Obstetric Patient Referral – Admission and Transfer Criteria to a Higher or Tertiary Level of Care Procedure for WACHS Kimberley Birthing Sites

1. Guiding Principles

This procedure relates to women who can be delivered in WACHS Kimberley hospitals and has been developed with reference to Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the King Edward Memorial Hospital (KEMH) guidelines.

From the beginning of 2012, a full time Specialist Obstetric and Specialist Paediatric service has been available in Broome. This means the procedure for delivery at the Broome Hospital will be different to that of the Derby and Kununurra hospitals.

Midwives, District Medical Officers (DMOs), both obstetric and anaesthetic, specialist obstetricians, specialist physicians and paediatricians work collaboratively in the Kimberley so all antenatal patients of concern are discussed at a regular multi-disciplinary meeting currently held at 13:15 hours (1:15 pm) on Thursdays in Broome, and during the regular obstetrics and gynaecologist (O&G) visits at other sites. This allows management to be individualised.

2. Procedure

Patients who fall into the following high-risk categories must be considered for transfer to a tertiary unit for treatment and management. Consultation should be undertaken with the regional obstetrician for all high-risk acute situations, or where further clarification and individualisation of care is needed.

The majority of Kimberley Obstetrics patients requiring transfer are referred through to King Edward Memorial Hospital (KEMH). Patients however that are likely to require ICU or other adult specialist medical services not readily available at KEMH, should be considered for referral to Fiona Stanley Hospital (FSH). All patients requiring acute transfer to FSH need to be accepted by the on-call Obstetrics consultant at that hospital.

2.1 Blood Transfusion Risk

As there is a limited blood supply in the Kimberley, patients who are at risk of requiring a large volume of blood cannot be delivered in the Kimberley. This includes placenta praevia, placenta accreta, and patients that have previously had a massive post-partum haemorrhage (PPH) thought to be likely to recur. These patients must be transferred to tertiary facilities except in emergency situations. In acute bleeding or for patients that have had a previous large PPH that are being considered for delivery in the Kimberley, the case must be discussed with a regional specialist obstetrician.

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2.2 Intensive Care

The other major restricting factor for women to be cared for in the Kimberley is the absence of an Intensive Care Unit (ICU). This means women with severe cardiac, respiratory and neurological conditions and women who are likely to require ICU pre or post birth are required to deliver outside of the Kimberley region. The cases should be considered for transfer to FSH.

2.3 BMI Guidelines

It is recognised that the Body Mass Index (BMI) of women is generally increasing, however limits need to be applied to the BMI that can be safely managed in the Kimberley, primarily based on the anticipation of anaesthetic difficulty. Currently Broome and Derby Hospital will consider patients with a BMI up to 40, and Kununurra Hospital to a BMI of 35. However patients' other risks factors must also be considered including anticipated mode of delivery, other medical conditions and their obstetrics history in determining the appropriate place for delivery.

The BMI is preferably measured in the first trimester. If the BMI in the first trimester is greater than 40, women are to be advised that it would be safer to deliver outside of the Kimberley, unless there are particularly favourable features such as previous uncomplicated deliveries at the same, or close to the same BMI. In this circumstance, the patient must be reviewed and cleared by the specialist obstetrician and anaesthetic DMO, and the woman is to be advised of the importance of restricting further weight gain, in the interests of her own health, her baby's wellbeing and her chances of remaining in the Kimberley.

BMIs between 35 and 40 in first trimester must also be reviewed by both the anaesthetic DMO and specialist obstetrician and discussed collaboratively. Decisions are not to be solely based on BMI, but also on her past history and other concurrent medical conditions.

The aim in all cases, is to provide an early decision to give the woman consistent advice as to place of delivery as early in the pregnancy as possible. An individual plan is also to be put into place for these women including referral to a dietician. A woman may need to be reviewed later in pregnancy if her BMI is borderline during first trimester and her weight gain has been excessive.

2.4 Gestation

Broome Hospital has a Level 2a Special Care Nursery. Gestation cut off for Broome delivery, with the exception of emergencies, is 34 weeks. Consideration must also be given to the Estimated Foetal Weight (EFW) and other potential risk factors.

The gestation cut off for Derby and Kununurra is 37 weeks. If a woman presents in labour between 36 and 37 weeks, the case must be discussed with the regional obstetrician, paediatrician and the local DMO team, and may be permitted to stay if care for the preterm neonate can be adequately provided.

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2.5 Remote Area Transfers

In general, pregnant women from remote areas with low risk pregnancies are to be transferred to the confinement location late in pregnancy, most often at 37 weeks.

2.6 Twins

Twins are excluded from delivery at Derby and Kununurra hospitals, but every effort will be made to accommodate twin pregnancies reaching 35 weeks without significant complication or risks, for delivery in Broome. In general, women with twin pregnancy are to be transferred to the Broome Hospital at 34 weeks. Each woman will require an individual assessment and plan based on their circumstances.

2.7 Diabetes

Patients who have well controlled gestation diabetes (GDM) on diet control or low dose oral hypoglycaemics and have no foetal concerns may be considered for delivery at Kununurra or Derby Hospitals. These cases should be discussed with the regional obstetrician and at the multi-disciplinary team meetings so as to determine if they are suitable for delivery at the local hospital.

Patients with type one or type two diabetes, or GDM requiring insulin or having moderate or poor glycaemic control must be transferred to Broome at 34-35 weeks gestation.

2.8 HIV

All women with HIV are to be referred to a tertiary centre.

2.9 Prior Exclusion Criteria

With a specialist O&G available in **Broome**, many prior exclusion criteria no longer apply.

- **Previous Caesarean sections**

  There is no automatic restriction on the number of previous C/S that can deliver in Broome hospital. It is important however, to advise all women with prior multiple caesarean deliveries of the proven increasing risks with each delivery and counsel them to strongly consider family completion particularly after the fourth C/S.

  For Derby and Kununurra Hospitals, women who have had two (2) previous caesarean sections must have the notes of the previous surgery and the patient's risks factors reviewed and the case discussed with the regional obstetrician and at the local multidisciplinary team meeting as to the most appropriate place for the patients' 3rd caesarean section to be performed. Women who have had a difficult second c/s, significant other risk factors or have had 3 or more previous c/s should be transferred to Broome Hospital or a tertiary health service.

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- **Prior Termination**

  Multiple prior terminations are not exclusion criteria for delivery anywhere in the Kimberley.

- **Adolescent pregnancy and substance abuse**

  While the specific programs for adolescent pregnancy and substance abuse in pregnancy at KEMH are excellent programs, neither young maternal age nor substance abuse is a reason for transfer out of the Kimberley unless there is genuine belief the girl is in danger at home, more likely to attend school in Perth, and / or may comply with an abstinence program in Perth.

  Prior experience has demonstrated that those referred to these programs do not consistently attend. This has been discussed with the program leaders at KEMH who agree there needs to be special circumstances for transferring a patient away from their home.

  For substance abuse patients, risk of withdrawal for the neonate must be discussed with the regional paediatrician, and a decision made regarding the most appropriate place for the delivery that can provide the required neonatal care.

2.10 High Risk Pregnancy Clinic

A High-Risk Pregnancy Clinic is conducted weekly at Broome hospital by the Regional Obstetrician and High Risk Coordinator (Midwife). Referrals should be undertaken for the following conditions and any other case deemed as high risk by the primary care team:

- Pre-existing medical conditions:
  - cardiac disease
  - diabetes
  - thyroid disease
  - connective tissue disease such as Systemic Lupus Erythematosus (SLE)
  - pre-existing hypertension
  - haematological disorders
  - previous venous thromboembolism
  - gastrointestinal disorders.
- Pre-existing gynaecological or structural uterine abnormalities or uterine surgery apart from lower uterine segment caesarean section
- Previous spontaneous pre-term delivery. These referrals should be undertaken by 12 weeks to allow all treatment options.
- Multiple pregnancy

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- Disorders arising during the pregnancy
  - Poorly control Gestational Diabetes
  - Red Blood Cell Antibodies
  - Pre-eclampsia
  - Abnormalities of Foetal Growth
  - Intrahepatic Cholestasis of Pregnancy
- Previous poor obstetric history including FDIU.

Some of these patients, if very complex, will continue through the High-Risk Obstetric Clinic. Many will be reviewed through the clinic intermittently after a plan has been made, and will continue to have their routine antenatal care at BRAMS or with the DMO, Midwifery Group Practice (MGP) or core midwife antenatal clinics. Patients identified as potentially high risk of complications in delivery must have their labour actively overseen by the on call regional obstetrician.

3. Definitions

RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
DMO	District Medical Officer
KEMH	King Edward Memorial Hospital
BRAMS	Broome Aboriginal Medical Service

4. Roles and Responsibilities

Regional Obstetrician
The Regional Obstetrician is to be available for consultation

District Medical Officer - Obstetrics
All obstetric DMOs are to refer to this procedure when considering ongoing care of high risk antenatal patients. All decisions regarding ongoing care at site are to be made in consultation with the multidisciplinary maternity care team, and must include the regional obstetrician.

Midwife
All midwives are to refer to this procedure when caring for women in the antenatal period. When a variance from normal arises during a woman's care, it is recommended the midwife undertakes one or more of the following steps:

A. Discuss the situation with a senior colleague – clinical midwife, and / or with a medical colleague.
B. Consult with a medical or other health care provider.
C. Use the exclusion criteria listed in this procedure, in collaboration with the medical officer, to assist in determining whether there is a need for transfer to a secondary or tertiary unit.

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5. Compliance

Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Evaluation

This procedure is to be reviewed by the Regional Obstetrician every two years or as required.

7. Standards

National Safety and Quality Healthcare Standards (Second edition 2017) - 1.7, 5.5, 5.6, 6.4, 6.9, 6.10, 7.10

8. References

Australian College of Midwives - National Midwifery Guidelines for Consultation and Referral, 3rd edition, Issue 2, 23rd Feb 2015.

Queensland Health, Clinical Services Capability Framework, version 3.2, October 2014

King Edward Memorial Hospital (KEMH) Guidelines, guideline section B- 1.1.2.1, 1.1.2.2, 1.1.2.3

WA Health Clinical Services Framework 2014-2024

The Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) Statements/ Guidelines ‘ Antenatal care in pregnancy’

9. Related Policy Documents

WACHS Maternity Body Mass Index Risk Management Policy 2012

This document can be made available in alternative formats on request for a person with a disability

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