of a multidisciplinary team.

**Women with sepsis or suspected sepsis** have regular checks of heart rate, blood pressure, breathing, temperature and urine during labour by a multidisciplinary team. Their level of risk determines how often they are monitored, and which professionals are involved, so that they have the right level of care according to their symptoms.

## Source guidance

[Intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121/) (2019) NICE guideline NG121, recommendations 1.11.6, 1.13.2 and 1.13.3.

## Definitions of terms used in this quality statement

### Observations

Routine maternal observations for women in labour with suspected sepsis and sepsis

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Complication** | **Frequency of maternal observations1** | | | | | | |
|  | Pulse | Blood pressure | Respiratory rate | Temperature | Level of consciousness (AVPU) | Oxygen saturation | Urine |
| Suspected sepsis – concern insufficient for antibiotic treatment | Hourly | 4-hourly, and hourly in the second stage | 4-hourly | Hourly | Hourly | 4-hourly | Record output |
| Sepsis or suspected sepsis – on antibiotic treatment | Continuous, or at least every 30 minutes | Continuous, or at least every 30 minutes | Continuous, or at least every 30 minutes | Hourly | Every 30 minutes | Continuous, or at least every 30 minutes | Record output, hourly if catheterised |
| 1 The frequency of observations should be adjusted if necessary based on the level of clinical concern.  Abbreviation: AVPU, alert, voice, pain, unresponsive. | | | | | | | |

[NICE’s guideline on [intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121/) (2019) NICE guideline NG121, adapted from table 4]

### Multidisciplinary team

Women in labour with suspected sepsis should have ongoing multidisciplinary review from a team with a named lead, which includes:

* a senior obstetrician
* a senior obstetric anaesthetist
* a senior midwife
* a labour ward coordinator.

Women in labour with sepsis should have ongoing multidisciplinary review from a team with a named lead, which includes:

* a senior obstetrician
* a senior obstetric anaesthetist
* a senior neonatologist
* a senior microbiologist
* a senior midwife
* a labour ward coordinator.

A senior obstetrician or senior obstetric anaesthetist are defined as an obstetrician or obstetric anaesthetist having at least 5 years of speciality (obstetrics or anaesthetic) training.

Include a senior intensivist (critical care specialist), if a woman in labour with sepsis has any of the following signs of organ dysfunction:

* altered consciousness
* hypotension (systolic blood pressure less than 90 mmHg)
* reduced urine output (less than 0.5 ml/kg per hour)
* need for 40% oxygen to maintain oxygen saturation above 92%
* tympanic temperature of less than 36°C.

[Adapted from NICE’s guideline on [intrapartum care for women with existing medical conditions or obstetric complications and their babies](https://www.nice.org.uk/guidance/ng121/) (2019) NICE guideline NG121, recommendations 1.13.4, 1.13.5 and 1.13.6, and evidence review M]

### About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See [quality standard advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) on the website for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the [quality standard’s webpage](https://www.nice.org.uk/guidance/indevelopment/gid-qs10081)

This quality standard has been included in the NICE Pathway on [intrapartum care for women with existing medical conditions](https://pathways.nice.org.uk/pathways/intrapartum-care-for-women-with-existing-medical-conditions) and [intrapartum care for women with obstetric complications](https://pathways.nice.org.uk/pathways/intrapartum-care-for-women-with-obstetric-complications) overview which brings together everything we have said on a topic in an interactive flowchart.

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes in in women with existing conditions, obstetric complications and who have had no antenatal care:

* maternal mortality
* maternal morbidity
* still birth and neonatal death
* neonatal morbidity
* maternal mental health
* health-related quality of life
* satisfaction with results of care
* shared decision-making and confidence in care providers
* birth experience
* patient safety incidents relating to intrapartum care

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

* [NHS outcomes framework](https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework)
* [Public health outcomes framework for England](https://www.gov.uk/government/collections/public-health-outcomes-framework).

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [resource impact statement](https://www.nice.org.uk/guidance/ng121/resources/resource-impact-statement-6717122605) and [baseline assessment tool](https://www.nice.org.uk/guidance/ng121/resources/baseline-assessment-tool-excel-6716838781) for the source guidance to help estimate local costs.

## Diversity, equality and language

During the development of this quality standard, equality issues were considered and [equality assessments](https://www.nice.org.uk/guidance/indevelopment/gid-qs10081/documents) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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