

Compliance with selected GPICS obstetric standards and recommendations in both COVID-19 and non COVID-19 patients in a Scottish Intensive Care Unit.

K Boussouara, C McCue
Glasgow Royal Infirmary, Glasgow

Introduction

Care of the critically ill obstetric patient is a key chapter of the GPICS standards and recommendations, based on the previously produced Enhanced Maternal Care guideline (1). We assessed our units compliance with selected standards and recommendations regarding obstetric MDT review, provision of breastfeeding assistance, facilitation of mother and baby contact, and provision of critical care follow up. A comparison was made between patients with COVID-19 and other diagnoses.

Methods

Caldicott guardian approval was obtained. Patients admitted to the intensive care unit at Glasgow Royal Infirmary between 2016 and 2021, who were currently or recently pregnant, were identified using Wardwatcher. Patients below 20 weeks gestation were excluded from analysis. An extensive review of the CareVue electronic notes was performed to audit compliance with the standards and recommendations displayed in Table 1.

References:
1. FICM/ICS (2019) Guidelines for the Provision of Intensive Care Services 2. London: FICM/ICS. Available at: <https://www.ficm.ac.uk/standardssafetyguidelinesstandards/guidelines-for-the-provision-of-intensive-care-services>

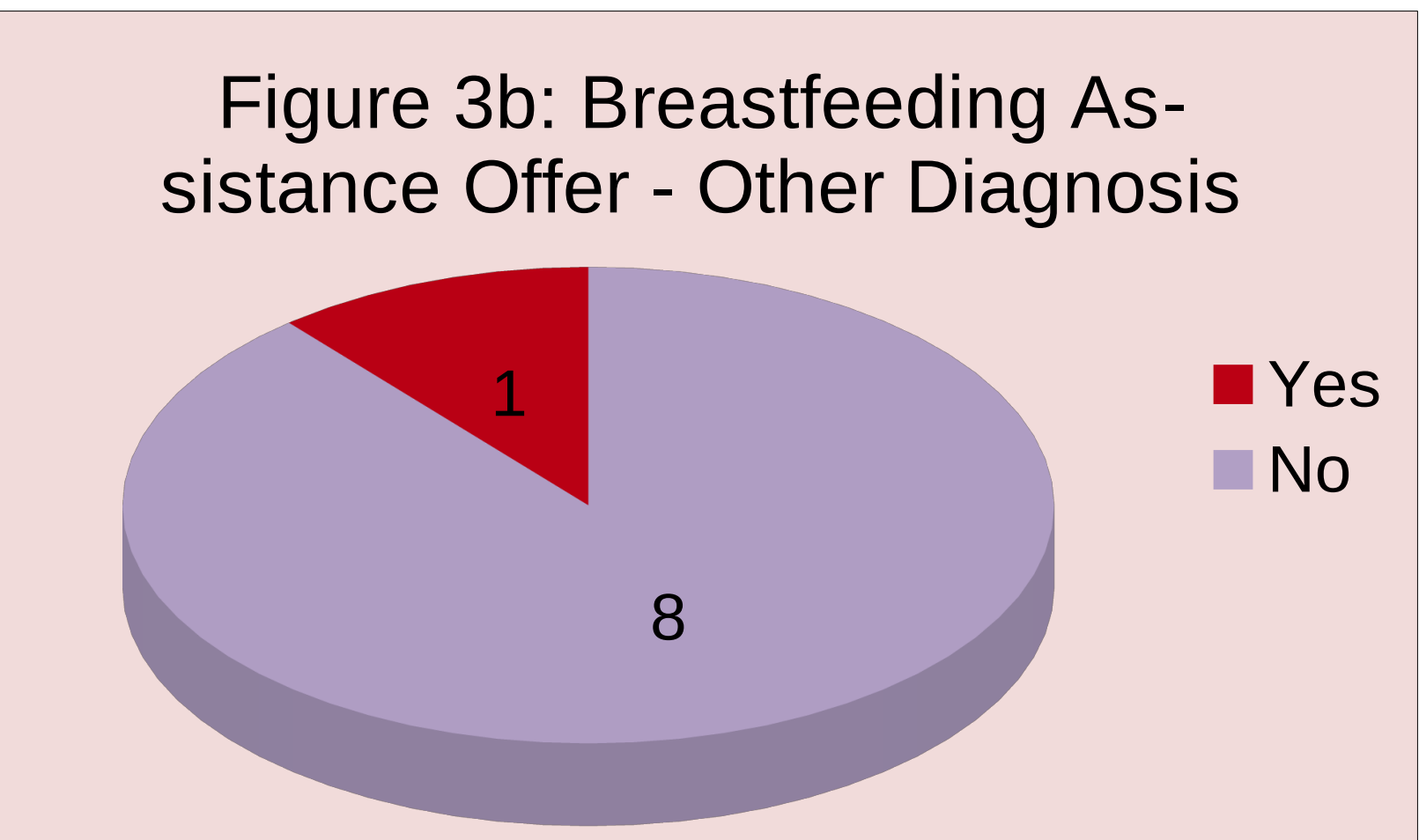
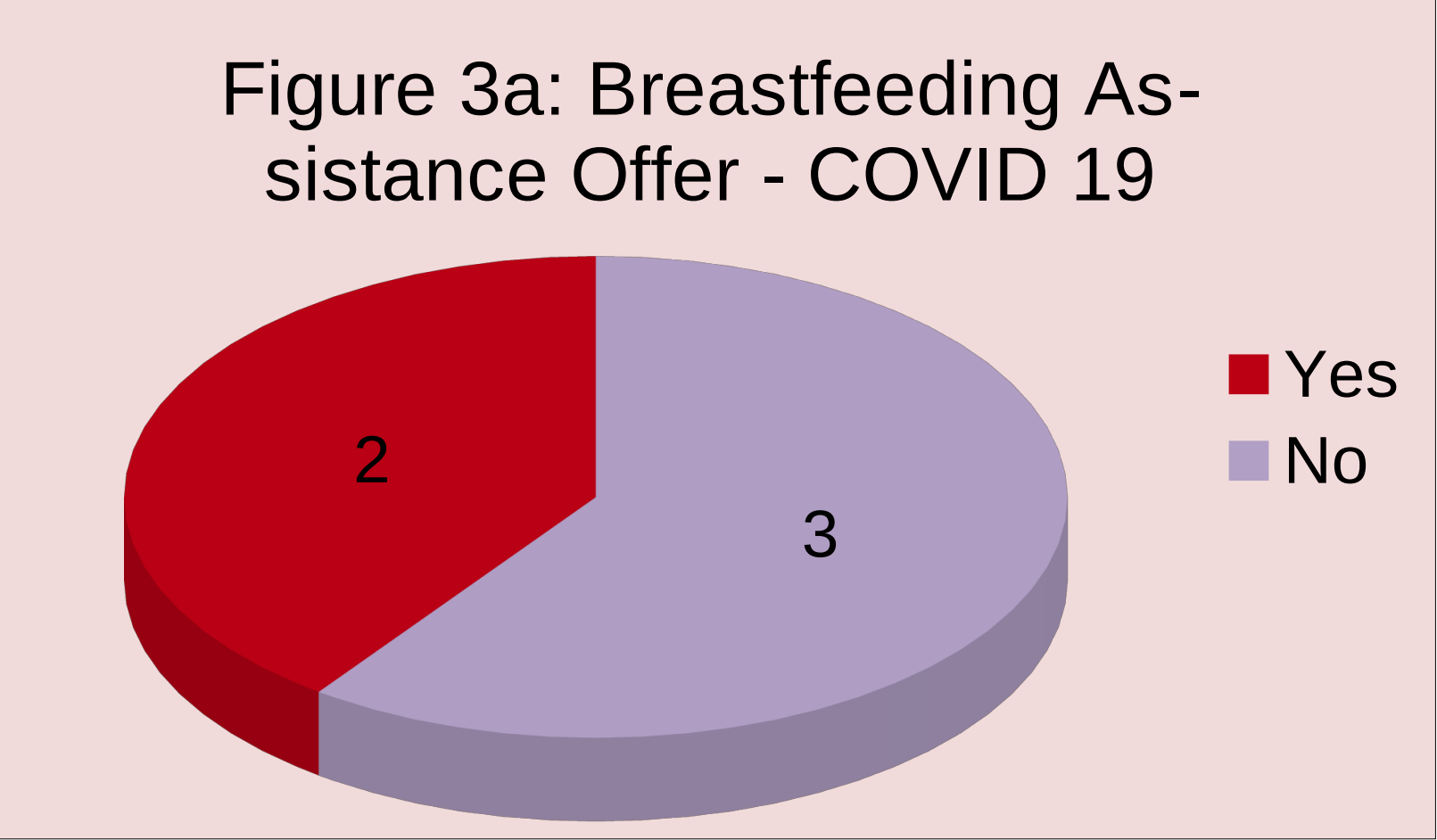
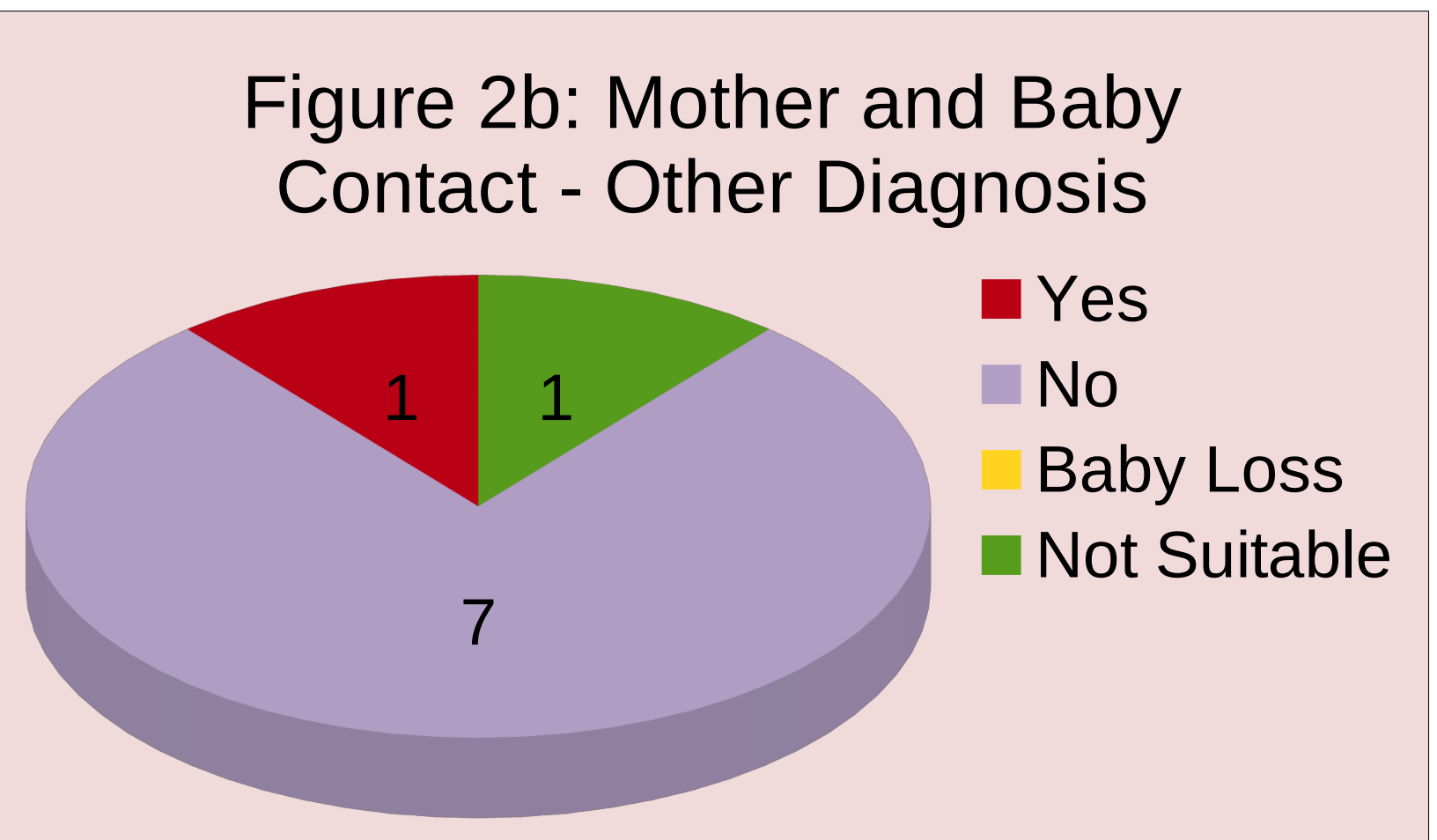
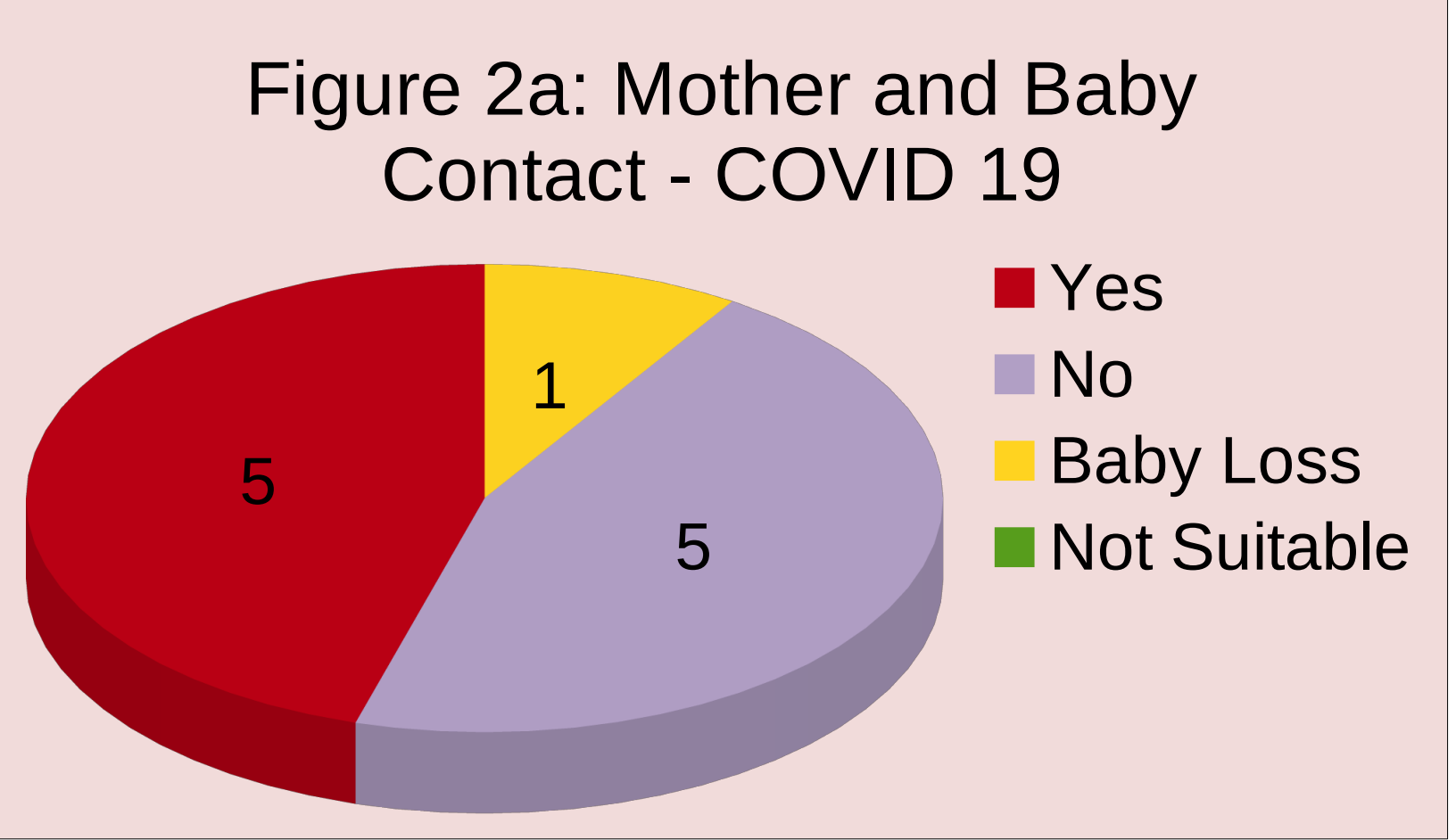
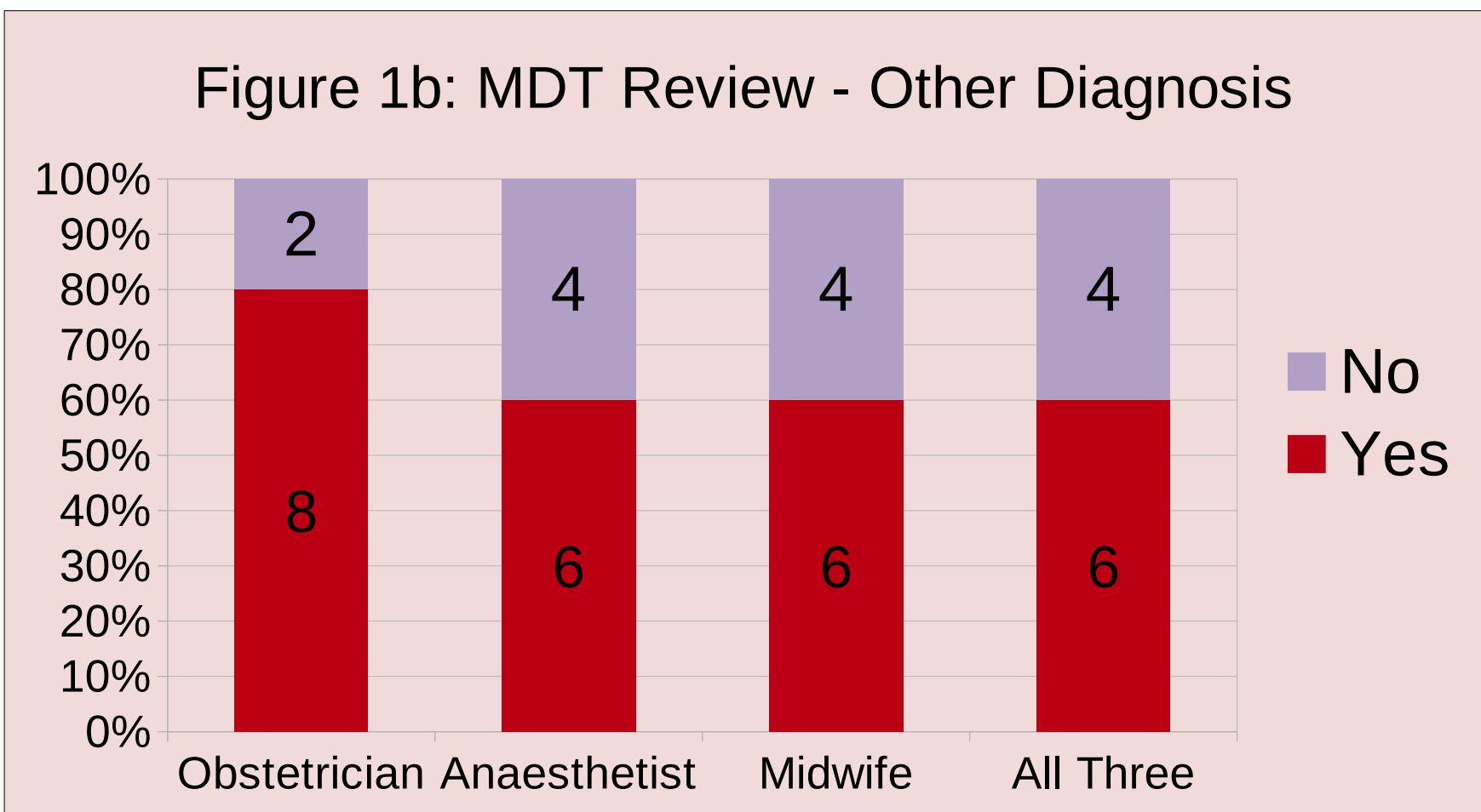
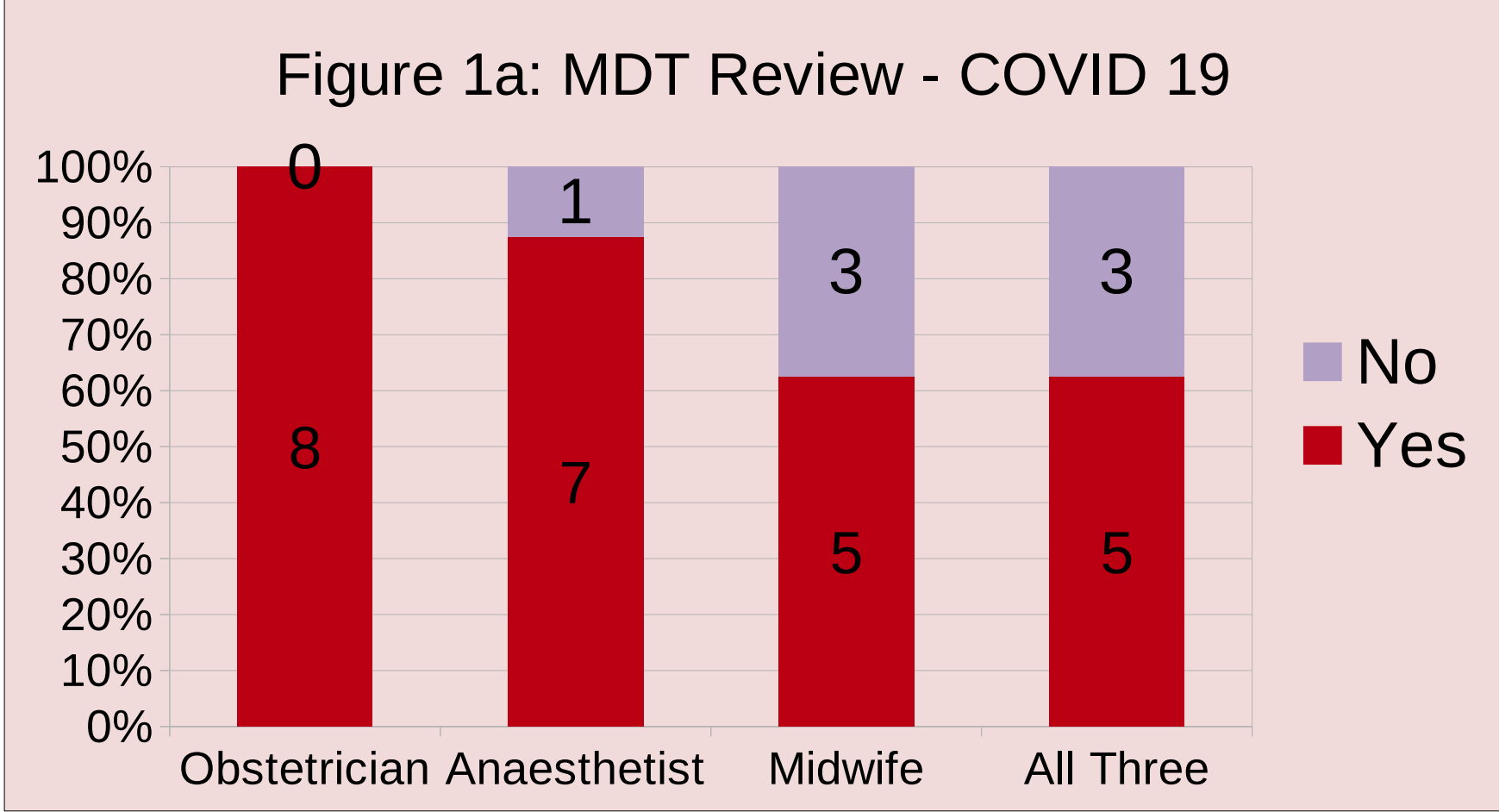
Correspondence: khalid@boussouara.co.uk

Table 1: Selected GPICS Standards and Recommendations

Standard 2	An obstetric team (normally a consultant obstetrician, a consultant obstetric anaesthetist and a midwife) must review all pregnant women admitted to critical care at least once in every twenty-four hour period.
Standard 5	Breast feeding (including the use of breast pumps) must be encouraged and supported in all post-natal women admitted to critical care.
Recommendation 2	Physical contact between a mother and her baby should be maintained during post-natal critical illness, even if the mother is unconscious. This contact and other events of the admission should be recorded in a critical care diary which can be used in psychological rehabilitation after critical care or in bereavement counselling.
Recommendation 3	All women admitted to critical care should be offered an appointment in a critical care follow up clinic or a post-natal review, which includes input from a clinician with experience in critical care follow-up..

Results

35 patients were identified and 25 were eligible for inclusion. COVID-19 patients were more likely to have documented review by an Obstetrician (100% vs 65%), Obstetric Anaesthetist (86% vs 47%), or Midwife (62% vs 53%). Of postpartum patients COVID-19 patients were more likely to have documented evidence of mother and baby contact (60% vs 11%), and provision of breastfeeding assistance (40% vs 11%). Follow up via the INSPIRE programme (post ICU rehabilitation and follow up) was also more likely to have taken place (62% vs 0%), however the majority of the non COVID-19 patients were not eligible for INSPIRE due to a shorter length of stay.



Discussion

Compliance with the selected standards and recommendations was higher in the COVID-19 patient cohort. A number of good areas of practice were highlighted including the use of novel ways to facilitate mother and baby contact. However MDT review did not always occur every 24 hours, and could be sporadic with different members visiting at different times. Some caveats limited our interpretation of the data:

- A number of the postpartum non COVID-19 patients had brief admissions for level 2 care only. This limits comparison with a cohort of COVID-19 patients, some of whom required extended stays for level 3 care.
- There may be undercounting of MDT visits of patients due to the documentation being made on Badgernet. This seems particularly plausible with the lower documentation of midwife presence, which would have been unusual given the requirement for daily CTG in many of the antepartum admissions. However the ICU staff do not routinely have access to this system.

The findings have generated significant discussion, and have contributed to an ongoing push to improve documentation quality and MDT working within our unit.