Specialist Obstetrician Services Procedure

Effective: 26 February 2019

1. Guiding Principles

The Albany Health Campus (AHC) provides level 4 Obstetrics and a level 3 Newborn Services, according to the WA Health Clinical Services Framework[1], and employs specialist obstetricians to support obstetric care provision in the Great Southern region (GSR). The Albany Health Campus, like all WA Country Health Service (WACHS) sites, seeks to comply with relevant policies and procedures including the WACHS Maternity and Newborn Services Policy. [2, 3]

The WACHS Maternity and Newborn Services Policy of September 2011 outlines a clear expectation that each unit providing obstetrics and newborn services will clearly define referral and escalation plans for local use. Such referral procedures and escalation pathways ensure that all clinicians provide a safe service in line with their scope of practice and the service level available at Albany Hospital.

In accordance with WACHS policy, General Practice Obstetricians (GPOs) are credentialed to deliver maternity and newborn service up to level 3 while specialist can provide services above this level. [1]

The AHC continues to support a General Practice model of care and GPOs will continue to maintain overall clinical responsibility for their patients. The role of Specialist Obstetricians in this regard will consist of directing Obstetric care as well as providing clinical support and governance.

In this model, GPOs, Specialist Obstetricians, midwives along with other care providers are to work in a collaborative manner to maintain the standard of obstetrics and newborn care and improve it where necessary.

Purpose and scope

The aim of this document is to serve as the blueprint that sets out the pathway identifying the conditions and situations that require the input of a Specialist Obstetrician. This will assist GPOs and other health care providers in determining when the input of a Specialist Obstetrician is required in the Albany Hospital, as a level 3 Neonatal and a level 4 Obstetrics Service provider.

2. Procedure

2.1 Antepartum care

Specialist Antenatal Clinic at the Albany Health Campus (AHC)

Background

Specialist Antenatal clinics at AHC support existing antenatal clinics conducted by GPOs for their patients in the region. The Specialist ANC fulfils the collaborative care expected by WACHS[1] between GPOs credentialed to deliver a level 3 service and the Specialist Obstetricians delivering services at levels 4 and above. This is in accordance with the WACHS Maternity and Newborn Services Policy and to the extent that resources and local variations allow.

This document aims to provide clarity with regard to the indications and escalation pathway to the specialist ANCs. It will also ensure that timely and appropriate referral of women (identified as being at higher risk of complication in pregnancy) to the Specialist ANC takes place. The referring GPO retains the overall clinical responsibility for the patient and will arrange referral to King Edward Memorial Hospital (KEMH) where indicated. The Specialist Antenatal Clinic will not take over the care of any pregnant woman but is to provide guidance, advice and recommendations to both patients and referring GPOs.

The referral indications listed below are mainly based on the WACHS Maternity and Newborn Services Policy[2]. These indications are by no means exhaustive and hence GPOs are advised to refer any pregnant patient requiring a level 4 review in accordance with WACHS policy.[3]

Referral Criteria to the Specialist Antenatal Clinic

Pre-existing maternal medical conditions:

- Poorly controlled thyroid disease
- Epilepsy with seizures in past 12 months
- Rheumatic / other heart disease
- Renal disease
- Autoimmune disease such as SLE
- Respiratory disease such as severe asthma
- Previous thromboembolic disorder or known coagulopathy (von Willibrands, ITP)
- Cone biopsy/cervical amputation.

Risk factors in previous obstetric history:

- Previous preterm delivery less than 35 weeks
- Suspected cervical incompetence
- Previous history of significant shoulder dystocia
- Previous history of FDIU/SB/NND/Perinatal morbidity (referral for known causes like aneuploidy, at the discretion of the GPO)
- Previous significant IUGR with fetal weight under 2.5kg
- Previous severe PET or HELLP syndrome
- Symptomatic 3rd/4th degree tear.

Risk factors in current pregnancy:

- Diabetes requiring insulin
- Multiple pregnancy
- Suspected cervical incompetence
- Breech at 35-36 weeks if ECV is being considered
- Development of IUGR/SFGA or macrosomia
- Proteinuric hypertension (140/90mmHg)
- Any low lying placenta/placenta previa persisting at 32weeks
- Polyhydramnios/oligohydramnios
- Active blood group incompatibility.

Referral Procedure to the Specialist Antenatal Clinic

The steps outlined below are to be followed by referring GPOs where referral to the specialist ANC is indicated.

- Complete and fax the Specialist ANC referral template.
- The Specialist ANC administrator is to contact the patient and offer her an appointment. Specialist ANC clinic slots are available most Wednesdays and Friday afternoon and a clinic appointment will be offered usually within two weeks.
- The outcome of the specialist consultation is to be relayed to the referring GPO by fax and a copy given to the patient to return to her GPO.
- Copies of the correspondence between the GPO and Specialist Obstetrician is to be retained in the patient's file in hospital.

Referral and Transfer of Patients to KEMH

The referring GPO is to discuss any antepartum referral to KEMH with the on-call Specialist Obstetrician in situations where the specialist team are not already aware of such transfer.

Other Conditions and Services

- In accordance with WACHS policy[1], the Albany Hospital offers a level 3 neonatal service and therefore cannot support planned pre-term birth (under 37completed weeks) or planned term births that may require higher level of neonatal support (e.g. babies of diabetes patients on insulin). Transfer to KEMH under these conditions is to be arranged by the GPO in consultation with the on-call specialist.
- Diabetes requiring insulin: The specialist ANC can support the GPO in managing the pregnancy, but not the insulin or other aspects of their management. GPOs are advised to liaise with KEMH for input from obstetric physicians and for the birthing of these patients.
- Placenta previa persisting at or near term: Albany Hospital is currently unable to support planned placenta previa caesarean sections and GPOs are to arrange transfer to KEMH in consultation with the specialist obstetricians.
- Planned Home Birth: GPOs are advised to refer to the WACHS Great Southern Home Birth guidance.
- Albany Hospital maternity care standards will be based on the WACHS policy and KEMH guidelines except otherwise indicated.

- The Specialist Obstetrician on duty will be the clinical team leader for all aspects of the intrapartum care (including where emergency Caesarean Section is required) of twins/multiple pregnancy. This does not affect planned/elective Caesarean Section for uncomplicated twins at term.

Antepartum Admissions

Where a GPO admits a patient that falls into any category listed in this document (or for other significant reasons), the admitting GPO is to consult with the on-call Specialist Obstetrician regarding the case.

2: Intrapartum Care and Emergencies

Trigger List

The "trigger list" of conditions requiring the presence of a Specialist Obstetrician has been in place in Albany Hospital since December 2011. The trigger list is designed to provide a clear escalation pathway for health care providers and ensure a safe and patient-centred service that complies with WACHS policy[1]. With this is mind, this document details such mandatory conditions contained in the trigger list and divides them into three parts:

(a) Obstetrics Emergency: Trigger list requiring immediate attendance by all members of the obstetrics emergency team (OET) on duty

These conditions are:

(1) maternal collapse
(2) unstable and deteriorating maternal vital signs
(3) eclampsia/seizures
(4) obstetrics haemorrhage more than 1000ml and unresolved
(5) shoulder dystocia
(6) umbilical cord prolapse
(7) other major significant events.

The Obstetrics Emergency Team (OET) includes:

- **Senior midwife on duty**
- **GPO to the patient**
- **Specialist obstetrician on-call**
- **Obstetric Registrar**
- **Anaesthetist on duty**.

Given that some of the OET members are not always onsite, the responders to Code Blue events are to respond to these Obstetric emergencies along with those members of the OET onsite.

Responding to an Obstetric Emergency or Code Blue event

The attending staff (or their representative) will initiate the call by dialling **55** to the switch board stating that an **obstetric emergency and Code Blue** event has occurred**.** It is the responsibility of the senior midwife to contact the Obstetrician, and the Specialist Obstetrics team separately.

On arrival, the Code Blue team and available OET are to start attending to the patient and determine who the absent member(s) of the OET is (are). The switchboard is to be further contacted via **55** and informed of these absent members of the OET so they can be contacted by phone to attend.

(b) Trigger list requiring escalation to and attendance by the Specialist Obstetrician

The conditions listed below require that the attending GPO contacts the on-call Specialist Obstetrician for attendance. If they are unable to do so however, the attending midwife, anaesthetist or other health care providers may initiate the request for attendance if necessary.

1. Failed instrumental delivery
2. Trial of instrumental delivery
3. Vaginal breech delivery
4. Vaginal delivery of twins
5. 4th degree tear
6. EUA for Post-Partum Haemorrhage
7. Suspected ruptured uterus
8. Pre-eclampsia needing magnesium sulphate or emergency treatment of hypertension.
9. Malpresentation e.g. face, brow
10. Any Caesarean section for Placenta Previa/low lying placenta.
11. Emergency Caesarean section for suspected abruption.
12. Other conditions at the discretion of the GPO
13. Admission (planned or unplanned) of any high risk obstetric patient.

On arrival, the Specialist Obstetrician is to assume the role of clinical team leader for that episode of care and will determine the level of specialist involvement required.

(c) Trigger list requiring consultation by the GPO with the specialist Obstetrician on-call

In consultation with the GPO, the specialist obstetrician will decide if attendance is required in these cases:

(1) Caesarean section or vaginal birth in a patient with BMI of 40 or more
(2) Prior to the commencement of oxytocin for a trial of scar
(3) Intra-uterine death/Still birth/neonatal death

(4) Admission to high dependency unit (HDU)
(5) Unsuccessful induction of labour
(6) Preterm (<37weeks) rupture of membranes/ labour
(7) Significant APH
(8) Other significant issues of concern to the GPO.

Caesarean Section availability by the Specialist Obstetrics team

The specialist Obstetrics team is available to perform Caesarean Sections for patients of GPOs not credentialed to perform Caesarean Section. In cases of planned Caesarean Section, GPOs can access the service of the Specialist Obstetric team through the Specialist ANC. In cases of emergency Caesarean Section, the on-call Specialist Obstetrician can be contacted by the GPO.

Neonatal resuscitation arrangement for any birth where fetal distress is suspected or anticipated

In line with WACHS policy, a GPO will be asked to attend and act as lead neonatal resuscitator. The GPO acting in this capacity will work alongside the midwifery team.
In situations that involve procedures in theatre, the on-call Specialist Obstetrician is also to be called in by the patient's GPO.

These conditions have been divided into two categories to aid understanding.

1. Procedures occurring in the birthing room (normal vaginal and instrumental birth): Only the GPO acting as lead neonatal resuscitator is to be called in by the patient's GPO.

2. Procedures occurring in theatre (Caesarean Section, trial instrumental delivery): A GPO is to be called in to act as the lead neonatal resuscitator. In addition, the on-call Specialist Obstetrician is to be consulted by the patient's GPO. This is made up of the three categories below:

- Trial of instrumental delivery**:** A GPO (e.g. on the roster) is to act as lead neonatal resuscitator. The attending on-call Specialist Obstetrician is to determine the level of specialist involvement required.
- Caesarean section where the GPO to the patient is credentialed for Caesarean section: A GPO (e.g. on the roster) is to act as lead neonatal resuscitator. The on-call Specialist Obstetrician is to either act as second surgeon or delegate this role to the obstetrics registrar.
- Caesarean section where the GPO to the patient is not credentialed for Caesarean section**:** A GPO (e.g. on the roster) is to act as lead neonatal resuscitator. The on-call Specialist Obstetrician is to either act as lead surgeon or delegate this role to the obstetrics registrar.

Management of women with High BMI:
Please refer to the Elective Surgical and Obstetric Patients with an Elevated Body Mass Index, Management of Procedure (9)

It is recognised that women with high BMI in pregnancy pose additional obstetrics and anaesthetic risks. In some instances, the GPO to the patient will be advised to transfer such women to KEMH on safety grounds due to Albany Hospital's resource limitations. The GPOs to the women have the responsibility for organising such transfers. As per WACHS policy, the GPO to the women are to discuss and document the anaesthetic and obstetric risks, offer women the "obesity and pregnancy consumer" fact sheet and use the maternal BMI risk assessment and management tool. The Albany Hospital's procedure (adopted from WACHS policy) for managing these women is set out below:

- **Moderate Risk Women BMI 35-39.9:**
  - Calculate BMI based on earliest pregnancy visit at GP rooms
  - Obese II - at moderately increased obstetric and maternal risk
  - Recommended weight management: 4 kg gain
  - Follow relevant KEMH and WACHS guidelines
  - Except where otherwise indicated (presence of other obesity related comorbidity), GP obstetrician is to be the team leader for all aspects of the woman's intrapartum and postpartum care.

- **High Risk Women BMI 40-45:**
  - See early, calculate BMI based on earliest pregnancy visit at GP rooms
  - Obese III - Significantly increased obstetric and maternal risk
  - Recommended weight management : safe to lose up to 4 kg
  - Discuss weight management, dietician referral early
  - Discuss Absolute BMI limit for this site - BMI of 45 and above will need transfer to tertiary centre
  - Refer for anaesthetic consult and to specialist obstetrician clinic between 24-30 weeks
  - Follow relevant KEMH and WACHS guidelines
  - Shared antenatal care with consultant obstetrician
  - Will need specialist obstetrician input for intrapartum and immediate post-partum care.

- **Transfer to KEMH for birth:**
  - All women with booking BMI more than 45
  - Women with BMI 40- 45 on the advice of either the consultant anaesthetist or consultant obstetrician.

The Datix Clinical Incident Management System (Datix CIMS) form is to be used to monitor the escalation process contained in this document as a safety and quality activity to evaluate the process, patient outcome and identify any clinical risk.

3. Abbreviations

FDIU	Fetal death in-utero
SB	Still birth
NND	Neonatal death
IUGR	Intrauterine growth retardation
SFGA	Small for gestation age
PET	Pre-eclamptic toxaemia
HELLP	Haemolysis. Elevated liver enzymes and low platelets
SLE	Systemic lupus erythematosus
ITP	Idiopathic thrombocytopenic purpura
ECV	External cephalic version
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
ANC	Antenatal Clinic
OET	Obstetric Emergency Team
BMI	Body mass index
WACHS	WA Country Health Service

4. Roles and Responsibilities

The Specialist Obstetricians Services Procedure aims to enlist clinical settings requiring escalation and consultation with the Specialist Obstetrician.

The Chair of the Obstetric Review Group (ORG) and the members have responsibility in overseeing the implementation of The Procedure.

All staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

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

Monitoring of compliance with this document is to be achieved through clinical governance processes including:

- clinical incident and adverse event reporting and investigation
- sentinel event reporting, monitoring and clinical investigation
- two monthly perinatal mortality and morbidity review and presentation to the Obstetric Review Group (ORG) at two monthly meetings

The ORG and its Chair are responsible for undertaking at least two yearly reviews of the Procedure and implementation of recommendations.

7. Standards

National Safety and Quality Health Service Standards (Second edition 2017) - 1.1b, 1.1c, 1.7a, 1.27a, 2.5a, 2.5b, 2.6, 2.7, 5.3, 5.5, 6.1, 6.11, 8.8, 8.10

8. References

1. WA Health Clinical Services Framework 2014-2024
2. WACHS Maternity and Newborn Policy
3. WACHS Maternity and Neonatal Consultation and Referral Guideline for Clinical Service Levels - January 2017
4. King Edward Memorial Hospital (KEMH) Clinical Guidelines
5. WACHS intranet page: Obstetrics and Gynaecology Guidelines: for WACHS Clinicians and Managers
6. RANZCOG: Maternal suitability for models of care, and indications for referral within and between models of care - March 2018
7. The Whole Nine Months Booklet, First Edition, November 2014
8. WACHS Primary Postpartum Haemorrhage Guideline Change of Practice Update, January 2018
9. WACHS Maternity Body Mass Index Risk Management Policy, June 2018
10. WACHS Management of Elective Surgical and Obstetric Patients with an Elevated Body Mass Index, Management of Procedure - March 2016
11. WACHS Clinical Escalation Including Code Blue Medical Emergency Response (MER) Policy, January 2018
12. WACHS Operative Vaginal Delivery Procedure

9. Related Policy Documents

KEMH Induction of Labour Guideline

WACHS Electronic Fetal Heart Rate Monitoring Policy November 2018

WACHS Credentialing Requirements for Non-Specialist Obstetricians Guideline, October 2015

KEMH Antenatal Shared Care - Guidelines for General Practitioners, Sixth Edition, June 2015.

WACHS Obesity, Bariatric Surgery and Pregnancy - Consumer Fact Sheet, June 2018

WACHS Maternity and Newborn Services Policy

WACHS Induction of Labour Guideline

10. Related WA Health System Policies

Mandatory Policy MP 0086/18 Recognising and Responding to Acute Deterioration Policy v1.1

Operational Directive OD 0482/13 WA Health Policy for publicly funded Home Births including guidance for consumers, health professionals and health services (Revised October 2013)

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

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