8

Sandra Loveday [WRDHB]

From: Chris Smith [WRDHB]
Sent: Thursday, 10 September 2015 3:04 p.m.
To:
Subject: Email from Leona providing meeting minutes (Dec 14) and referal guideline literature for Maternity
Attachments: 6 Meeting anaes and mat services WDHB Dec 14.doc; referral-glines-jan12 Materniity.pdf 8a

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From:
Sent: Wednesday, 7 January 2015 3:59 p.m.
To:
Cc: Petr ; Chris Smith [WairDHB];
Subject: RE: Notes of meeting 17th Dec

Dear . bstetricians and anaesthesia team,

Please find attached my notes of decisions from the meeting. I've also added in in italics the results of the audit relevant to the BMI standard that I undertook.
I've also attached the maternity referral guidelines that are referred to in the body of the notes of the meeting.

Many thanks

From: .org.nz]
Sent: Tuesday, 6 January 2015 12:40 p.m.
To:
Cc:
Subject: Notes of meeting 17th Dec

Hello

Hope you had a good Christmas and New Year.
I'm just following up on our meeting on the 17th Dec and am wondering if you have written up the notes that you made and if I could have a copy?
We have a core staff meeting coming up and it would be good to feedback to the staff.
Thanks
Kind Regards

Charge Midwife Manager
Wairarapa DHB

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Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)

These guidelines, previously appended to the Section 88 Maternity Services Notice 2002, are to be used in conjunction with the Primary Maternity Services Notice 2007

Cover photo:
Kindly provided by Karen Schwoerer

Citation: Ministry of Health. 2012. *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)*. Wellington: Ministry of Health.

Published in February 2012 by the Ministry of Health
PO Box 5013, Wellington 6145, New Zealand
ISBN 978-0-478-37339-4 (print)
ISBN 978-0-478-37340-0 (online)
HP 5417

This document is available on the Ministry of Health's website:
www.health.govt.nz

Contents

List of figures

List of Tables

1. Purpose

These revised Referral Guidelines are intended to:

1. improve maternity care safety and quality
2. improve the consistency of consultation, transfer and transport processes
3. give confidence to women, their families and whānau, and other practitioners if a primary health care or specialist consultation, or a transfer of clinical responsibility is required
4. promote and support coordination of care across providers.

The Referral Guidelines are based on best practice and are informed by available evidence, expert opinion and current circumstances in New Zealand.

This version is based on the 2007 Ministry of Health publication *Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines)*. It has been extended to include:

- referral to a primary health care provider
- guidelines for emergency transport
- what to do when a woman declines referral, consultation or transfer of clinical responsibility, or care or transport in an emergency.

Revision of the Referral Guidelines

The Ministry intends these Guidelines to be reviewed at five-yearly intervals; the review of this version should be completed by December 2016. The Guidelines may be partially or wholly reviewed before this date if emerging evidence indicates a review is appropriate; or in the event of a significant change in policy or service structure, or any other matter that may affect the way the Guidelines are used.

The Guidelines were revised with the assistance of an Expert Working Group. The Ministry of Health wishes to acknowledge and thank the following people for their participation and contribution.

Maggie Banks	Midwife; editor *Birthspirit*
Sue Bree	LMC Midwife
Norma Campbell	Midwifery Advisor, New Zealand College of Midwives
Sharron Cole	Chair, Parents Centre
Gillian Gibson	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Karen Guilliland	CEO, New Zealand College of Midwives
Elaine Langton	New Zealand Society of Anaesthetists
Mark Peterson	Royal New Zealand College of General Practitioners
Corli Roodt	Midwifery Clinical Director, Waikato DHB
Joan Skinner	Midwife Researcher, Victoria University
Lynda Williams	Auckland Maternity Services Consumer Council
Mollie Wilson	CE, Paediatric Society

2. Guiding principles

The following principles about the care of women, babies and families/whānau through pregnancy, birth and the postpartum period underpin the Referral Guidelines.

1. The woman, her baby and family/whānau (as defined by the woman) are at the centre of all processes and discussions.
2. The woman should have continuity of maternity care through a single point of contact regardless of how her care is provided.
3. The woman has the right to receive full, accurate, unbiased information about her options and the likely outcomes of her decisions. The woman has a right to make informed decisions on all aspects of her care, including the right to decline care, and to decline referral for specialist consultation or transfer of clinical responsibility.
4. Practitioners are responsible for their clinical decisions and actions, and for acting within their competency and scope of practice.
5. The approach to referral for consultation, transfer of clinical responsibility and emergency transport will be nationally consistent, with some allowance for local needs and conditions.
6. Communication between all practitioners involved with the woman will include her, and will be open, clear, timely and appropriately documented.
7. Transfer of clinical responsibility is a negotiated three-way process involving the woman, her Lead Maternity Carer and the practitioner to whom clinical responsibility is to be transferred.
8. Practitioners are responsible for appropriately documenting their decisions, including any variation from the Referral Guidelines or other guidelines, and the circumstances of any such variation.

3. Categories of referral

These Guidelines define four categories of referral.

Table 1: The four categories of referral

Referral category	Consequent action
Primary	The Lead Maternity Carer (LMC) discusses with the woman that a consultation may be warranted with a general practitioner, midwife or other relevant primary health provider (eg, physiotherapist, lactation consultant, smoking cessation services, drug and alcohol services, maternal mental health services) as her pregnancy, labour, birth or puerperium (or the baby) is, or may be, affected by a condition that would be better managed by, or in conjunction with, another primary provider. Where a referral occurs, the decision regarding ongoing clinical roles and responsibilities must involve three-way conversation between the primary care provider, the LMC and the woman. This should include discussion of any ongoing management of the condition by the primary care provider. Clinical responsibility for the woman's maternity care remains with the LMC. A referral to a primary care provider may result in a referral for consultation or a transfer of clinical responsibility. In this event, the provider must notify the LMC of any referral or transfer.
Consultation	The LMC must recommend to the woman (or parent(s) in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. Where a consultation occurs, the decision regarding ongoing care, advice to the LMC on management, and any recommendation to subsequently transfer care must involve three-way conversation between the specialist, the LMC and the woman. This should include discussion of any need for and timing of specialist review. The specialist will not automatically assume responsibility for ongoing care. This responsibility will vary with the clinical situation and the wishes of the woman. A consultation may result in a transfer of clinical responsibility. In this event, the consulting specialist formally notifies the LMC of the transfer and documents it in the woman's records.
Transfer	The LMC must recommend to the woman (or parent(s) in the case of the baby) that the responsibility for her care be transferred to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The decision regarding ongoing clinical roles/responsibilities must involve three-way conversation between the specialist, the LMC and the woman. The specialist will assume ongoing clinical responsibility and the role of the LMC from that point on will be agreed between those involved. This should include discussion about timing of transfer of clinical responsibility back to the LMC when the condition improves. Decisions on transfer should be documented in the woman's records.

Referral category	Consequent action
Emergency	An emergency necessitates the immediate transfer of clinical responsibility to the most appropriate practitioner available. Responding to an emergency may include providing emergency transport by road or air to a facility able to provide the necessary level of care (see Process Map 5). In such circumstances the clinical roles and responsibilities are dictated by the immediate needs of the mother and/or baby and the skills and capabilities of practitioners available including those involved in providing emergency transport if it is required. The LMC is likely to have an ongoing role throughout the emergency, with the nature of that role depending on the other practitioners present.

Discussions about the timing of and transfer of clinical responsibility back to the LMC and/or other providers must involve the woman, the relevant specialist and the LMC.

4. Processes for referral for consultation and transfer of clinical responsibility

The following process maps set out referral processes: guidance for LMCs and other involved practitioners on referral for consultation, transfer and emergencies; and guidance on what to do if a woman declines any of these options.

Timing of referrals and transfer of clinical responsibility

The decision to refer and the timeliness of being seen will depend on factors such as the severity of the condition, the LMC's experience and scope of practice, the availability of services and the woman's access to them. All practitioners are responsible for their clinical decisions, including the timing of referral.

For these reasons the revised Guidelines do not include timing recommendations for each condition.

There may be situations when services required for a woman are not available in the area, or not available at the time she needs them (eg, the woman cannot be seen in outpatient clinic in a timely fashion). In this situation, the referring LMC should make the referral and document it in the woman's records. Where appropriate, the LMC should contact the service and advise it of the situation. The LMC should, where necessary, discuss other options for care with the woman.

Process maps

The process maps that follow show the steps for LMCs to undertake.

- A **Primary condition** in the referral criteria refers to a condition for which an LMC will discuss with the woman that referral to another primary care provider may be warranted.
- A **Consultation condition** in the referral criteria refers to a condition for which the LMC must recommend to the woman that a consultation with a specialist is warranted.
- A **Transfer condition** in the referral criteria refers to a condition for which the LMC must recommend to the woman that there is a transfer of clinical responsibility from the LMC to a specialist.
- An **Emergency condition** in the referral criteria refers to a condition that requires immediate transfer of clinical responsibility for care from the LMC to the most appropriate available practitioner (where possible).

The maps are designed to show the critical steps that should be undertaken in each instance. Flexibility is, however, important if the Referral Guidelines are to be used effectively. Local situations vary in their geography, demographics, workloads and workforce. Situations can change rapidly, especially in emergencies.

The aim is a consistent level of service that is delivered according to local needs and conditions. Women should have access to an evidence-based and consistently high standard of care, regardless of where they live. The ways that this standard of care is achieved may differ depending on local situations.

The process should provide a framework for, but not override, local protocols that have been developed involving a multidisciplinary approach to achieve the same outcome in ways that work for local needs and circumstances.

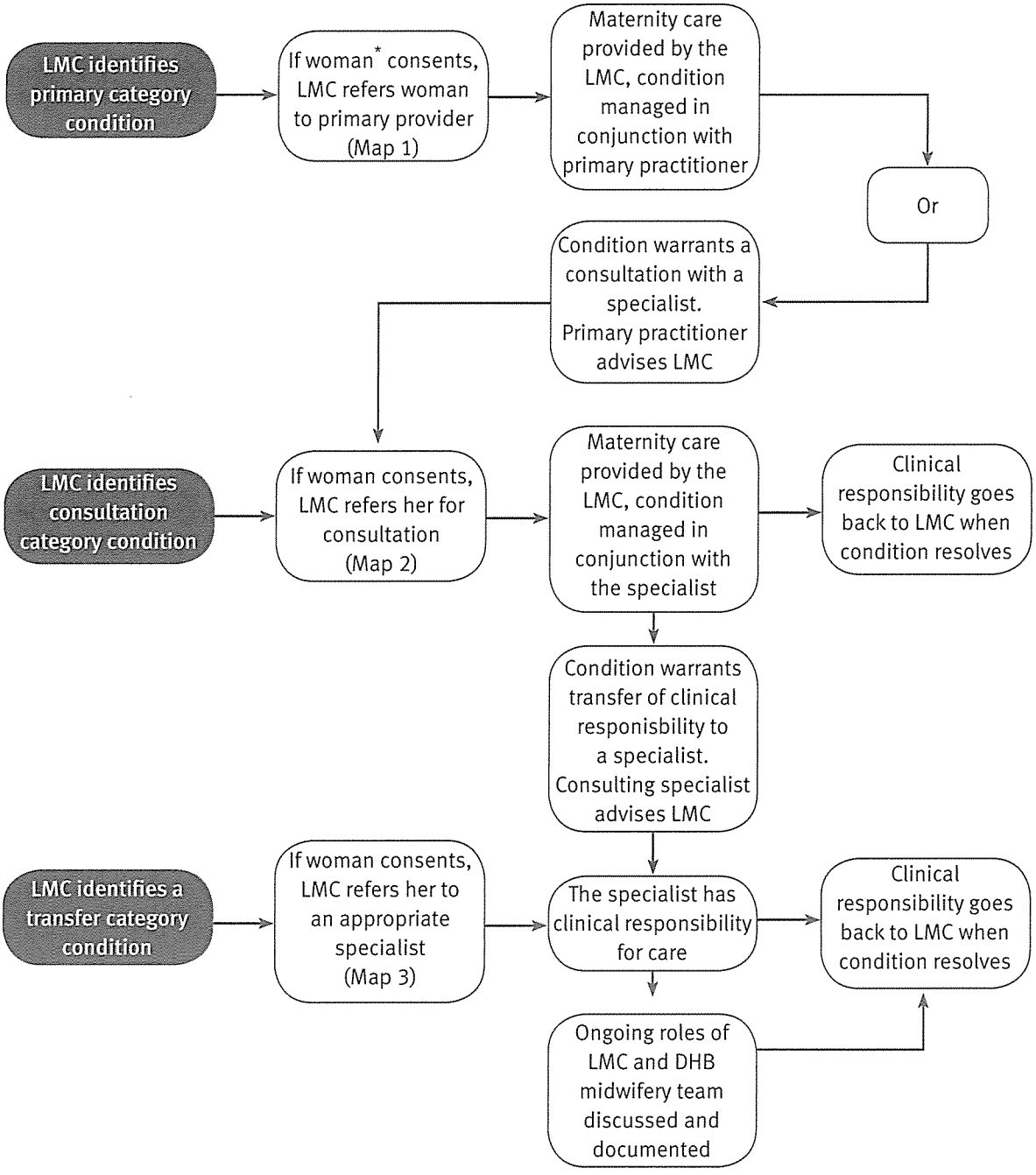
Key points common to all five process maps are that:

- the woman, her baby and family/whānau are at the centre of decision-making
- full and timely communication between practitioners is important
- documentation of all steps by all involved is necessary, particularly where there is transfer of clinical responsibility from one practitioner to another
- where LMCs transfer clinical responsibility for care to another practitioner and, where appropriate and with the agreement of the woman, they are able remain and continue to provide midwifery care within their scope of practice and competence, and with the support of the hospital team
- the process maps are a continuum: a referral may result in a specialist consultation or a transfer of clinical responsibility if that is found to be necessary.

Each of the five process maps must be used with reference to the process notes.

LMCs should not rely on the process maps alone for guidance.

Figure 1: Referral, consultation and transfer: process maps as a continuum



* The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care.

4.1 Process of referral from a LMC to a GP, midwife or other primary care provider

If an LMC finds (on booking or at any time) that a woman has a condition in the **Primary** referral category, the LMC discusses with the woman that a consultation may be warranted with a general practitioner (GP), midwife or other relevant primary health provider (eg, physiotherapist, lactation consultant, smoking cessation services, drug and alcohol services, or maternal mental health services).

There are many health-related conditions that may affect pregnant women and newborn infants. The list of referral criteria does not attempt to cover all of them but instead includes those of particular relevance during pregnancy. It may be appropriate for an LMC to recommend that a woman consult her GP or other primary care provider regarding a condition that is not listed.

Most New Zealand women are enrolled with a general practice or primary health care clinic which holds their medical records and provides care for ongoing medical needs. Many women attend their general practice to confirm pregnancy and receive initial advice. General practice and maternity care are separately funded. Maternity care provided by a midwife, a GP or a hospital team is free of charge to all eligible women; if a woman chooses a private specialist obstetrician, she pays a charge in addition to the government subsidy. General practice care is partially subsidised, and normally incurs a part charge even when it is provided to women who are pregnant. Charges are set by each practice.

The LMC must advise the woman that there may be a charge to her for her consultation with a GP or other primary care provider.

Roles and responsibilities

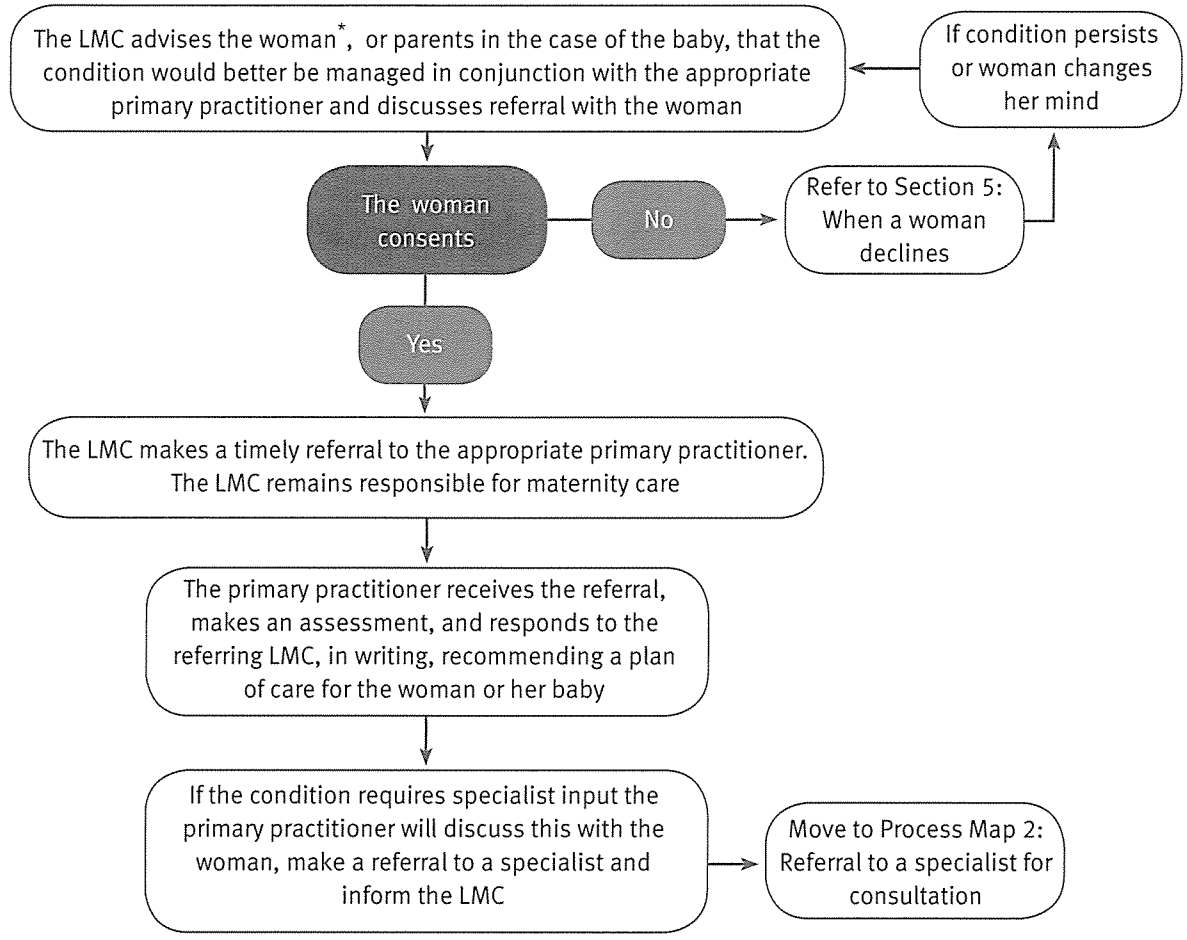
When a woman is referred by an LMC for primary care, the GP or other primary care provider may provide advice or ongoing management for the condition while the LMC retains the clinical responsibility for maternity care. The referral may result in a recommendation that the condition requires a referral for specialist consultation or a transfer of clinical responsibility, covered by the consultation or transfer process maps. In all cases, there is a professional responsibility to maintain communication, collaboration and documentation and to inform the LMC, in writing, of the outcome of the referral.

If a woman's pregnancy is confirmed by a GP who is not the woman's chosen LMC, the GP should provide all relevant information to the chosen LMC. If the woman does not already have an LMC, the GP should assist her to make a choice and offer to provide all relevant information. If the GP is the chosen LMC, it is their responsibility to assist the woman to find midwifery support that she is comfortable with. Likewise if an LMC confirms pregnancy and takes on maternity care for a woman, the LMC should advise the woman's GP (if she has one) and provide all relevant information to the GP.

Communication

Referral to another primary care provider requires the LMC to send adequate information to that provider, including any relevant maternity notes, test results, histories and so on. It also requires that the other provider notify the LMC of any subsequent referrals, any recommendations for management of the pregnancy by the LMC, changes in medication or management of the condition itself, test results or any other relevant information. Communication and information sharing by all parties must be timely, appropriate and complete.

Figure 2: Process Map 1: Referral to primary health care



* The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care.

4.2 Process notes for referral to a specialist for consultation

Conditions listed in the **Consultation** referral category are those for which the LMC must recommend to the woman that she has a consultation with a specialist. Consultation can be in the form of a discussion between the LMC and the specialist on the phone or by letter, and/or the specialist seeing the woman. The specialist consultation may be done by an individual practitioner, and may include review by a secondary services team.

If a woman sees her GP before she has chosen an LMC and the GP identifies a condition that requires a specialist consultation, the GP can refer as per Process Map 2. Once the woman has chosen an LMC, the GP should provide the LMC with all the relevant information.

In most cases the specialist will be an obstetrician; however in some circumstances a referral to another specialist, such as an anaesthetist, physician, psychiatrist, surgeon or paediatrician, may be appropriate.

Roles and responsibilities

At the time of the consultation, the responsibility for maternity care remains with the LMC. The specialist may advise the LMC of recommended monitoring or provide a care plan to be agreed in a three-way conversation between the specialist, the LMC and the woman. The specialist may be responsible for management of the specific condition if that is appropriate and warranted.

Communication

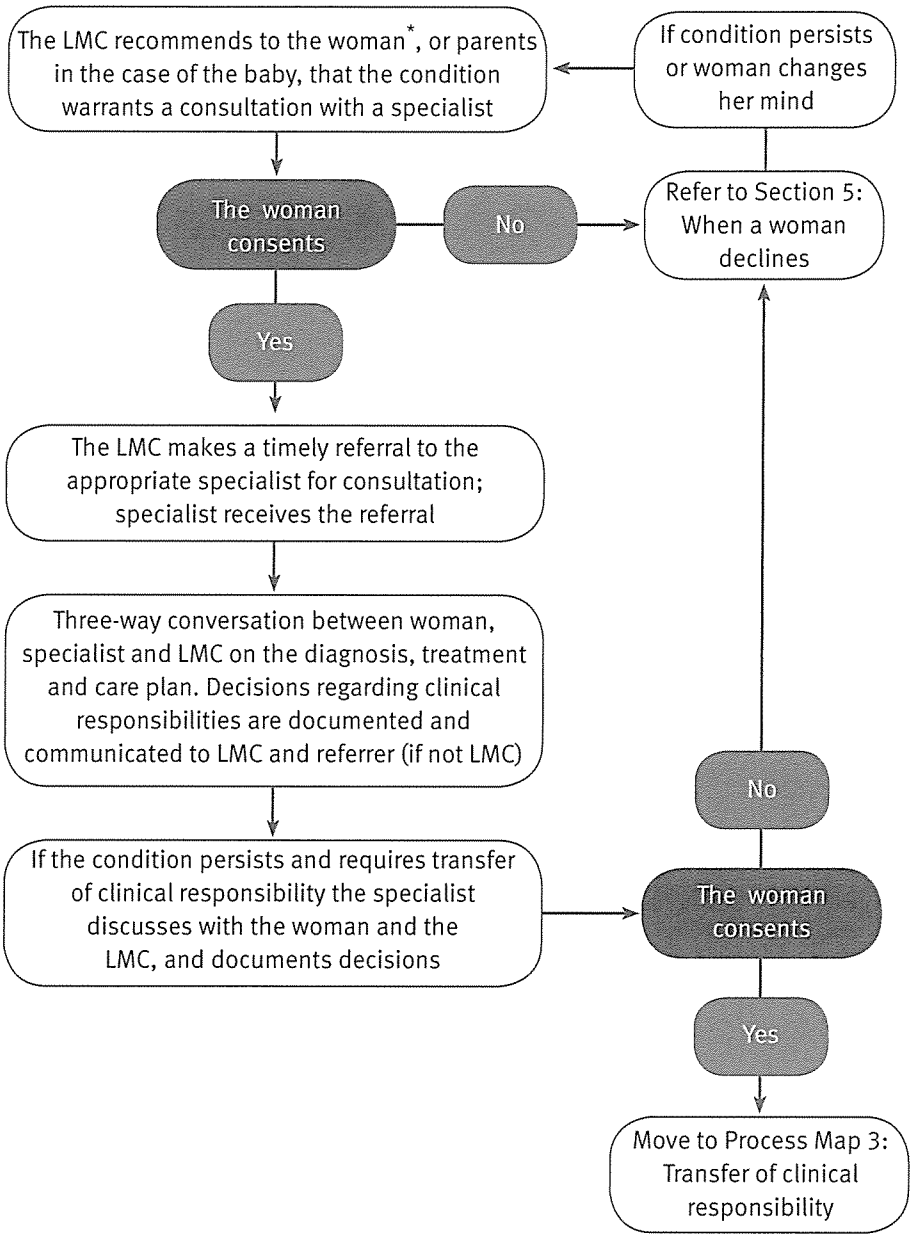
This process assumes that the decisions about a woman's care are based on a three-way conversation between the woman, the LMC and the specialist. The LMC should provide all necessary notes and information to the specialist along with the referral. If someone other than the woman's LMC is making the referral, the LMC needs to be informed. The specialist is responsible for informing the LMC (and the referrer, if different) of decisions, recommendations and advice following the consultation. It is the LMC's responsibility to provide any necessary information to the woman's GP.

Meeting local conditions

The process will need to take account of:

- capacity of local/regional secondary care services to see referred women in a timely manner
- access to the required specialist services in the area (eg, genetic services are not readily available in all areas of New Zealand)
- distances, time and cost for the woman to reach a hospital if she needs to be seen in person by a hospital-based specialist.

Figure 3: Process Map 2: Referral to a specialist for consultation



* The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care.

4.3 Process for transfer of clinical responsibility for care

Roles and responsibilities

Conditions listed as **Transfer** are those for which the LMC must recommend transfer of clinical responsibility from the LMC to a specialist. Once clinical responsibility for care is transferred, clinical decisions and decisions on the roles and responsibilities of all other practitioners involved with the woman's care rest with the specialist, taking into account the needs and wishes of the woman.

There is potential for LMCs to retain a role providing care for the woman, especially where the LMC is a midwife. Continuity of care should be preserved wherever possible. For example, where a woman who is pregnant with twins requires specialist oversight but continues to receive antenatal care from her LMC, the specialist has clinical responsibility.

An LMC may decline ongoing involvement with a woman's care if the clinical situation is outside their scope of practice or experience or unreasonably impacts on their workload.

Communication

The critical part of this process is documenting the point at which responsibility for coordination and provision of maternity care is formally transferred from the LMC to the specialist. This requires:

- a three-way conversation between the LMC, the woman and the specialist to determine that the transfer of care is appropriate and acceptable
- the LMC to provide all relevant information, including any relevant maternity notes, test results, and histories, to the specialist
- a discussion and documented decision about the nature of the ongoing role of the LMC or whether all care, including midwifery care, is transferred to the specialist and the DHB midwifery team.

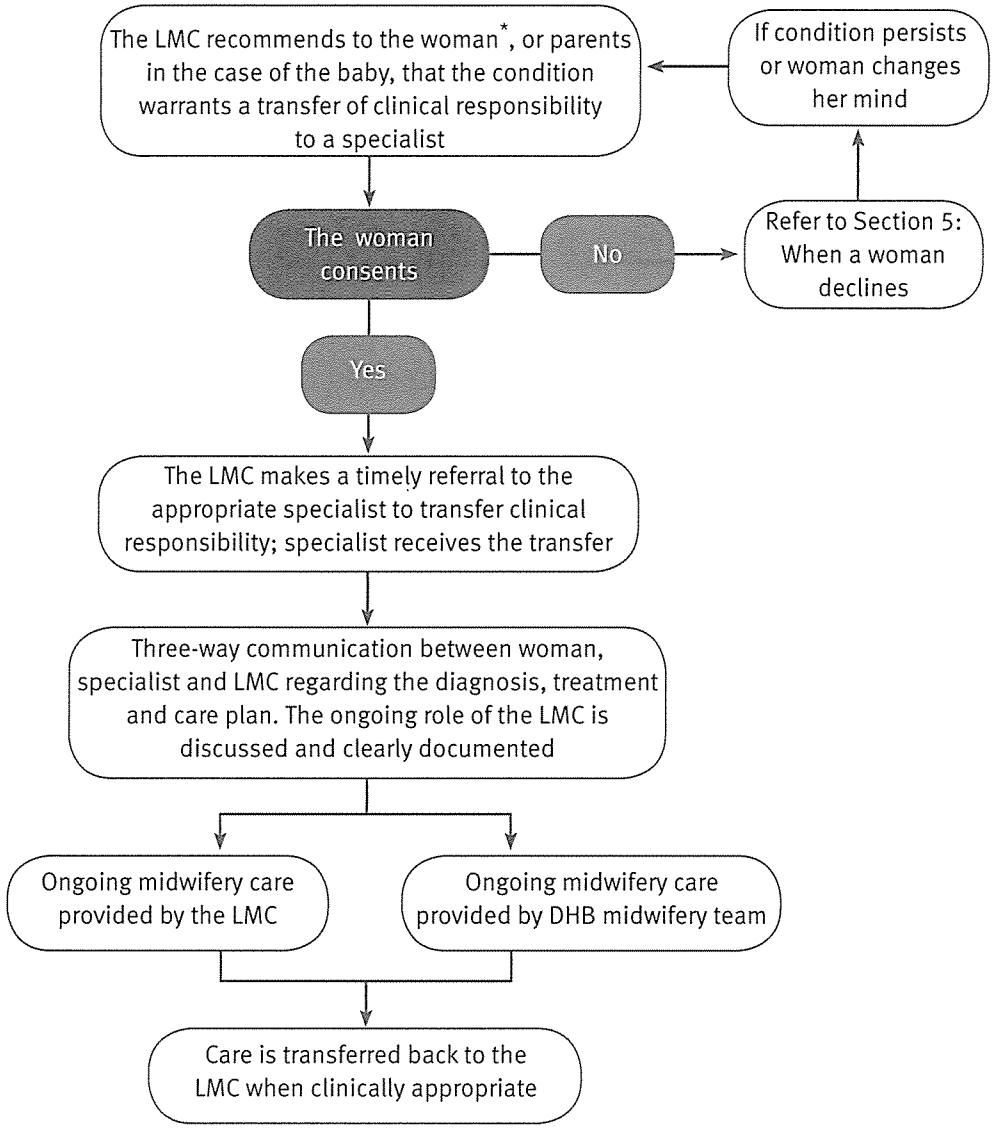
Transfer of clinical responsibility requires timely and full communication from the LMC to the specialist; and then from the specialist back to the LMC. All other practitioners involved in the process (eg, GP or other primary care practitioner) should be informed of the decisions made.

Meeting local conditions

The detail of transfer of care processes will differ depending on the scope of practice and experience of the LMC and others involved in the woman's care. It will also vary according to geographical considerations; some women may be transferred to the care of a specialist in the nearest main centre due to limited options in their local area.

A number of district health boards (DHBs) have formalised systems for tracking the transfer process. The steps in Process Map 3 should be reflected in local processes or protocols.

Figure 4: Process Map 3: Transfer of clinical responsibility for care



* The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care.

4.4 Process for emergency transfer of clinical responsibility

Conditions listed as **Emergency** are those that require immediate attention by the most appropriate practitioner available. The type of practitioner will depend on the specific condition and whether the emergency is taking place within a hospital, in the community or at a primary unit. The most appropriate practitioner may include (but is not limited to):

- midwives in addition to the woman's LMC and core midwives
- the nearest GP, especially in rural localities
- obstetricians, either in person or by telephone if no obstetrician is on site or the emergency is taking place in the community or at a primary facility
- an obstetric registrar on site at a tertiary maternity service
- an anaesthetist, paediatrician or other relevant specialist.

Roles and responsibilities

The roles and responsibilities during the emergency will be defined by clinical need. Generally, the most experienced and relevant practitioner will take the lead and advise others of what actions they should take. The LMC has the lead until such time as they transfer the clinical responsibility for care to the most appropriate practitioner (where this is possible). An obstetric emergency often but not always involves a transfer of clinical responsibility from an LMC if it requires transport to or occurs within a secondary or tertiary facility.

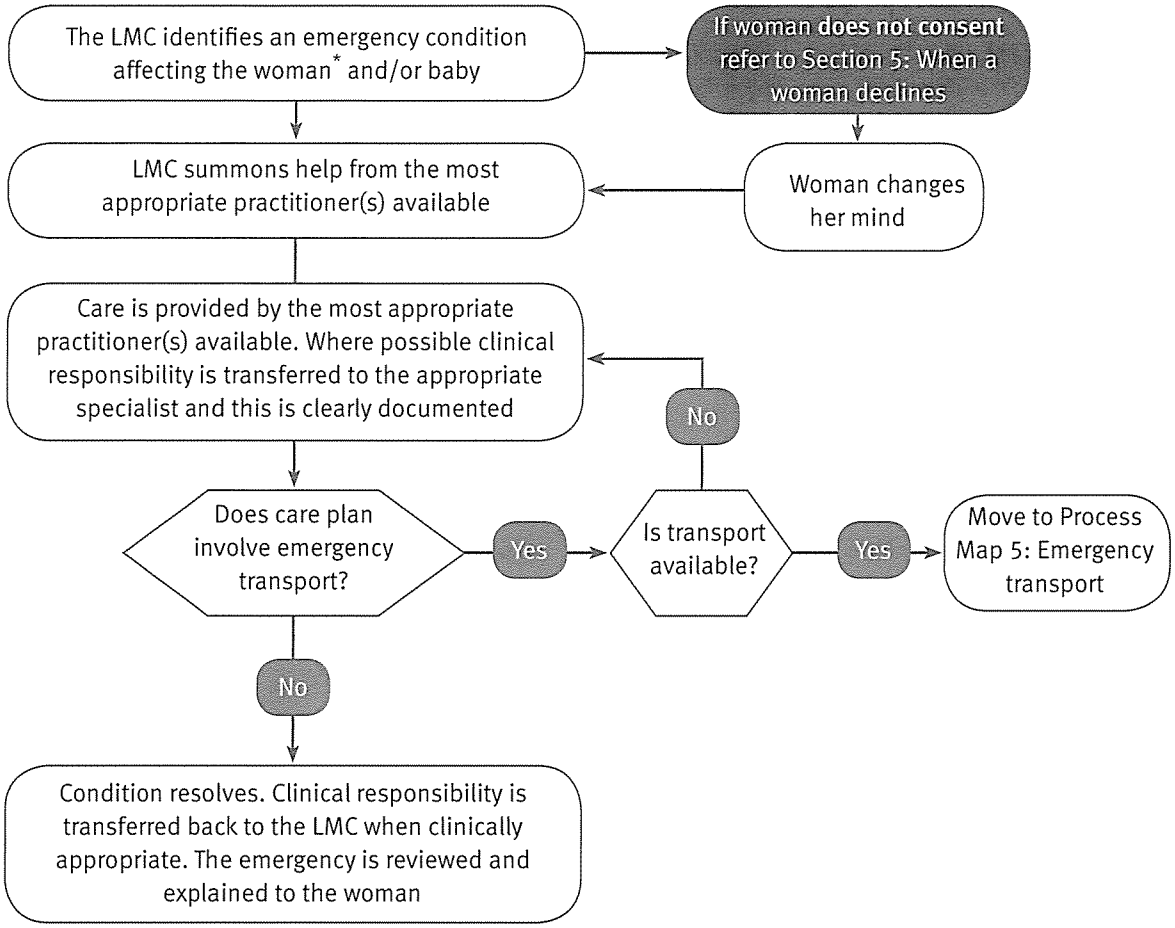
The transfer of clinical responsibility must be clearly established and documented at the time or as soon as practicable once the situation has stabilised.

Communication

Effective communication with the woman and her family/whānau (as defined by the woman) is essential in an emergency. The LMC must provide as much information as possible to the woman and her family/whānau, and to others responding to the emergency. It is expected that the LMC will have discussed the management of obstetric emergencies with the woman prior to the occurrence of such an emergency.

Communication with the woman may be difficult in some cases due to the nature of the emergency. Although the woman retains the right to decline treatment or transport and also the right to receive complete information, the situation may mean that a comprehensive discussion of benefits, risks and options is not possible. The woman may not be legally competent to make decisions due to the nature of the emergency. Under the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Regulations 1996, when a woman is not competent to make an informed choice, the provider may provide services in the best interests of the consumer.

Figure 5: Process Map 4: Emergency transfer of clinical responsibility



* The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care.

4.5 Process for emergency transport

Emergency transport refers to transport used in situations in which the woman must be moved from the community to a DHB facility, or between DHB facilities. During this period the LMC may be consulting and working with other practitioners as shown in Process Map 4. Transfer of clinical responsibility may have occurred before transport.

Clinical responsibility during transport

Until care is formally transferred to a specialist, the LMC retains clinical responsibility for care. This means that paramedics or ambulance crew must take clinical direction from the LMC when they are responding to an obstetric emergency.

If the LMC cannot provide a clinical escort during transport, clinical responsibility is transferred to the crew for the period of transport only. This clinical responsibility will normally be considered to have been transferred when the woman arrives at the DHB facility.

Transport between DHB facilities

Each DHB has a specific process for requesting emergency transport from one facility to another. LMCs should ensure they are aware of the processes in their local area. For the purposes of these Guidelines, DHB facilities include primary units, base hospitals and other DHB facilities from which women may need to be transferred in the event of an obstetric or neonatal emergency.

If the agreed emergency transport process is not practical in the situation or is not working (eg, due to communications difficulties), LMCs should follow the procedure detailed in Process Map 5 for transport from the community to a DHB facility.

Emergency transport resulting from a telephone consultation with a specialist

If an LMC consults with a DHB specialist and the decision made is that emergency transport is required, the specialist decides on the most appropriate mode of transport in consultation with the emergency services. The DHB must inform the LMC of what transport to expect. The process is the same regardless of mode of transport (ie, air or road). If the woman is being transported in a private car, the LMC must explain this to the DHB.

If it decides on the use of a retrieval team, the DHB must tell the LMC that the team is coming and when it can be expected, and provide any specific instructions to maintain clinical safety until the team arrives.

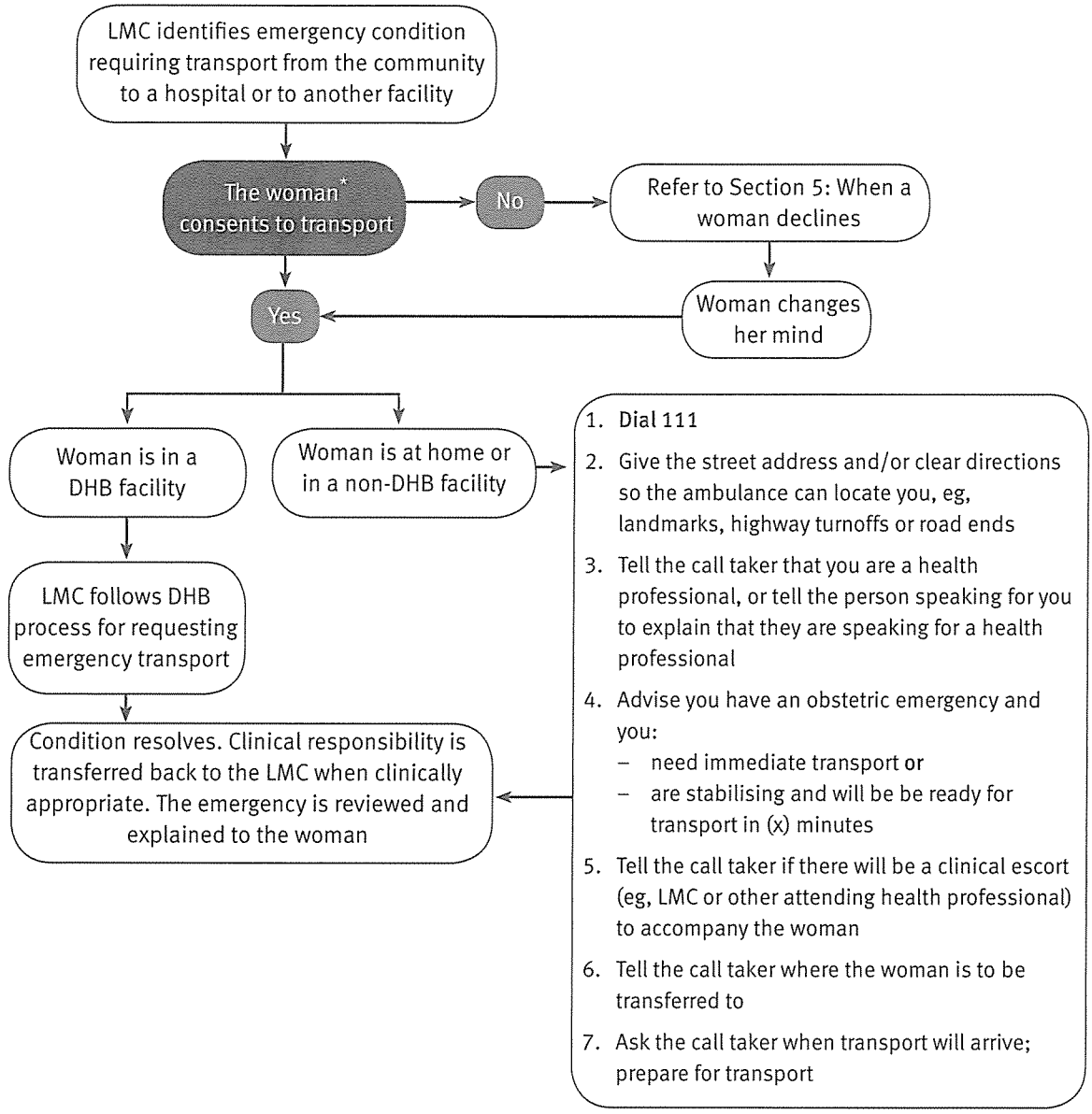
LMC responsibilities prior to and during the transfer process

In preparation, all LMCs should:[2]

- be familiar with the process of arranging an emergency transfer in their locality
- provide care until transport arrives – be prepared for a delay
- gain the informed consent of the woman
- provide up-to-date clinical records and necessary administrative data to facilitate transport and transfer.

2 New Zealand College of Midwives Transfer Guidelines, 2008

Figure 6: Process Map 5: Emergency transfer



* The woman, her baby and family/whānau (as defined by the woman) are at the centre of all conversations and decisions about her care.

5. When a woman declines a referral, consultation, transfer of clinical responsibility, emergency treatment or emergency transport

The right to informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility.

If a woman chooses not to be referred or not to consult with a specialist, her LMC may be left operating outside their experience or scope of practice, and/or may feel that they cannot provide the level of care the woman needs for her safety and the safety of her baby. The process maps reflect this possibility.

In the event that a woman declines a referral, consultation or transfer of clinical responsibility, the LMC should:

- **advise** the woman of the recommended care, including the evidence for that care
- **explain** to the woman the LMC's need to consider discussing her case with at least one of the following (ensuring that the woman's right to privacy is maintained at all times):
  - another midwife, GPO or GP
  - an appropriate specialist
  - an experienced colleague/mentor
- **share** the outcomes of the discussion and any resulting advice with the woman
- **document** in the care plan the process, the discussions, recommendations given and decisions made, and the woman's response.

If, after this process, resolution satisfactory to the LMC and the woman has not been reached, the LMC must decide whether to continue or to discontinue care.

If the LMC decides to continue care, she or he should:

- continue making recommendations to the woman for safe maternity care, including further attempts at referral
- engage other practitioners as appropriate for professional support (eg, secondary obstetric service, other midwives)
- continue to document all discussions and decisions.

If the LMC decides to discontinue care, she or he should:

- clearly communicate the decision and the reasons for it to the woman
- assist the woman to find alternative care within a reasonable timeframe.

In an **obstetric emergency**, the LMC cannot refuse to attend the woman. If the woman declines emergency transport or transfer of clinical responsibility while in active labour, the LMC should remain in attendance. The Guidelines recognise that this may result in the LMC being called on to

deal with a situation that is not within the LMC's scope of practice. It may be outside the LMC's experience or ability to safely deal with, or require treatment that the LMC cannot perform.

In these situations the LMC should:

- provide care within professional standards
- provide care to the best of their ability
- attempt to access appropriate resources and/or personnel to provide any needed care (dependent on the woman's consent)
- clearly document all discussions and actions
- debrief with clinical colleagues after the event with appropriate support.

When the woman/parents decline care for the baby

In the rare event that a woman or parents decline consent for treatment of her/their baby, LMCs should follow the guidelines above when discussing the baby's needs and treatment options with the woman or parents, and document all advice given and actions taken.

6. Conditions and referral categories

The following tables provide a list of conditions for which an LMC should advise or recommend to the woman that a referral, consultation or transfer of clinical responsibility takes place.

The referral categories are detailed in Section 3 of these Guidelines (page 3) and the processes that should be used are detailed in Section 4 (page 5).

LMCs must use their clinical judgement in deciding when and to whom to refer a woman. A condition that is normally a cause for a referral to a primary care practitioner may be severe enough on presentation to warrant a specialist consultation.

The referral categories may form part of a continuum. Placing a condition in the Consultation category does not preclude a subsequent transfer of clinical responsibility if that is indicated by the results of the consultation, or if the condition persists or worsens.

All decisions concerning a woman's care, including recommendations for referrals, consultations and/or transfer of clinical responsibility, must be made in discussion with the woman, and with all practitioners involved in her care.

If a woman wishes to have a consultation with a specialist or wishes clinical responsibility for her care to be transferred, she should discuss her request with her LMC.

Table 2: Conditions and referral categories

Code	Condition	Description	Referral category
1000–2000 Pre-existing and/or co-existing medical conditions			
Anaesthetics			
1001	Anaesthetic difficulties	Previous failure or complication (eg, difficult intubation, failed epidural, severe needle phobia)	Consultation
1002	Malignant hyperthermia or neuromuscular disease		Consultation
Autoimmune/rheumatology			
1003	SLE/connective tissue disorder	Active, major organ involvement, on medication	Transfer
1004		Inactive, no renal involvement, no hypertension, or only skin/joint problems	Consultation
1005	Thrombophilia including antiphospholipid syndrome	On warfarin, previous obstetric complications or maternal thrombosis	Transfer
1006		No previous obstetric complications or maternal thrombosis	Consultation
Cardiac			
1007	Arrhythmia/palpitations; murmurs	Recurrent, persistent or associated with other symptoms	Primary
1008	Cardiac valve disease	Mitral/aortic regurgitation	Consultation
1009		Mitral/aortic stenosis	Transfer
1011	Cardiac valve replacement		Transfer
1012	Cardiomyopathy		Transfer
1013	Congenital cardiac disease		Consultation
1014	Hypertension	>140/90 or on antihypertensive medication	Consultation
1015		>150/100	Transfer
1016	Ischaemic heart disease		Transfer
1017	Pulmonary hypertension		Transfer
Endocrine			
1019	Diabetes	Pre-existing (insulin dependent or non insulin dependent)	Transfer
1020		Gestational, well controlled on diet	Consultation
1021		Gestational, requiring insulin	Transfer
1022	Thyroid disease	Hypothyroidism	Primary
		Hyperthyroidism	Consultation
1023	Hypopituitarism		Consultation

Code	Condition	Description	Referral category
1024	Prolactinoma		Consultation
	Other known endocrine disorder significant in pregnancy	Eg, Addison's disease, Cushing's disease	Consultation
Gastroenterology			
1025	Cholelithiasis	Symptomatic	Primary
1026	Cholestasis of pregnancy		Transfer
	Previous fatty liver in pregnancy		Consultation
1027	Inflammatory bowel disease	Active or on medication	Consultation
1028		Inactive	Primary
1029	Hepatitis	Acute	Consultation
1030		Chronic active	Consultation
1081		Active chronic on immunosuppressants	Transfer
1031	Oesophageal varices		Transfer
Genetic			
1033	Marfan's		Transfer
1032	Any known genetic condition significant in pregnancy		Transfer
Haematological			
1034	Anaemia	Hb < 90 g/l, not responding to treatment	Consultation
1035	Haemolytic anaemia		Transfer
1036	Bleeding disorders	Including Von Willebrands	Consultation
1037	Thalassaemia		Consultation
1038	Thrombocytopaenia		Consultation
1039	Sickle cell disease		Transfer
1040	Thromboembolism	Emergency eg, previous deep vein thrombosis, pulmonary embolism	Transfer
1041	Thrombophilia		Consultation
Infectious diseases			
1042	CMV/toxoplasmosis	Acute	Transfer
1044	HIV positive		Transfer
1045	Listeriosis	Acute	Transfer
1046	Rubella		Consultation
1047	Syphilis		Consultation
1048	Tuberculosis	Active	Transfer
		Contact	Primary
1049	Varicella	Acute	Transfer

Code	Condition	Description	Referral category
Neurological			
1050	Arteriovenous malformation, cerebrovascular accident, transient ischaemic attacks		Consultation
1051	Epilepsy	Controlled	Primary
1052		Poor control or multiple medications	Transfer
1053	Multiple sclerosis		Consultation
1054	Myasthenia gravis		Transfer
1055	Spinal cord lesion		Transfer
1056	Muscular dystrophy or myotonic dystrophy		Transfer
Mental health			
1058	Current alcohol or drug misuse/ dependency		Primary
	Depression and anxiety disorders		Primary
1059	Other mental health condition	Stable and/or on medication eg, bipolar disorder	Consultation
		Acute unstable psychosis	Transfer
Renal disease			
1061	Glomerulonephritis		Transfer
1062	Proteinuria	Chronic	Consultation
1063	Pyleonephritis		Consultation
1064	Renal failure		Transfer
1065	Renal abnormality or vesico-ureteric reflux		Consultation
Respiratory disease			
1066/ 1067	Asthma	Mild or moderate	Primary
1068		Severe (continuous or near continuous oral steroids)	Consultation
1069	Acute respiratory condition		Primary
1070	Cystic fibrosis		Transfer
Transplant			
1080	Organ transplant		Transfer

Code	Condition	Description	Referral category
2000–3000 Previous gynaecological conditions or surgery			
2001	Cervical surgery including cone biopsy, laser excision or large loop excision of the transformation zone (LLETZ)	Without subsequent term vaginal birth (excluding LLETZ where histology available and depth of cone ‹ 16 mm). Note: previous spontaneous preterm birth requires consultation	Consultation
2003	Congenital abnormalities of the uterus	Without previous normal pregnancy outcome	Consultation
2007	Previous uterine surgery	Myomectomy	Consultation
2008		Previous uterine perforation	Consultation
2009	Prolapse	Previous surgery	Consultation
2010	Vaginal abnormality	Eg, septum	Consultation
2011	Female genital mutilation		Consultation
3000–4000 Previous maternity history			
3001	Previous placental abruption		Consultation
3002	Alloimmune thrombocytopaenia	As risk to fetus of thrombocytopenia	Transfer
3003	Caesarean section		Consultation
3004	Cervical incompetence		Transfer
3005	Trophoblastic disease	Hydatidiform mole or vesicular mole, within last 12 months	Consultation
3008	Hypertensive disease	Pre-eclampsia with significant intrauterine growth restriction (IUGR) or requiring delivery ‹ 34 weeks or with multi-organ involvement	Consultation
3009	Large for gestational age	Birthweight › 97th percentile on customised growth chart	Consultation
3010	Intra-uterine growth restriction (IUGR)	Birthweight ‹ 5th percentile on population chart; 10th percentile if a customised growth chart is used	Consultation
3011	Manual removal	With adherent placenta; consider previous management of third stage	Consultation
3012	Perinatal death		Consultation
3013	Postpartum haemorrhage	› 1000 ml	Consultation
3014	Preterm birth	‹ 35 weeks	Consultation
3015	Recurrent miscarriage	Three or more	Consultation
3016	Shoulder dystocia		Consultation
3017	Termination of pregnancy	Previous complications of termination and or three or more surgical terminations	Consultation
3018	SUDI (Sudden unexplained death of an infant)		Primary
3019	Fetal congenital abnormality		Consultation

Code	Condition	Description	Referral category
3020	Third or fourth degree tear	Compromised bowel function	Consultation
4000–5000 Current pregnancy			
4001	Acute abdominal pain		Consultation
4002	Abdominal trauma		Consultation
4003	Abnormal CTG		Consultation
4004	Antepartum haemorrhage		Consultation
4005	Blood group antibodies		Consultation
4006	Eclampsia		Emergency
4007	Fetal abnormality		Consultation
4008	Gestational proteinuria	› 0.3 g / 24 hours proteinuria protein/creatinine ratio ≥ 0.3 2+ protein on random dipstick testing	Consultation
4009	Gestational hypertension	New hypertension presenting after 20 weeks with no significant proteinuria	Consultation
4010	Intrauterine death		Consultation
4011	IUGR/small for gestational age (SGA)	Estimated fetal weight (EFW) ‹ 10th percentile on customised growth chart, or abdominal circumference (AC) ‹ 5th percentile on ultrasound, or discordancy of AC with other growth parameters, normal liquor	Consultation
4012		EFW ‹ 10th percentile on customised growth chart, or AC ‹ 5th percentile on ultrasound, OR discordancy of AC with other growth parameters, reduced liquor or abnormal umbilical doppler	Transfer
4013	Infant large for gestational age	EFW on a customised growth chart › 90th percentile	Consultation
4015	Malignancy		Transfer
4016	Malpresentation	› 36 weeks; breech, transverse, oblique or unstable lie	Consultation
4017	Morbid obesity	Body mass index (BMI) › 40; may include an anaesthetic consultation	Transfer
	Obesity	BMI › 35	Consultation
4018	Multiple pregnancy	Twins and higher order multiples	Transfer
4019	Oligohydramnios	No pool depth equal or greater than 2 cm on scan or amniotic fluid index ‹ 7	Consultation
4020	Placenta praevia; vasa praevia	At or › 32 weeks	Transfer
4021	Polyhydramnios	Scan pools › 10 cm	Transfer

Code	Condition	Description	Referral category
4022	Pre-eclampsia	BP of ≥ 140/90 and/or relative rise of › 30/15 mmHg from booking BP **and** any of: 1. proteinuria › 0.3g / 24 hours; **or** protein/creatinine ratio ≥.3, **or** 2+ protein on dipstick testing 2. platelets ‹ 150 x 10/9/l 3. abnormal renal or liver function 4. imminent eclampsia	Transfer
4023	Preterm rupture of membranes	‹ 37 weeks and not in labour	Consultation
4024	Prolonged pregnancy	Refer in a timely manner for planned induction by 42 weeks	Consultation
4025	Premature labour	34 – ‹ 37 weeks	Consultation
4026		‹ 34 weeks	Transfer
4027	Prelabour rupture of membranes at term	Consult before 24 hours	Consultation
4028	Confirmed reduced fetal movements	Following normal cardiotocograph but still concern – may require liquor assessment/ growth assessment	Consultation
4029	Herpes genitalis	Active lesions	Consultation
4031	Uterine fibroids		Consultation
4032	Urinary tract infection (UTI)	Recurrent	Consultation
4033	Influenza-like illness		Primary
5000–6000 Labour and birth – first and second stage			
5001	Amniotic fluid embolism		Emergency
5002	Anhydramnios		Transfer
5003	Cerebral anoxia/cardiac arrest		Emergency
5004	Complications of anaesthetic		Consultation
5005	Complications of other analgesia		Consultation
5006	Malpresentation	Compound presentation	Transfer
		Breech diagnosed in labour	Consultation
5007	Cord prolapse or presentation		Emergency
5008	Deep transverse arrest		Transfer
5009	Epidural		Consultation
5010	Failed instrumental vaginal delivery		Transfer
5011	Fetal heart rate abnormalities		Consultation
5012	Hypertonic uterus		Consultation
5013	Induction of labour		Consultation
5016	Intrapartum haemorrhage		Transfer
5017	Maternal tachycardia	Sustained	Consultation

Code	Condition	Description	Referral category
5018	Meconium liquor	Moderate or thick	Consultation
5019	Obstetric shock		Emergency
5020	Obstructed labour		Transfer
5021	Prolonged first stage of labour	‹ 2 cm in 4 hours for nullipara and primipara. Slowing in the progress of labour for second and subsequent labours. Take into consideration descent and rotation of fetal head, and changes in strength, duration and frequency of contractions.	Consultation
5023	Prolonged active second stage of labour	› 2 hours of active pushing with no progress for nullipara or › 1 hour of active pushing with no progress for multipara	Consultation
5024	Pyrexia in labour	› 38 degrees with or without fetal tachycardia	Consultation
5025	Shoulder dystocia		Emergency
5026	Uterine inversion		Emergency
5027	Labour requiring syntocinon augmentation		Consultation
6000–7000 Labour and birth – third stage			
6001	3rd and 4th degree lacerations		Transfer
6002	Cervical laceration		Transfer
6003	Postpartum haemorrhage (PPH)	› 500 ml of blood loss with ongoing losses	Consultation
6004	Retained placenta		Transfer
6005	Shock		Emergency
6006	Vaginal laceration	Complex	Consultation
6007	Vulval and perineal haematoma		Transfer
7000–8000 Services following birth – mother			
7001	Breast infection	Suspected abscess or not settling with antibiotics	Consultation
7002	Neonatal death	Discussion and plan	Consultation
7003	Post delivery neurological deficit	For example neuropraxia	Consultation
7004	Postnatal depression		Primary
7005	Postnatal psychiatric disorder	Including bipolar, psychosis	Consultation
7006	Puerperal sepsis		Transfer
7007	Pyrexia of unknown origin	With rigors	Consultation
7008	Secondary PPH		Consultation
8000–9000 Services following birth – baby			
General			
8001	Abnormal neonatal examination	Minor abnormalities not specified elsewhere	Primary

Code	Condition	Description	Referral category
8002	Fetal ultrasound abnormality	Any	Consultation
8003	Congenital anomalies	Conditions that may require early treatment	Consultation
8057	Birth injury		Consultation
8058	Absent femoral pulses		Consultation
Cardiovascular			
8004	Heart murmur, no symptoms		Consultation
8005	Heart murmur with symptoms		Transfer
8006	Persistent or recurrent cyanosis		Transfer
CNS			
8007	Microcephaly	Head circumference (HC) < 3rd percentile	Consultation
8008	Convulsions or unresponsiveness		Emergency
8009	Excessive irritability		Consultation
8010	Limpness, lethargy, hypotonic		Consultation
8011	Severe infant depression at birth	eg, Apgar score of 6 or less at 5 minutes with little improvement by 10 minutes	Emergency
Growth and feeding			
8013	Sustained feeding difficulties in a newborn not related to gestational age		Consultation
8014	Dehydration or > 10% weight loss since birth		Consultation
8015	Persistent vomiting without blood or bile		Consultation
8016	Intra-uterine growth restriction	Birthweight < 5th percentile or asymmetric growth	Consultation
8017	Low birthweight	Birthweight 2000–2500 g	Consultation
8018		Birthweight < 2000 g	Transfer
8019	Poor weight gain	Birthweight not regained by 14 days	Consultation
8021	Preterm	Gestation >35 – <37 weeks	Consultation
8022		Gestation < 35 weeks	Transfer
Gastrointestinal			
8023	Suspected oesophageal atresia	Unable to pass a gastric tube in a mucousy baby	Transfer
8024	Abdominal distension or mass		Consultation
8025	Persistent or bile stained vomiting or persistent fresh blood in stools		Consultation
8026	No passage of meconium by 36 hours		Consultation
8027	Inguinal hernia		Consultation

Code	Condition	Description	Referral category
Genitourinary			
8028	Failure to pass urine in the first 36-hour period		Consultation
8029	Hypospadias or foreskin abnormality		Consultation
8030	Undescended testes		Primary
Haematology			
8031	Evidence of a bleeding tendency	Haematemesis, melena, haematuria, purpura, generalised petechiae	Transfer
8032	Haemorrhage from cord or other site		Transfer
8033	Maternal isoimmunisation	Rhesus or other antibodies. Refer prior to delivery	Transfer
8034	Maternal thrombocytopaenia		Consultation
Infection			
8036	Suspected chorio-amnionitis	Fetal tachycardia, maternal pyrexia, offensive liquor	Consultation
8037	Temperature instability	Temp < 36.0°C or > 37.5°C confirmed within one hour following appropriate management	Consultation
Jaundice			
8038	Any in first 24 hours		Transfer
8039	Bilirubin > 250 micromol/l in first 48 hours		Consultation
8040	Bilirubin > 300 micromol/l at any time		Consultation
8041	Late jaundice: visible or > 150 micromol/l from 2 weeks in term infant and 3 weeks in preterm infant		Consultation
8042	Significant jaundice in previous infant		Consultation
Maternal Factors			
8043	Infant of a mother with history of substance or alcohol misuse/ dependence in this pregnancy	Eg, methadone, marijuana, alcohol, codeine, valium, methamphetamines	Consultation
8044	Infant of mother with diabetes	With any abnormal findings eg, hypoglycaemia, poor feeding, macrosomic	Transfer
8045		Apparently normal infant	Consultation
8046	Intrauterine infection	Toxoplasmosis, rubella, cytomegalovirus (CMV), other. Referral before delivery often appropriate	Consultation
8048	Maternal medication with risk to baby	Eg, carbimazole, antipsychotics, antidepressants, anticonvulsants	Primary

Code	Condition	Description	Referral category
8049	Maternal/family history with risk factors for baby	Eg, vesico-ureteric reflux, bleeding disorder, congenital heart disease, deafness, Graves disease, syphilis, severe handicap in parent, bipolar disease, schizophrenia, other psychiatric condition	Consultation
Orthopaedics			
8051	Congenital hip problem	Unstable hips, breech delivery, family history of dislocated hips	Consultation
8052	Congenital foot problem	Talipes equinovarus or significant positional foot deformity	Consultation
Respiratory			
8053	Respiratory distress	Any cyanosis, persistent grunting, pallor	Transfer
8054	Apnoea		Transfer
8055	Persistent tachypnoea	With respiratory rate greater than 60/min for greater than 1 hour from birth	Consultation
8056	Stridor, nasal obstruction, or respiratory symptoms not specified elsewhere		Consultation

Definitions

Consultation	The process by which, in communication with the woman, an **LMC** seeks an assessment, opinion and advice about the woman and/or her baby from another primary care provider or a secondary/tertiary care **specialist**, by way of a **referral**. A consultation may or may not result in **transfer of clinical responsibility**. Consultations may involve the woman and/or baby being seen by the other practitioner; however, a discussion between practitioners is often appropriate on its own. Consultations can take place in person, by telephone, or by other means as appropriate in the situation.
DHB Midwifery Team	The employed midwifery core staff rostered on the shift/s in which the transfer of clinical responsibility occurs.
Emergency transport	The physical transport of a woman and/or baby in an emergency.
General practitioner obstetrician (GPO)	A general practitioner who holds a Diploma in Obstetrics (or equivalent, as determined by the Royal New Zealand College of General Practitioners). GPOs are Authorised Practitioners under the Primary Maternity Services notice and provide LMC services. GPOs may work in conjunction with midwives.
Lead Maternity Carer (LMC)	A person who is a midwife, GPO, or obstetrician who is either a maternity provider in his or her own right, or an employee or contractor of a maternity provider, and who has been selected by the woman to provide her lead maternity care.
Primary birthing unit	A community-based birthing unit, usually staffed by midwives. Primary birthing units provide access for women assessed as being at low risk of complications for labour and birth care. They do not provide epidural analgesia or operative birth services.
Primary care provider	A health care provider who works in the community and who is not a specialist for the purposes of these Guidelines. This provider may be a general practitioner, midwife, physiotherapist or lactation consultant, or smoking cessation services, drug and alcohol services or maternal mental health services.
Referral	The process by which an **LMC** seeks consultation with or **transfer of clinical responsibility** to another practitioner, for a condition affecting the woman and/or the baby.

Specialist	A medical practitioner who is registered with a vocational scope of practice in the register of medical practitioners maintained by the Medical Council of New Zealand and who holds a current annual practising certificate. For the purposes of these Guidelines, the definition of 'specialist' excludes general practitioners (covered by the primary referral process). The term 'specialist' refers to a person or their delegate, not a service or a team.
LMCs	**LMCs** will most commonly refer a woman to an obstetrician; however an LMC may refer a woman to specialists in fields that may include (but are not be limited to): maternal fetal medicine, anaesthetics, paediatrics, psychiatry and/or genetics.
Secondary maternity hospital	A hospital that provides care for normal births, complicated pregnancies and births including operative births and caesarean sections plus specialist adjunct services including anaesthetics and paediatrics. As a minimum, secondary facilities include an obstetrician rostered on site during working hours and on call after hours, with access to support from an anaesthetist, paediatrician, radiological, laboratory and neonatal services. Registrars involved in the provision of secondary care are required to follow applicable clinical guidelines endorsed by the relevant professional college.
Tertiary maternity hospital	A hospital that provides care for women with high-risk, complex pregnancies, by specialised multidisciplinary teams. Tertiary maternity care includes an obstetric specialist or registrar immediately available on site 24 hours a day. Tertiary maternity care includes an on-site, level 3 neonatal service. New Zealand's tertiary services are at Auckland City Hospital (National Women's Hospital), Waikato Hospital, Wellington Women's Hospital, Christchurch Women's Hospital and Dunedin Hospital. These hospitals also provide primary and secondary services.
Transfer of clinical responsibility for care	The transfer of clinical responsibility from the **LMC** to a **specialist.** Responsibility for care may be transferred back to the LMC if and when appropriate. In obstetric emergencies, transfer of clinical responsibility will be to the most appropriate available practitioner.
Woman	When the term woman is used, it includes her baby and family/whānau, as defined by her.

9

Sandra Loveday [WRDHB]

From: Chris Smith [WRDHB]
Sent: Thursday, 10 September 2015 3:04 p.m.
To: RDHB]
Subject: email from asking for input into Obstetric BMI Guideline

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From:
Sent: Wednesday, 7 January 2015 4:40 p.m.
To: Chris Smith [WairDHB];
Cc:
Subject: limits for WDHB operating

Dear all,

I forgot to ask you all about the WDHB policy for patients that are accepted for operating at WDHB re BMI. I know that we've covered obstetrics, but that was treated as a stand alone issue. What is the BMI for all operations, noting that for the very obese different equipment is required to ensure safety?
I've also asked (acting CMO) about the ED acute surgical pathway, and how we can ensure that its followed by all.

10

Sandra Loveday [WRDHB]

From: Chris Smith [WRDHB]
Sent: Thursday, 10 September 2015 3:05 p.m.
To:]
Subject: Email from raising awareness of BMI guideline at WDHB

From:
Sent: Friday, 30 January 2015 1:51 p.m.
To: Doctors [WairDHB]
Cc: HB]
Subject: Surgical patients with a high BMI

Good afternoon
I have had to respond to a reportable event regarding a patient with a very high BMI being put forward for surgery.

In a small peripheral hospital there is a limited range of equipment, and limited resources to cope with the potential problems associated with treating these high risk patients. It was for this reason that in March 2011, the requirement that all patients with a BMI of greater than 45 be transferred to a tertiary hospital for surgical intervention. It was also recommended that as a professional courtesy to our anaesthetic colleagues, that cases with a BMI of greater than 40 be discussed with them. There may be times where it is in the patients best interest to have two anaesthetists present during the surgery, particularly when difficult venous access, invasive monitoring, or problematic airways management is anticipated. This support is best achieved by early notification of the case to the anaesthetic service.

It appears that the policy regarding high BMI patients has been present, but not necessarily communicated to the staff who have joined the DHB since 2011. This is simply a reminder to those who were aware of the policy, and notification to those who were unaware of its existence.

Clinical Director
Wairarapa DHB
PO Box 96
Masterton

11

Sandra Loveday [WRDHB]

From: Chris Smith [WRDHB]
Sent: Thursday, 10 September 2015 3:05 p.m.
To:
Subject: Email from summarising meeting discussion

From:
Sent: Monday, 23 March 2015 2:05 p.m.
To: Chris Smith [WairDHB];
Cc:
Subject: anaesthetising at Masterton Hospital

Dear anaesthetists,

Please find below my summary of the current rules for patients that can be accepted for anaesthesia at Masterton Hospital. Once you've indicated that the summary is as you believe, we need to have that incorporated into the hospital policies.
Please let me know if I've got anything wrong

Obstetric services at Hutt valley DHB have discussed the guideline re BMI and delivery at WDHB, and will contact WDHB obstetricians to make suitable arrangements for such patients.

Many thanks

1. The limitations placed on patients accepted for anaesthesia within Masterton Hospital are as follows, and reflect the capabilities and equipment available:
    a. No patients under 3 years of age
    b. No patients with a BMI >45
    c. No obstetric patients with a BMI > 40 at booking
    d. No patients of ASA 4 and 5 class, or complex ASA3 patients (ie no patients with significant co-morbidities relevant to anaesthesia).
    e. No patients who will require ICU post-operatively.

12

Sandra Loveday [WRDHB]

From: Chris Smith [WRDHB]
Sent: Thursday, 10 September 2015 3:06 p.m.
To:
Subject: Email from Leona (reference staff meeting notes appendix 4)
Attachments: staff meeting 20th March 2015.docx

From: z]
Sent: Monday, 23 March 2015 3:52 p.m.
To: Chris Smith [WairDHB];

Cc:
Subject: anaesthesia meeting on Friday

Dear all,

Please find my notes and subsequent actions from the staff meeting last Friday.
Many thanks

12a

Anaesthesia Staff Meeting WDHB 20th March 2015

Present: , Chris Smith,
Leave:

5. Acceptance criteria at WDHB: the current understanding is to be circulated: The limitations placed on patients accepted for anaesthesia within Masterton Hospital are as follows, and reflect the capabilities and equipment available:

No patients under 3 years of age
No patients with a BMI >45
No obstetric patients with a BMI > 40 at booking
No patients of ASA 4 and 5 class, or complex ASA3 patients (ie no patients with significant co-morbidities relevant to anaesthesia).
No patients who will require ICU post-operatively.

13

Sandra Loveday [WRDHB]

From: Chris Smith [WRDHB]
Sent: Thursday, 10 September 2015 3:07 p.m.
To:
Subject: Email from to team with draft notes that would form the 2015 Guideline draft
Attachments: Guidelines re patient acceptance for anaesthesia at Masterton Hospital.doc

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From:
Sent: Monday, 11 May 2015 1:38 p.m.
To: Chris Smith

Cc:
Subject: anaesthesia referral guidelines

Dear all,

My apologies, I let this lapse while I was away. I've done the latest draft, based on feedback, please let me know if you're happy with this.

We've had informal reports of cases referred from WDHB to HVDHB then sent onto CCDHB. We can't track down any patient names, and so can't investigate. If you know the names, please let me know and I can try to find out what happened.

13a

Guidelines re patient acceptance for anaesthesia at Masterton Hospital

The limitations placed on patients accepted for anaesthesia within Masterton Hospital are as follows, and reflect the capabilities and equipment available:

- No patients under 3 years of age
- No patients with a BMI >45
- No obstetric patients with a BMI > 40 at booking
- No patients of ASA 4 and 5 class, or complex ASA3 patients (ie no patients with significant co-morbidities relevant to anaesthesia).
- No patients who will require ICU post-operatively.

Exceptions to the above:

- Patients suffering from fractured neck of femur who are ASA 4, provided that:
    - the surgeon and anaesthestist agree that it is a palliative procedure for that patient,
    - the person giving consent accepts the limitations on post-operative management consequent on operation at Masterton Hospital
    - the anaesthetist agrees that they are able to anaesthetise safely at Masterton Hospital
    - (this exception takes specific note of the issues with transferring an elderly patient with a significant fracture)

Process to be followed:
Referral by clinician with primary responsibility to clinician at neighbouring DHB: this will take into account the needs related to:

- Mode of transfer (no helipad at Hutt)
- Management of significant co-morbidities eg renal dialysis

Anaesthesia advisor, WDHB
11/5/15

14

Sandra Loveday [WRDHB]

From: Chris Smith [WRDHB]
Sent: Thursday, 10 September 2015 3:07 p.m.
To: n [WRDHB]
Subject: Email from ı on behalf of re BMI Guideline (document reference Appendix 1)
Attachments: Patient acceptance for anaesthesia.docx

From:
Sent: Friday, 12 June 2015 10:47 a.m.
To: [WairDHB]; Chris Smith [WairDHB];

Subject: Guideline for BMI limitations

Hi all

This is the finalised guideline for BMI limitations on patient acceptance for surgery at Wairarapa Hospital. Please read it, and if you have any submissions to make, they need to be sent to the quality office with one week. If accepted it will become policy following consideration of any submissions received.
Thank you

Clinical Director
Wairarapa DHB
PO Box 96
Masterton

Wairarapa DHB
Wairarapa District Health Board

Patient Acceptance for Anaesthesia	
Type: Guideline	**HDSS Certification Standard** [optional]
Issued by: Anaesthesia Advisor	**Version:** 1
Applicable to:	**Contact person:** Leona Wilson

Purpose:

- To place safe limitations on patients accepted for anaesthesia within Wairarapa Hospital and reflect the capabilities and equipment available.

Guideline content

The limitations placed on patients accepted for anaesthesia within Masterton Hospital are as follows:

- No patient under 3 years of age
- No patients with a BMI >45
- No obstetric patients with a BMI >40 at booking
- No patients of ASA 4 and 5 class, or complex ASA3 patients (ie no patients with significant co-morbidities relevant to anaesthesia)
- No patients who will require ICU post-operatively

Exceptions to the above are as follows:

- Patients suffering from fractured neck of femur who are ASA 4, provided that:
  - The surgeon and anaesthetist agree that it is a palliative procedure for that patient
  - The person giving consent accepts the limitation on post-operative management consequent on operation at Masterton Hospital. (this exception takes specific note of the issues with transferring an elderly patient with a significant fracture)

Process to be followed:

Referral by clinician with primary responsibility to clinician at neighbouring DHB: this will take into account the needs related to:

- Mode of transfer (no helipad at Hutt)
- Management of significant co-morbidities eg renal dialysis

15

Sandra Loveday [WRDHB]

From: Chris Smith [WRDHB]
Sent: Thursday, 10 September 2015 3:08 p.m.
To:
Subject: to C Smith re literature on obstet anaes and high BMI 9 July 2015
Attachments: 4 15.-March-2010-Management-of-Women-with-Obesity-in-Pregnancy-Guidance.pdf; ATT00001.htm; Ana rev (06) Obesity and obstetric anaesthetics.pdf; ATT00002.htm 5

From: [WairDHB]
Sent: Thursday, 9 July 2015 3:41 p.m.
To: [WairDHB]; Chris Smith [WairDHB];
Subject: Fwd: literature on obstet anaes and high BMI

To keep you updated

P.

Begin forwarded message:

From: "l
To:
Cc:

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<!
Subject: FW: literature on obstet anaes and high BMI

Dear David,

the lead obstetric anaesthetist for CCDHB (has sent me these two references delineating the increased risk with BMI>40 at booking for obstetric patients. These refs could be considered background reading for understanding the limits we placed on patients at Wairarapa, taking into account the very limited ability to manage complications (only one anaesthetist on call, no ICU)
Many thanks
L

From: [CCDHB]
Sent: Wed 7/8/2015 10:24 AM
To:
Subject: RE: literature on obstet anaes and high BMI

Dear

I am just going to list a few things, you probably know it all though. The above two attachments may be useful.

One cause of confusion is which weight; booking or actual. Some women can put on an impressive amount of weight changing their BMI significantly.

- Obesity was a core topic on the last PMMRC report although mainly talking about neonatal issues.

- 45 % of mothers that died were overweight or obese.
- In the UK if the BMI is >35 the women are unsuitable for midwifery only care.

Box 1.6. Risks related to obesity in pregnancy[14]
For the mother increased risks include:
- spontaneous first trimester and recurrent miscarriage
- maternal death or severe morbidity
- cardiac disease
- pre-eclampsia
- dysfunctional labour
- gestational diabetes
- thromboembolism
- higher chance of needing a caesarean section
- post-caesarean wound infection
- postpartum haemorrhage
- low breastfeeding rates.

For the baby increased risks include:
- stillbirth and neonatal death
- congenital abnormalities
- prematurity.

BMI 35 and 40 seem to be used as cut offs talked about.

Good luck

as

From: I
Sent: Monday, 6 July 2015 10:39 a.m.
To: '(
Subject: literature on obstet anaes and high BMI

Hi

Can you please send me info on risk for obstetric anaesthesia with higher BMI patients? I'm currently discussing with Wairarapa the limits we placed on patients anaesthetised there (with no ICU on site, and at times tricky transfer, not to mention other issues), and wanted to send them some info on increased risk
Many thanks

Clinical Head of Anaesthesia Department
H

16

Sandra Loveday [WRDHB]

From: Chris Smith [WRDHB]
Sent: Thursday, 10 September 2015 3:09 p.m.
To:
Subject: Chris Smith to : re DHB response to developing guildline following complaint 15 August 2015

From:
Sent: Saturday, 15 August 2015 7:34 a.m.
To: Chris Smith [WairDHB]
Subject: Re: BMI Guideline so far

Perfect, I added a few very valid points

On 14/08/2015, at 07:39, Chris Smith [WairDHB] <Chris.Smith@wairarapa.dhb.org.nz> wrote:

> Here is an email from
> Your input would be helpful
> This needs to get sorted asap to avoid any further complaints
> Chris
>
> http://m.anesthesiologynews.com/Article.aspx?ses=ogst&d=Educational+Reviews&d_id=161&i=July+2015&i_id=1203&a_id=32991
>
> Sent from my iPhone
>
> Begin forwarded message:
>
> > **From:**
> > **Date:** 13 August 2015 9:05:59 pm NZST
> > **To:** Dr Chris Smith <Chris.Smith@wairarapa.dhb.org.nz>,
> > <
> > **Subject: BMI Guideline so far**
> >
> > Find attached the guideline so far.
> > The aim is to give LMCs clear guidance to advise their patients and what to do next.
> > Equally guidance for Obstetricians, esp. locums, of what to (consistently) advise and do
> >
> > Chris…can you add anything to anaesthetic considerations?
> > Happy with the idea that the Obstetricians will filter cases to Anaesthetic clinic?
> >
> > ..thoughts about safety of transfer/transport/financial support

etc
Will secondary care be responsible for transfer or LMC? Who will the patient ring in labour or do we expect them just to jump in the car and skedaddle? Whose responsible if something goes wrong? Does a Greytown patient come here first for assessment then turn round and go to Hutt?
Patient information leaflet will be an important sister document.
Will just a referral letter do or should we have a inter-DHB proforma which makes is a bit more obvious?

Add stuff and bounce the document around the four of us.

<Increased BMI maternity doc.rtfd.zip>

17

Sandra Loveday [WRDHB]

From: Chris Smith [WRDHB]
Sent: Thursday, 10 September 2015 3:13 p.m.
To: [illegible] WRDHB]
Subject: Email 16 Feb [illegible] to Chris Smith BMI

From:
Sent: Wednesday, 16 February 2011 4:18 p.m.
To: Chris Smith
Subject: RE: BMI

Good thanks Chris.

Preadmission and Anaesthetic Clinic
Quality Leader
Outpatients Department
Wairarapa Hospital
Ph. (06) 9469800 Ext
Cell
Email
Fax (06) 9469830

From: Chris Smith
Sent: Wednesday, 16 February 2011 2:52 p.m.
To:
Subject: FW: BMI

FYI [illegible]-hopefully wheels in motion
chris

From: Chris Smith
Sent: Wednesday, 16 February 2011 11:43 a.m.
To: [illegible]
Subject: BMI

Hi

At the recent visit(November 2010) by the Chairperson of the NZ National committee of ANZCA , Vanessa Beavis, the ongoing issue of BMI was discussed.She stated in the discussions that it would be best practise to transfer patients to tertiary centres if their BMI was 45 or greater.
We need to discuss the implications of this wrt our ongoing care of patients at Masterton.
I will ask I [illegible] e to place this on the next SMS meeting.
Thanks

18

Sandra Loveday [WRDHB]

Subject: FW: Surgical patients with a high BMI

From: "Chris Smith [WairDHB]" <Chris.Smith@wairarapa.dhb.org.nz>
Date: 11 August 2015 11:48:23 NZST
To: "
Subject: FW: Surgical patients with a high BMI

From: [WairDHB]
Sent: Friday, 30 January 2015 1:51 p.m.
To: Doctors [WairDHB]
Cc:
Subject: Surgical patients with a high BMI

Good afternoon
I have had to respond to a reportable event regarding a patient with a very high BMI being put forward for surgery.

In a small peripheral hospital there is a limited range of equipment, and limited resources to cope with the potential problems associated with treating these high risk patients. It was for this reason that in March 2011, the requirement that all patients with a BMI of greater than 45 be transferred to a tertiary hospital for surgical intervention. It was also recommended that as a professional courtesy to our anaesthetic colleagues, that cases with a BMI of greater than 40 be discussed with them. There may be times where it is in the patients best interest to have two anaesthetists present during the surgery, particularly when difficult venous access, invasive monitoring, or problematic airways management is anticipated. This support is best achieved by early notification of the case to the anaesthetic service.

It appears that the policy regarding high BMI patients has been present, but not necessarily communicated to the staff who have joined the DHB since 2011. This is simply a reminder to those who were aware of the policy, and notification to those who were unaware of its existence.

Clinical Director
Wairarapa DHB
PO Box 96
Masterton