COVID MBRRACE report

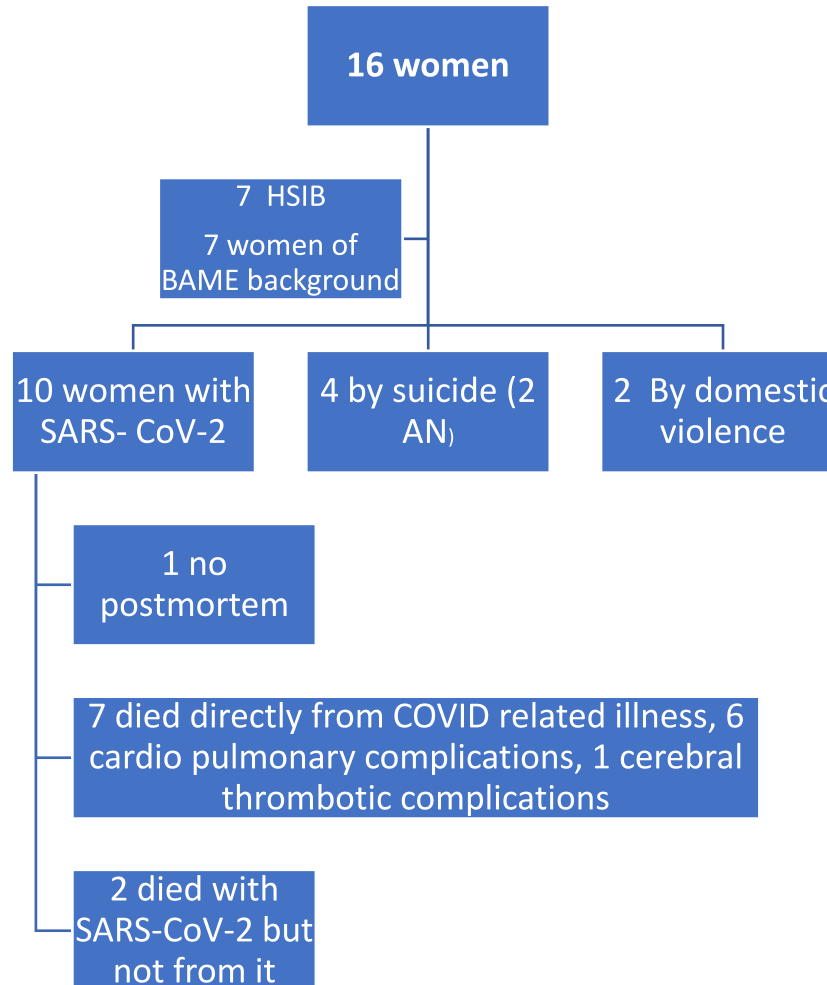
Rapid learning from SARS-CoV-2

March- May 2020

LR UHD 14/10/2020

Wessex **Patient Safety Collaborative**

Cohort included in MBRRACE quick review n= 16



Responsibilities:
High risk women

- Women of BAME background
- Hypertension
- Raised BMI (30kg/m^2)
- Diabetes
- All staff that have contact with these women should advise at higher risk of deterioration and should advise to seek health if they have concerns about their wellbeing
- Dorset Maternity Voices highlighted this on 04/10/2020 on their Facebook page- also on Maternity matters website
- Triage with this awareness

Key messages

- Ensure all pregnant or PN women receive MDT care with leadership from obstetric team and daily review when inpatient.
- Ensure they are considered for antiviral or other specific therapies for COVID-19- do not exclude from clinical trials on basis of pregnancy
- Safety netting to be given about symptoms of deterioration
- Good communication with family when critically unwell
- Triage for mental health concerns- inc PNMH
- Ensure 2 plus referrals to mental health team is a red flag
- Update safeguarding actions re place of safety during periods of lockdown.

NHS

Escalation

- Plans should be made for daily review of outside maternity unit and considerations for timing of escalation and place of care factored into ongoing plans.
- If oxygen requirements or FiO2 of >40% consider or normal saturations with Raised respiratory rate, drowsiness or reduced urine output- escalate care- facilitate higher levels of care until appropriate place of care identified with support from critical care.

- *A woman in her third trimester was admitted with a week history of COVID-19 symptoms. She remained in ED for several hours and was assessed by medical staff as having mild- moderate symptoms. She deteriorated overnight and had a respiratory rate of 70 with an oxygen saturation of 94% on 4l O2 at the time decision was made for a caesarean birth. She improved initially but subsequently deteriorated and died.*

- Consideration of lack of staff not being familiar with caring for pregnant or newly delivered women and review by midwifery/ obstetric staff may have expedited some of the care provision

Place of care

- *A woman in her third trimester was admitted to ED with one week symptoms of COVID-19. Her observations were recorded on a NEWS chart instead of MEOWS. Her respiratory rate was 36- this was not recognised as significant. Her first review by obstetrics was 11 hours after admission and noted there were no obstetric concerns. She deteriorated a few days later and was documented as needing HDU or ITU care- no beds available. Her care was discussed with a Consultant Obstetrician at the time of deterioration and the decision made to perform a caesarean. Again after LSCS no level 2 or 3 beds available and she went back to a general ward where she deteriorated. She was intubated and transferred to the ITU but her condition worsened and she died a few days later.*

- She moved wards five times within her care with no one having direct oversight of her care.
- Consideration of this is required especially for those not quite sick enough to require level 3 care with no one taking overall leadership for her care.
- As in the 2015 MBRRACE report they pointed out critical care may need to be commenced out of the ITU setting with support until a be becomes available.

NHS

Low Molecular Weight Heparin

- All women admitted should have MDT plan for LMWH including ongoing care on discharge
- Utilise maternity specific VTE charts with treatment for 10 days after discharge if their symptoms have necessitated admission. – consider extending this to 6 weeks if significant ongoing morbidity

Treatment with anti virals or other therapies for COVID- 19

- For any women with a positive result- consider and offer enrolment to the RECOVERY trial (unless a clear contraindication to this)
- Recovery has a specific maternity treatment arm. For current info https://www.recoverytrial.net/files/recovery-information-for-pregnant-patients-v7-0-2020-10-05.pdf (notes pages contains further information)

Treat pregnant women the same as non-pregnant women
MDT review of appropriate medication

Safety netting advice/ communication

- *Three women died at home or presented to hospital late, either because of reluctance to attend hospital for fear of infection, or due to following advice to stay at home*

- Women need to know when to stay at home and self medicate and when to call for further support- including where to be admitted (ensure interpretation services included as required)

- RCP toolkit red flags (2019)

Red flags in a pregnant patient presenting with breathlessness:

- Sudden-onset breathlessness
- Orthopnoea
- Breathlessness with chest pain or syncope
- Respiratory rate >20 breaths per minute
- Oxygen saturation <94 % or falls to <94 % on exertion
- Breathlessness with associated tachycardia

NHS

Mental health care

- *A postnatal woman with known mental health problems contacted her GP during the early days of lockdown requesting an increase in her antidepressants. She had contacted the crisis team and was said to be 'not suicidal'. She was re-referred to PNMH team. The next day she rang the crisis team. She had several further phone calls with perinatal mental health and crisis teas but was not seen face to face. She died by suicide the following day.*

NHS

She should have had face to face consultation (that may have picked up on her weight loss, persistent poor sleep, agitated state) but PNMH and the crisis team both felt it was the other teams responsibility. Again this echoes previous reports where previous history, escalating patterns of symptoms and abnormal behaviour not noted.

Repeated referrals for mental health concerns should be viewed as a red flag

- Consideration of utilising the lead obstetrician for mental health or midwife in triage of these women if still under care of the maternity services

Domestic violence

- *A woman with multiple disadvantages and past mental health difficulties was known to have a violent partner. No consideration appears to have been made around the protection of the woman herself. She died after a violent assault a few months postpartum during the lockdown period.*

- *A second postpartum woman disclosed domestic violence to her Health visitor on several occasions prior to lockdown. Her partner made an attempt on her life during lockdown and she was advised to lock herself and her children into her home and seek family support. Neither she nor her family were removed to a place of protection. She was killed the following day.*

Conclusions

- All staff have a responsibility to:
- Be aware what to do when a woman is tested as positive to COVID
- Include advice to the woman on symptoms of deterioration and when to seek further help
- Be aware of high risk groups- women of BAME background, higher BMI, diabetes, hypertension and triage appropriately
- Use the MDT during any admission- seek support out of the maternity unit as required planning place of care, treatments and initiating care until level 3 care available
- Consider mental health needs and face to face care
- Understand processes for local reporting and safeguarding when domestic violence reported.