Boston Medical Center Maternity Care Guideline
Guideline: Complex Obstetric Patient Preparation for Delivery
Accepted: October 19, 2022
Updated: October 19, 2022

Introduction:

The purpose of this guideline is to assist with the preparation for admission for pregnant people with complex conditions which may impact their labor and delivery and postpartum care. It assists in providing complete, organized care upon arrival to Labor and Delivery Unit (L&D) and continuing to their postpartum care and discharge.

Logistics:

- Pregnant people with the diagnoses and clinical indicators listed in Table 1 should be identified as early as possible in pregnancy. This list is not exhaustive.
- The primary prenatal provider:
    - Is responsible for identifying complex conditions in their patients and following the recommended flow (see Table 2).
    - Creates a Complex Care Coordination problem in the patient's EPIC Problem List to clearly define the antenatal, intrapartum and postpartum plan of care.
    - Sends an epic message to the Perinatal Safety Specialist.
    - Schedules surgery/induction Mon-Thurs and not on weekends/holidays.
- The Perinatal Safety Specialist:
    - Maintains a list of the Complex Care patients including relevant diagnoses, assessments, consults and relevant testing and/or imaging and organizes the Complex OB Patient monthly meeting with the Complex OB Patient team.
    - Posts the Complex Care list on BO Complex Care Patient List in BOXThe Complex OB Patient team:
    - Is a multi-disciplinary team, including MFM, L&D and postpartum nursing, resource nursing as well as anesthesia and relevant consult services.
    - Reviews the complex care plan addressing the following potential needs for patients expected to deliver in the next 8 weeks:
        - Recommends team to manage patient on Labor and Delivery and postpartum.
        - Recommends location of surgery - use of main OR is addressed in Table 3.
        - Identifies potential need for invasive monitoring.

- Describes hemorrhage contingency planning. For example: complex crossmatch with multiple antibodies; Jehovah's Witness limitation on blood products; hysterectomy versus massive transfusion.
- Recommends immediate postpartum/PACU needs – nursing, diuretics, consultation, etc.
- Recommends level of care for first 48 hours postpartum.
- Anticipates discharge planning issues – anticipated prolonged stay, VNA, follow up.
- Education opportunities for all staff.

Table 1: Conditions warranting complex case planning (not exhaustive)

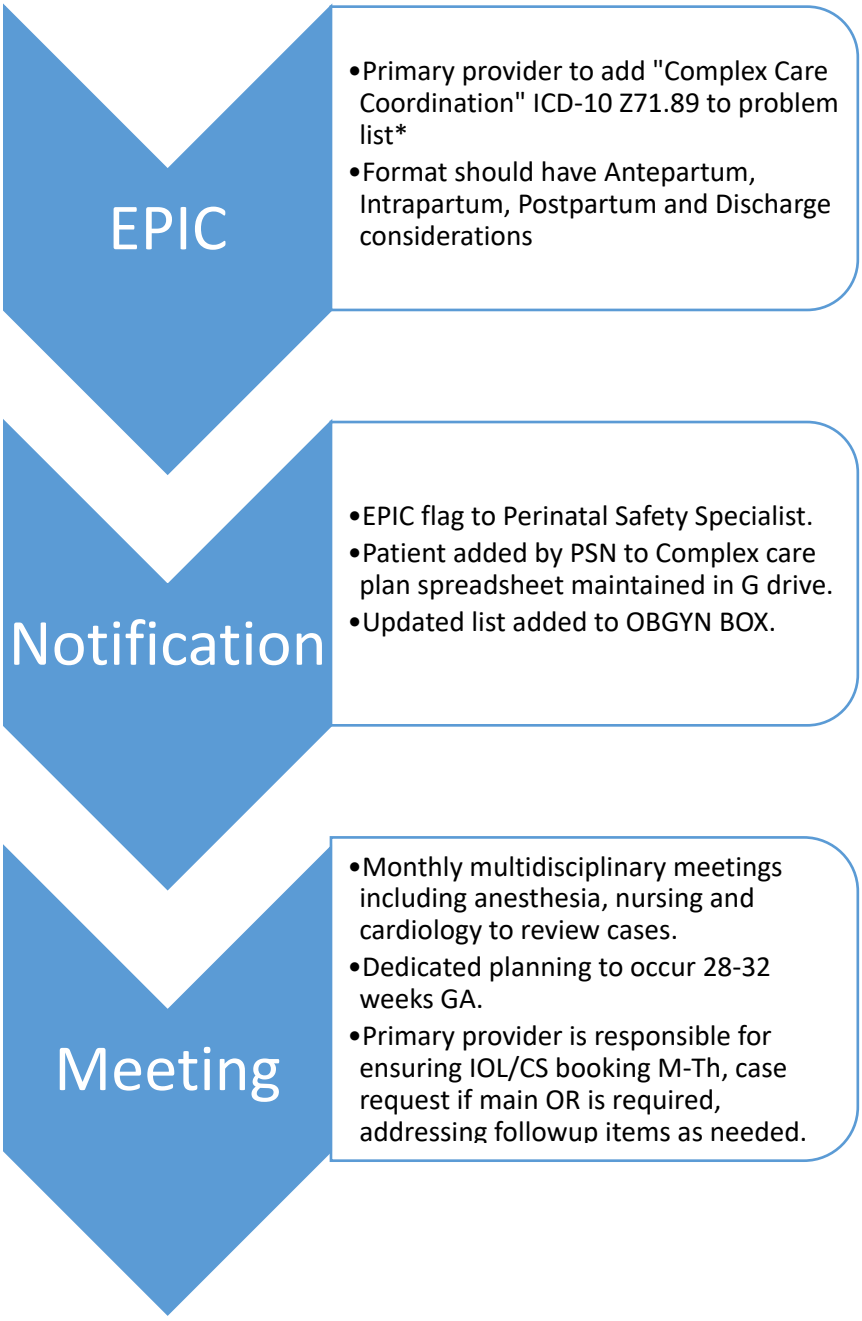
Cardiac
Congenital and acquired – e.g. repaired TOF or TGA
Cardiomyopathy
Valvular disease
Pulmonary HTN/Eisenmengers*
Rhythm abnormalities – SVT, WPW
HTN w sequelae (LVH, Cr>0.8 in pregnancy)
Pacemaker or defibrillator
Hematologic
ITP w severe thrombocytopenia
Sickle Cell Disease
Coagulation abnormalities (e.g. vWD)
Current anticoagulant medications
Spinal/MSK/Neuro
Seizure disorder
CNS anomaly e.g. AVM, aneurysm, Chiari malformation, VP shunt
Hepatic/Renal/GI
Chronic renal insufficiency
Hepatitis or Cirrhosis WITH abnormal LFTS/coags
IBD/CD w h/o abdominal surgery
Miscellaneous Medical
H/o solid organ transplant
Myasthenia gravis
Uncontrolled HIV
Neurofibromatosis
Major disability including blindness, deafness
Obstetric complications
Suspected accreta*
Non-OB surgery during pregnancy

* Indications for use of main or hybrid OR, see policy: 15.05.003 OB High Risk Cesarean Planning Guideline

** See Fetal Board plan

Planned CD w concurrent major abdominal procedure*
Fetal anomaly **
Anticipated neonatal death/palliative care needs**
Psychiatric
PTSD from prior obstetrical events
Schizophrenia

Table 2: Flow for Complex Case Planning



***Example Complex Care Coordination Problem note:**

Antepartum:
Fetal testing plan
Specialty consultation
Imaging performed
Anesthesia consult in PPC

Intrapartum:
Book Mon-Thurs, no holidays
MOD
Inpatient consults required
Invasive monitoring requirement
Team to manage care

Postpartum:
Level of care – PP, Step down, ICU
Team to manage care
Nursing requirement/anticipatory education opportunities

Discharge:
VTE ppx needs
HTN monitoring needs
VNA
Book follow up before IOL/CS

Table 3: OB High Risk Delivery Planning Checklist **Patient Name:** **MRN:**	
EDD	
Gravida/Para	
Surgical Date	
GA at delivery	
Surgery location (Main/Labor and Delivery)	
Preoperative Diagnosis	
Placental position	
Relevant radiologic findings	
Obstetric History:	
Number of prior cesarean sections	
Other prior uterine or abdominal surgery	
Anesthesia planned	
Maternal blood type/Ab screen (date)	
Maternal Hct/Hgb (date)	
Maternal creatinine (date)	
Planned hysterectomy? (yes/no)	
Surgical Consent signed? (date)	
Anesthesia Consent signed? (date)	
Pre-procedure clinic (date)	
Pre-admission day prior (yes/no, reason)	
Pre-operative consult (PPC)? (date)	
Pre-operative COVID testing (date)	
Antenatal fetal steroids? (dates)	
NICU considerations	
Delivery Team:	
Primary Obstetric surgeon	
MFM consult	
Event Manager	
Anesthesia attending	
NICU attending	
Primary Nurse	

GYN oncologist/Trauma/Vascular surgeon	
Interventional Radiologist Name/pager:	
Blood Bank Contact Name/Pager:	
Other service Name/ pager:	
Blood Products	
Ligasure/Novasure	
C/S Cart, OB Trauma Cart	
Cell Saver	
Underbody Bair Hugger	
MTP lab forms, patient labels, OBH protocol, OBH meds, scale, Baby & LD Meds, blood gas kits	
NICU equipment in OR	

REFERENCES:

Clapp et al. Hospital acuity and maternal morbidity. Am J Obstet Gynecol 2018