

Exceptional People. Exceptional Care.



Mater Mothers' Hospital Guidelines for Consultation and Referral



Introduction

The Mater Mothers' Hospital Guidelines for Consultation and Referral is designed to help Primary Carers (a Midwife or General Practitioner) provide the best possible care for women during pregnancy. As the Primary Carer, you will be the first port of call for women seeking advice and/or treatment for a variety of health conditions.

This guide will help you decide the best course of action, depending on the severity of a woman's health condition. Should a condition be identified that is not included in this booklet, a consultation with a Specialist Obstetrician should occur.

The Guidelines for Consultation and Referral are underpinned by:

- Principles of Clinical Governance
- Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Midwife (2006)
- Scope of Practice (QNC, 2001)

Each of the health concerns listed in this guideline have a recommended course of action that will be categorised by the letters A, B and/or C, further explained below:

A. Discuss

- The Primary Carer shall provide clinical care and, if necessary, call upon a qualified health professional as may reasonably be expected to have the necessary skills and experience to assist them in the provision of care.
- The Primary Carer will recommend to the woman that consultation with a suitably qualified health professional is warranted, if her pregnancy, labour, birth or postnatal period (or the baby) may be affected by a suspected or recognised condition.
- It is the Primary Carers' responsibility to initiate a discussion with, or provide information to another practitioner, with whom the care is shared, in order to plan and provide care appropriately.
- Where a consultation occurs, the decision regarding ongoing clinical roles/responsibilities should involve communication between all carers including the Specialist Obstetrician, the Primary Carer and the woman concerned. This should include discussion of the need for and timing of any further review.
- The Specialist Obstetrician/health care professional will not routinely assume responsibility for ongoing care, they will work collaboratively with the Primary Carer to safely meet the wishes of the individual woman.
- Areas of discussion and involvement must be clearly agreed upon and clearly documented.



B. Consult

- Consult with a Mater Mothers' Hospital Specialist Obstetrician.
- A consultation refers to the situation where a Primary Carer recommends the woman consult a Specialist Obstetrician or where the woman requests another opinion.
- The individual situation of the pregnant woman is evaluated and agreements are made about the responsibility for maternity care based on the guidelines.
- It is the Primary Carer's responsibility to initiate a consultation and to communicate clearly to the Specialist Obstetrician that they are seeking a consultation.
- The consultation involves addressing the issue that led to the referral, a 'face-to-face' assessment, and the prompt communication of the findings and recommendations to the woman and the referring professional.
- Where a consultation occurs, the decision regarding ongoing clinical roles/responsibilities should involve communication between all carers including the Specialist Obstetrician, the Primary Carer and the woman concerned. This should include discussion on any need for, and timing of, any further obstetric review.
- The Specialist Obstetrician will not routinely assume responsibility for ongoing care, depending on the situation; they will work collaboratively with the Primary Carer to safely meet the wishes of the individual woman.
- After consultation with a Specialist Obstetrician, it should be clear whether primary care and responsibility continues with the primary carer or is transferred to the Specialist Obstetrician.
- The Specialist Obstetrician may be involved in, and responsible for, a discrete area of the woman's care, with the primary carer maintaining overall responsibility within their scope of practice.
- Where urgency, distance or climatic conditions make a 'face-to-face' consultation between a woman and a Specialist Obstetrician impossible, the Primary Carer must seek advice from the Specialist Obstetrician by phone. The Primary Carer should document this request for advice in their records, and discuss with the woman the advice received.
- Areas of discussion and involvement must be clearly agreed upon and clearly documented.

C. Transfer

- Transfer responsibility for the woman's care to a Mater Mothers' Hospital Specialist Obstetrician.
- When primary care is transferred, permanently or temporarily, from the Primary Carer to a Specialist Obstetrician, the Specialist Obstetrician assumes full responsibility for subsequent decision-making or for that period of care if temporary, in consultation with the woman.
- When primary care is transferred to a Specialist Obstetrician, if the Midwife is the Primary Carer, they may continue to provide midwifery care and support within their scope of practice, in collaboration with the Specialist Obstetrician.
- Areas of discussion and involvement must be agreed upon and clearly documented.



Indications at booking history

The following are specific indications for discussion, consultation and/or transfer of care when first discussing a woman's needs during a booking visit. The main purpose of the indication list is to provide a guide for risk selection.

1. Medical conditions

| | |
|---|-----|
| Anaesthetic difficulties | |
| Previous failure or complication (e.g. difficult intubation, failed epidural) | B/C |
| Malignant hyperthermia or neuromuscular disease | C |
| Cardiovascular disease | |
| A heart condition with haemo dynamic consequences | C |
| Hypertension | C |
| Chronic hypertension, with or without medication | C |
| Arrhythmia | B/C |
| Drug dependency and prescription medicine | |
| Use of alcohol and other drugs | B/C |
| Medicine use (Category B or higher) | B/C |
| Endocrine – Diabetes mellitus | |
| Pre-existing insulin dependent or non insulin dependent | B/C |
| Gestational diabetes requiring insulin | C |
| Gastroenterology | |
| Inflammatory Bowel Disease including ulcerative colitis and Crohn's disease | B/C |
| Genetic – any condition | B/C |
| Haematological | |
| Thrombo-embolic Disease | C |
| Coagulation disorders | C |
| Anaemia from any cause | B/C |
| Infectious diseases | |
| HIV-infection | C |
| Rubella | B/C |
| Toxoplasmosis | B/C |
| Cytomegalovirus | B/C |
| Parvo virus infection | B/C |
| Varicella Zoster virus infection | C |
| Hepatitis from all causes | B/C |
| Tuberculosis | C |
| Herpes genitalis | |
| Primary infection/recurrent | B/C |
| Syphilis | B/C |



| | |
|--|-------------------------------------|
| Neurological Epilepsy Subarachnoid haemorrhage, aneurysms Multiple sclerosis AV malformations Myasthenia gravis Spinal cord lesion Muscular dystrophy or Myotonic Dystrophy | B/C C B/C C C C C |
| Psychiatric disorders Care during pregnancy and birth will depend on the severity and extent of the psychiatric disorder | B/C |
| Renal function disorders Disorder in renal function, with or without dialysis Recurrent urinary tract infections Pyelonephritis | C B/C B/C |
| Respiratory disease Mild asthma Moderate asthma – requiring maintenance therapy Severe asthma | A/B B/C C |
| Autoimmune disease System/connective tissue diseases – these include rare maternal disorders such as systemic lupus erythematosus (SLE), anti-phospholipid syndrome (APS), scleroderma, rheumatoid arthritis, periarteritis nodosa, Marfan's syndrome, Raynaud's disease and other systemic and rare disorders | C |

2. Pre-existing gynaecological disorders

| | |
|---|------------------------|
| Pelvic floor reconstruction Refers to colpo-suspension following prolapse, fistula and previous rupture | B/C |
| Cervical abnormalities Cervical amputation Cervical cone biopsy Cervical surgery with or without subsequent vaginal birth Abnormal cervical cytology | C B/C B/C B/C |
| Myomectomy/hysterotomy | B/C |
| Infertility treatment | B/C |
| Pelvic deformities (trauma, symphysis rupture) | B/C |
| Female genital mutilation | B/C |



3. Previous obstetric history

| | |
|---|-------------------------------|
| Maternal antibodies against red blood cells or platelets eg Rhesus Isoimmunisation and Alloimmune thrombocytopenia | C |
| ABO-incompatibility | B/C |
| Hypertension | A/B |
| Pre-eclampsia | B/C |
| Eclampsia | C |
| Recurrent miscarriage (three or more times) | B/C |
| Pre-term birth (<37 weeks) | B/C |
| Cervical incompetence and cervical suture | C |
| Fetal growth Fetal Growth Restriction Small for Gestational Age (SGA) <10th centile or < 2.5kg after 37 completed weeks gestation Large for Gestational Age (LGA) | B/C B/C B/C |
| Previous difficult birth Shoulder dystocia Forceps or vacuum extraction Asphyxia (Defined as an APGAR score of <7 at five minutes) Caesarean section – LSCS Caesarean section – other | B/C A/B B/C B/C C |
| Perinatal death | B/C |
| Previous IUFD | B/C |
| Prior child with congenital and/or hereditary disorder | B |
| Postpartum haemorrhage > 1000mls | B/C |
| Placental abruption | B/C |
| Placenta accreta | C |
| Manual removal of placenta | A/B |
| 3rd or 4th degree perineal laceration Functional recovery No/poor function recovery | B C |
| Symphysis pubis dysfunction | A/C |
| Postnatal depression | A/B |
| Postpartum psychosis | C |
| Grand multiparity - defined as parity > 6 | A/B |
| Extreme of body mass BMI > 35 BMI < 18 | B/C B/C |
| Lack of social support | A/B |



4. Indications developed/discovered during pregnancy

The following are indications for discussion, consultation and/or transfer of care in response to conditions or abnormalities that are identified during pregnancy. The main purpose of the indication list specific is to provide a guide for risk-selection.

| | |
|--|-----------------|
| Uncertain dates after 20 completed weeks | B/C |
| Laparotomy during pregnancy | C |
| Abnormal cervical cytology – CIN II or higher | B/C |
| Psychiatric disorders | B/C |
| Hyperemesis gravidarum requiring admission to hospital | B/C |
| Suspected fetal abnormality or increased risk for fetal abnormality | B/C |
| Spontaneous rupture of membranes before 37 completed weeks | C |
| Hypertension arising in pregnancy – systolic BP > 140mmHg and/or Diastolic > 90 mmHg | B/C |
| Eclampsia | C |
| Coagulation disorders | B/C |
| Vaginal bleeding in the 2nd or 3rd trimester or suspected placental abruption | B/C |
| Placental abruption | C |
| Size/date discrepancy <ul style="list-style-type: none"> • Small for dates • Large for dates (Symphysis fundal height > 3cm or < 3cm from gestational age) | B/C B/C |
| Post-term pregnancy – longer than 41 completed weeks | B/C |
| Threatened pre-term labour | B/C |
| Suspected cervical incompetence | C |
| Multiple pregnancy | C |
| Abnormal presentation at 36 completed weeks | B/C |
| Breech presentation- consideration for ECV at 37 weeks | C |
| Suspected Cephalic Pelvic Disproportion (CPD) | B/C |
| No prior antenatal care prior to 28 completed weeks | B/C |
| Fetal death in utero | C |
| Endocrine disorders Diabetes – including gestational diabetes Thyroid disease | C B/C |
| Other endocrine disorders | B/C |
| Gastroenterology Cholestasis Inflammatory Bowel Disease Abnormal Liver Function Test (LFTs) | C B/C B/C |
| Haematological | |



| | |
|--|-----|
| Thrombosis | B/C |
| Coagulation disorders | B/C |
| Anaemia | B/C |
| Infectious diseases | |
| Hepatitis from all causes | B/C |
| HIV-infection | C |
| Rubella | B/C |
| Toxoplasmosis | B/C |
| Cytomegalovirus | B/C |
| Parvo virus infection | B/C |
| Varicella Zoster virus infection | C |
| Tuberculosis – this refers to an active tuberculous process | C |
| Genital Herpes | |
| Primary infection | B/C |
| Recurrent | B/C |
| Syphilis | B/C |
| Renal function disorders | |
| Recurrent urinary tract infections | B/C |
| Pyelonephritis | B/C |
| Respiratory disease | |
| Asthma | A/B |
| Severe chest infection | B/C |
| Pyrexia of unknown origin | B/C |
| Abdominal pain of unknown origin | B/C |
| Baby for adoption | B/C |
| Symphysis pubis dysfunction | B/C |
| Fibroids | B/C |

The Mater Mothers' Hospital Guidelines for Consultation and Referral are adapted from the following standards/practice guidelines:
Australian College of Midwives, (2001) National Midwifery Guidelines for Consultation and Referral: ACM.

National Collaborating Centre for Women's and Children's Health, (2003) Antenatal care: routine care for the health pregnant woman. Clinical Guidelines: Funded to produce guidelines for the NHS by NICE.

Three Centres Consensus Guidelines on Antenatal Care Project, Mercy Hospital for Women, Southern Health and Women's and Children's Health (2001): www.dhs.vic.gov.au/ahs/quality/effect.htm

Compiled by Anne Moore, Practice Development Midwife, Multi-disciplinary Antenatal Services Review Team, May 2007

Copyright © Mater Misericordiae Health Services Brisbane Limited ACN096 708 922

Notice: No part of this document may be produced by any process, electronic or otherwise, in any material form or transmitted to any other person or stored electronically in any form, without the prior written permission of the copyright holder, except as permitted under the Copyright Act 1968 (CTH).

