SESLHD POLICY COVER SHEET

NAME OF DOCUMENT	Time Critical Transfer of a Woman at 23^{+0}-26 weeks gestation within Tiered Perinatal Network (SESLHD and ISLHD)
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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Clinical Stream Director, Women's and Children's
AUTHOR	Tiered Perinatal Network Working Party
POSITION RESPONSIBLE FOR THE DOCUMENT	CMC Women's and Children's Clinical Stream
KEY TERMS	Critical In-Utero Transfer, 23^{+0}-26 Weeks Gestation, Counselling, Resuscitation
SUMMARY	This policy outlines the process for time critical transfer of a woman, with a pregnancy of 23^{+0}-26 weeks gestation, who is likely to require imminent delivery and/ or referral consultation and advice.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Time Critical Transfer of a Woman at 23+0 – 26 weeks gestation within Tiered Perinatal Network

SESLHDPD/302

1. POLICY STATEMENT

The policy outlines the process to expedite the time critical transfer of a woman with a pregnancy at 23+0-26 weeks gestation to the Royal Hospital for Women (RHW), the level 6 facility within the tiered network. This policy also supports the management of a woman with complex pregnancy issues at 23+0-26 weeks gestation who may also require transfer for consultation, which is not time critical.

The Tiered Perinatal Network (Tiered Network) of South Eastern Sydney Local Health District (SESLHD) and Illawarra Shoalhaven Local Health District (ISLHD) has five maternity services:

- The RHW is a tertiary and quaternary referral service providing level 6 Maternity and Neonatal Services, as well as stream leadership for the maternity facilities within the tiered network
- St George Hospital provides level 5 Maternity and level 4 Neonatal Services
- The Wollongong Hospital provides level 5 Maternity and level 4 Neonatal Services
- The Sutherland Hospital provides level 4 Maternity Service and level 3 Neonatal Services
- Shoalhaven Hospital provides level 3 Maternity Service and level 2 Neonatal Services
- Milton Ulladulla Hospital provides level 1 Maternity Services.

2. AIMS

- To assess a pregnant woman at 23+0-26 weeks gestation where delivery is anticipated for:
  - suitability for referral and consultation to the level 6 facility within the Tiered Network
  - allocation of Maternal Priority category for transfer in consulting the Maternal Decision-Making Tool (Appendix A), if transfer is required
- To expedite a seamless and appropriate transfer of a woman classified with a Maternal Priority (MP1), and at risk of imminent delivery between 23+0-26 weeks gestation, to the level 6 facility within the Tiered Network, irrespective of Neonatal Intensive Care Unit (NICU) bed status, as it is recognised there is a significantly decreased mortality and/or morbidity for a neonate at this gestation being delivered in a level 6 facility.

3. PATIENT

- Woman at risk of birth 23+0-26 weeks gestation.

4. STAFF

- Transfer Coordinator (TC) – which will be filled by either of the following roles as outlined in the Tiered Network Operational Plan:
  - Access Demand Manager (ADM)
  - After Hours Nurse Manager (AHNM)

- Patient Flow Managers (PFM)
- Birthing Services Midwifery Unit Managers (MUMs) Team Leaders (T/Ls)

- Midwifery/nursing staff
- NICU Nursing Unit Manager (NUM), T/L, and nursing staff
- Medical Staff - Obstetric and Neonatal
- Social Work Team.

5. PROCEDURE

Consultation and Transfer from Referring Hospital

- The referring obstetric registrar and/or consultant at the referring site will review the woman and make an assessment regarding her risk of preterm delivery and her need for ongoing higher level obstetric care in consultation with the Maternal Transfers Decision Making Tool.
- The decision to request transfer must be made in consultation with the referring obstetric consultant
- **The consultant at the referring site must authorise any transfer.**
- For MP 1 transfer requests AT ANY TIME
  - The TC will arrange an immediate conference call with the RHW obstetric consultant and/or registrar and the referring obstetric consultant and/or registrar referring to Appendix B
- Clinical history for handover must include:
  - Accurate dating of pregnancy, including method of establishing gestation
  - Obstetric history
  - Reason for risk of preterm birth
  - Current maternal condition – to assist with decision for transfer
  - Other maternal co-morbidities or risk factors
  - Current fetal condition and pregnancy history
  - Fetal presentation
  - Cervical status e.g. dilatation, shortening
  - Membranes ruptured or intact, and if ruptured description of liquor
  - Administration of corticosteroids or other medications
- The referring team will assess need for tocolysis, steroids and/or magnesium sulphate ($MgSO^4$). $MgSO^4$ should not be infused during transfer.
- **Ensure** referring obstetric registrar/consultant, the woman and her family are clear that the purpose of transfer is for assessment and counselling by a multidisciplinary team and that, notwithstanding the increasing obligation to treat with higher gestation, transfer of care is **not** necessarily a plan to immediately offer resuscitation +/- intensive care
- Obtain consent from the woman for the transfer, ensuring she understands that there may be insufficient time for the tertiary medical teams to provide adequate counselling on the risks of birth at extreme prematurity

- Inform the family of the risks involved and that resuscitation may not be offered if the neonate is born in the ambulance or transit
- Document all details in the Patient Flow Portal (PFP)/Inter Hospital Transfer (IHT)
- Confirm transport with the NSW Ambulance directly for time critical transfer (**131233**)
- Provide a registered midwife/medical escort for transfer
- If, after discussion and consultation, time critical transfer of the woman is deemed not appropriate:
    - RHW should continue to offer ongoing telephone support from the obstetric and Special Care Nursery (SCN) departments should expectant management continue in the woman's local hospital
    - Neonatal Emergency Transport Services (NETS) may need to be contacted if delivery is imminent and neonatal resuscitation required (**1300 362 500**).

Responsibilities of RHW once Time Critical Transfer has been accepted:

- Only a referral from the transferring obstetric consultant to the RHW obstetric consultant can be accepted
- The neonatal consultant to notify the NICU NUM/T/L and neonatal medical team
- The TC, following conference call with referring facility and the obstetric consultant/ registrar will manage the transfer coordination
- TC to confirm bed in the PFP/IHT.

Admission to RHW:

- Perform initial clinical midwifery and medical assessment in Delivery Suite
- Arrange consultation with the neonatal team as soon as appropriate to make a collaborative management plan with the woman and her family
- Document the management plan, including mode of delivery, timing of antenatal
  corticosteroids and consideration of magnesium sulphate
- Review the woman daily while an inpatient at RHW
- Adjust management plan as gestation and clinical circumstances dictate
- Support a woman and her family if, following counselling, they have made the decision not to undertake active resuscitation and wish to return to the referring hospital for ongoing management
- The RHW obstetric consultant will ensure the transferring hospital has documented all details in the Patient Flow Portal/IHT/Patient Transport Services (PTS) booking and book transfer with PTS
- Manage palliative care of the neonate if this is the decision that has been made
- Refer to Social Work department as indicated

- Where the woman/family identifies as Aboriginal and/or Torres Strait Islander, referral should be made to the Aboriginal health worker to provide cultural support.

6. DEFINITIONS

- **Time critical:** The condition of a woman or fetus is critical and requires immediate emergency treatment / delivery
- **23+0-26 weeks gestation** relates to chances of survival of neonates at gestations so early that consideration would be given to not offering resuscitation.

7. DOCUMENTATION

Documentation must be contemporaneous in the clinical record, and accurately reflect discussion and counselling at the transferring facility.

8. EDUCATIONAL NOTES

- Parents are more receptive to medical information and have more time to consider their preferences when they are given appropriate counselling in a non-acute situation
- The principal advantage of an in-utero transfer at early gestations of viability is a dramatic reduction in neonatal morbidity and mortality – only eight in-utero transfers are required to prevent one neonate with serious brain injuries (BMJ 2019) https://www.bmj.com/content/367/bmj.l5678

9. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- RHW LOP Corticosteroids for Woman at Risk of Preterm Birth or with a Fetus at Risk of Respiratory Distress – Antenatal
- RHW LOP Magnesium Sulphate Prior to Preterm Birth for Fetal Neuroprotection – Preterm Labour
- RHW LOP Referral to Department of Maternal Fetal Medicine - Fetal Indications
- RHW LOP Specialist Obstetrician - Conditions and Procedures Requiring Attendance
- SGH/TSH Clinical Business Rule - Premature Labour and Birth
- NSW Health Guideline GL2016_018 Maternity and Neonatal Service Capability Framework
- NSW Health Policy Directive PD2020_014 - Tiered Networking Arrangements for Perinatal Care in NSW
- Tiered Perinatal Network Operational Plan – SESLHD / ISLHD 2022

10. RISK RATING

- Medium

11. NATIONAL STANDARDS

- Standard 1 – Governance for Safety and Quality in Health Service Organisations
- Standard 5 – Comprehensive Care
- Standard 6 – Communicating for Safety

12. REFERENCES

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13. REVISION AND APPROVAL HISTORY

DATE	REVISION NO.	AUTHOR AND APPROVAL
March 2017	Draft	Sally Wise / Dee Sinclair
June 2017	Draft	Sally Wise / Dee Sinclair / Wendy Hudson
October 2017	Draft	Endorsed by Executive Sponsor
November 2017	Draft	To SESLHD Clinical and Quality Council for endorsement
December 2017	0	SESLHD Clinical and Quality Council endorsed for publishing
November 2019	1	Minor review undertaken by Sally Wise, Wendy Hudson, Wendy Hawke, Srinivas Bolisetty, Daniel Challis. Barbara Atkins, Trent Miller, Amanda Henry, Lorena Matthews, Louise Everitt, Joanna Pinder, Shea Caplice, Angela Jones (The Tiered Maternity

		Transfers Working Party). Additions have been made to the Procedure and Admission. Education notes and an extra appendix for the tiered perinatal network included. Note: Illawarra Shoalhaven Local Health District relies on the level 6 Royal Hospital for Women and has been included in the policy. Approved by Executive Sponsor.
December 2019	1	Discussion with Director, Clinical Governance and Medical Services and adjustments made.
January 2020	1	Processed by Executive Services prior to submission to the February 2020 Clinical and Quality Council meeting.
March 2020	1	Approved at the February 2020 Clinical and Quality Council. Published by Executive Services.
Dec 2022	2	Minor Review. Approved by Executive Sponsor

Appendix A

Health
South Eastern Sydney
Local Health District

Health
Illawarra Shoalhaven
Local Health District

MATERNAL TRANSFERS DECISION MAKING TOOL

NSW Health — Maternal Transfers Decision-Making Tool

MATERNAL TRANSFERS DECISION MAKING TOOL					
Maternity Priority	**MP1***	**MP2***	**MP3**	**MP4**	**MP5**
Medically agreed time frame (Time by which woman should be receiving higher level care)	Immediate Midwifery/ Medical escort required	< 3 hours Midwifery/ Medical escort required	< 12 hours Midwifery escort required	24 hours	72 + hours consultation or referral or back transfer
Transport determined by local LHD	NSW Ambulance/ ACC immediate dispatch	NSW Ambulance/ACC	NSW Ambulance/ ACC/PTS	PTS/ Private provider	PTS/ Private provider
Preterm Labour (PTL) (Regular contractions with any cervical change)	>26 progressive dilatation >3cm (if safe)	Dilated 1-3cm	Dilated <1cm and labour suppressed		
	23+0 – 26+0 with imminent birth	Gestation as per tiered perinatal network operational plan			<23 weeks
Threatened preterm labour (TPL), closed cervix - quantitative fFN			≥200 ng/mL	50–199 ng/mL	<50ng/mL or short cervix without symptoms
APH (stable) In absence of uterine activity				≥ 23 weeks as per operational plan	Consult / referral
PPROM (without labour)				≥ 23 weeks as per operational plan	< 23 weeks
Multiple pregnancy complication		23+0 – 26+0 weeks	>26 weeks as per operational plan		< 23 weeks
Maternal condition	Deteriorating +/- Planned urgent birth	Maternal deterioration whereby birth likely required within 12–24 hours			Consult / referral
Fetal condition	Deteriorating +/- Planned urgent birth	Fetal deterioration whereby birth likely required within 12–24 hours			Consult / referral

***Requires consultation with Obstetric Consultant**

ACC – Aeromedical Control Centre
APH – Antepartum Haemorrhage
Fetal condition – e.g. growth restriction
fFN – Fetal Fibronectin
Maternal condition – deterioration may increase MP

Medically agreed timeframe – transfer to higher level care may be impacted by geographical conditions
PTL – Pre-term labour
PPROM – Preterm premature rupture of membranes
PTS – Patient Transport Services
TPL – Threatened Preterm Labour – if cervical changes over time becomes PTL

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MATERNAL TRANSFERS DECISION MAKING TOOL INTERPRETATION

NSW Health

Maternal Transfers Decision-Making Tool

Maternal transfers decision making tool interpretation

Purpose

The Decision Making Tool supports the process for maternal transfers by standardising assessment of urgency and risk of clinical presentations to:

- reduce clinical variation
- prioritise resources, including transport logistics across NSW
- enable women to be observed in their local facilities rather than being transferred long distances.

Scope

The tool should be used to:

- determine the need for transfer
- accurately communicate the level of urgency and risk between facilities
- assist with a medically agreed timeframe in which transfer should occur
- inform the most appropriate mode of transport and escort required

Elements

The tool contains a number of elements that together assist clinical assessment and transfer decisions. The clinical indicators combined with other factors such as the geographical location of the woman, the capacity of the facility she is located at, available service options, and factors such as weather that could impact on transport, together provide a basis for decision making.

The Tool provides a framework for categorising women (MP1 to 5) according to urgency and need. The MP categories offer a common language for discussions with TPN and transport services. The medically agreed timeframe indicates when the woman should be receiving higher level care and provides guidance for transfer times.

Clinical indicators:

- weeks of gestation
- regular uterine contractions
- cervical dilatation
- quantitative fFN score
- rupture of membranes
- Antepartum haemorrhage
- Multiple pregnancies
- Maternal condition
- Fetal condition.

Maternity Priority (MP1 – MP5) indicates the level of urgency for transfer:

- MP1 is a time critical transfer and is not to be delayed. TPN facilities must accept MP1 regardless of capacity
- MP2 timeframe is within 3 hours for transfer
- MP3 timeframe is within 12 hours for transfer
- MP4 and MP5 category may be suitable for local observation or referral to the level 4, 5 or 6 units for ongoing assessment. This assessment may be as an outpatient.
- Assessment for Multiple Pregnancy should be categorised one maternal priority higher than a singleton pregnancy.

Currency of assessment

- Regular reassessment is required to assess for change in maternal priority, which may indicate an increase in maternal priority
- Assessment just prior to transfer is essential to ensure the mother and fetus are stable, this may include a repeat vaginal examination where appropriate.

Appendix B

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