In our first retrospective audit of fifteen obstetric women admitted to ITU over a period of two years, services were assessed using CNST standards 2.9, 4.8, 5.10. This audit highlighted poor documentation and difficulty in identifying evidence. Recommendations were made including defined auditable standards and a named person to ensure compliance. Local guidelines were revised. From recommendations we identified twelve auditable standards. Documentation of clearly defined reason for transfer to ITU, daily multidisciplinary review, SBAR (situation, background, assessment, recommendation) handover, entry level of ITU, length of stay, discharge criteria, outreach follow up and clinical incident form were assessed.

A repeat audit of eight obstetric ITU admissions in next twelve months was completed. Retrospective case notes review was conducted by the same person. Re audit confirmed improved documentation however extracting evidence continued to be difficult.

Numerous national guidance and standards can be confusing however it is possible to identify local auditable standards to improve care and assessment of care.

**REFERENCES**


**PM.56** AUDIT OF CARE OF CRITICALLY ILL PREGNANT WOMEN

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**Aim** To review series of critically ill obstetric patients admitted to ITU and to formulate a guideline for the care of these women.

**Background** The women who become critically ill during pregnancy should receive the same standard of care for both their pregnancy related and critical care needs, delivered by professionals with the same level of competences irrespective of whether these are provided in a maternity or general critical care setting.

**Methods** Retrospective study of 55 women who were admitted to critical care unit from 01/01/2006 to 31/12/2011. Patients were identified by ITU database.

**Results** Average ITU stay was 1–2 days in 50% of cases. 92% of patients were admitted postpartum. Massive obstetric haemorrhage (54%), sepsis (13%), Pre eclampsia/HELLP/Eclampsia (11%) and swine flu (5.4%) were the main indications. 100% compliance with MEWS chart was observed. The most common interventions were arterial line (64%) and CVP line (35%). VTE assessment on admission to ITU was observed in 65%, daptaparin (74%) and TEDS (74%) of cases. One case of group A streptococcus was seen. Maternal mortality was nil. Debriefing of the family (61%) and debriefing of patient (78%) cases. Datix completed (10%), external transfer (5.4%) cases.

**Conclusions** Massive obstetric haemorrhage, sepsis and pre eclampsia are the main reasons for admissions.

**Recommendations** Documentation of patient and family debrief needs to be improved. All these women should be seen in gynaecology follow up clinic for debriefing. Guidelines for critically ill pregnant or recently pregnant women and sepsis in pregnancy and puerperium should be formulated.

PM.58 CLINICAL OUTCOMES IN PREGNANT WOMEN NEWLY RECLASSIFIED AS GESTATIONAL DIABETES (GDM) USING IADPSG CRITERIA

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**Background** There are widespread concerns about the potential resource implications of implementing the International Association of the Diabetes and Pregnancy Study Group (IADPSG) criteria for diagnosing GDM. However, another important consideration is the risks facing undiagnosed cases if the new criteria are not adopted. In our unit, since 2006 we have offered a 3 point OGTT (fasting, 1 & 2 hours). Hence our projected increase in number of GDM cases is solely related to the lower IADPSG fasting threshold [5.1] and not it’s addition of a 1 hr threshold.

**Aims** To identify women with 75 g OGTT fasting levels between IADPSG and WHO thresholds [5.1–5.9], and normal 1–2 hour levels. To ascertain the extent of diabetes related outcomes in these undiagnosed cases.

**Materials and Methods** Retrospective study of OGTT results for all women who delivered in our unit between 1st January 2009 and 31st December 2011. Outcome data for 129 selected cases was obtained from our ProtoS Maternity information system.

**Results** All deliveries ended in live births but the fetal macrosomia rate (>4 kg) was 30% [39/129]. Using a cut off of 4.5 kg the macrosomia rate was 5.4%. The caesarean section rate for macrosomic babies was 23% [9/39]. Neonatal hypoglycaemia was diagnosed in 6.2% [4/129] of the babies and 3.1% [4/129] needed immediate admission to NICU. However, none of the admissions to NICU were directly related to neonatal hypoglycaemia.