Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET

Health
South Eastern Sydney
Local Health District

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EXECUTIVE SPONSOR	Co-Director Anaesthetics Maternity Services Clinical Co-Directors
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SUMMARY	Streamlined referral process for the pregnant woman with a moderate to high risk complexity requiring anaesthetic review antenatally
Key Words	Anaesthesia, pregnancy, antenatal

Contents

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Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

The Antenatal Obstetric Anaesthesia Clinic (AOAC) enables appropriate review of high-risk women requiring anaesthetic input antenatally to ensure effective and safe anaesthesia if required. Women referred to the AOAC are identified early in pregnancy and have complex medical, obstetric, or psychosocial needs that will impact their anaesthetic care.

The AOAC differs from the Caesarean Section Pre-anaesthesia Clinic (CS-PAC) in which all women who are scheduled for elective CS receive a pre-anaesthesia review. For details on both clinics, refer to education notes.

The aim of this CBR is to clarify the antenatal procedure of referral of a woman to the Antenatal Obstetric Anaesthesia Clinic according to the presence of risk factors, as follows:

- **High Risk** – referral to antenatal obstetric anaesthetic clinic required
- **Moderate Risk** – page anaesthetic registrar (44084) to confirm when/where referral required

High Risk
Previous epidural/spinal complications ○ Failed attempt to site epidural/spinal and or multiple resites ○ Ineffective neuraxial anaesthesia during caesarean section ○ Spinal cord or peripheral nerve injury following birth ○
High Risk of bleedingin current pregnancy ○ Disorders of placentation including placenta previa/accreta/increta/percreta ○ Multiple gestation (Tripet or higher) ○
Anaesthetic complications ○ Malignant hyperthermia ○ Suxamethonium apnoea ○ History of awareness under general anaesthesia

○ History of failed or difficult intubation ○ allergy to muscle relaxant anaesthetic drugs, local anaesthetics or **all** opioids ○ Previous difficulties with vascular access requiring central venous access ○
Cardiac disease ○ Congenital heart disease ○ Previous cardiac surgery or coronary artery disease with stent ○ Arrhythmias/palpitations ○ Cardiomyopathy ○ Valvular heart disease or HOCM ○ Cardiac pacemaker or defibrillator
Musculoskeletal disease ○ Myopathy ○ Muscular dystrophy ○ Achondroplasia ○ Osteogenesis imperfecta ○ Scoliosis/vertebral column abnormalities ○ Previous spinal surgery (spinal fusion and or in situ hardware (Harrington Rods)
Haematological disease ○ Von Willebrand disease ○ Factor V Leiden ○ Haemophilia ○ Thrombocytopaenia - severe (platelet <100) ○ Anticoagulation therapy ○ Jehovah's Witness (or any unable to use blood products) ○ Sickle cell anaemia
Neurological Disease ○ Multiple sclerosis ○ Neurofibromatosis ○ Arnold Chiari malformation ○ Spina bifida (occulta or cystica) ○ Myasthaenia gravis ○ Benign intracranial hypertension ○ Epilepsy (poorly controlled with seizures at least monthly) ○ Cerebral masses (e.g. tumour, AV malformations) ○ V-P shunt, hydrocephalus
Other serious systemic diseases ○ Marfan's Syndrome ○ Ehlers Danlos Syndrome (vascular or non-vascular type) ○ Systemic Lupus Erythematosus ○ Significant goitre ○ Morbid obesity BMI >45
Pain or Opioid Addiction

○ Chronic pain under the care of a pain specialist ○ Opioid Treatment Program (e.g. normally prescribed Methadone or Buprenorphine) ○ Recent (<12 months) illicit substance abuse and/or alcohol abuse

Moderate or Uncertain Risk
Previous obstetric complications ○ Traumatic birth or experience ○ Pre-eclampsia/eclampsia/HELLP ○ Significant complication requiring admission to Close Observation Unit or ICU
Other Medical conditions ○ Significant respiratory concerns (e.g. severe asthma) ○ Obstructive Sleep Apnoea
Psychosocial ○ Significant psychological/psychiatric disorders (e.g. postpartum psychosis)
Other ○ Conditions or history not listed above where staff hold concerns about anaesthesia risk

2 RESPONSIBILITIES

2.1 Medical and midwifery staff –

referral and escalation to antenatal obstetric anaesthetic clinic as per above

3 PROCEDURE

3.1 Clinical Practice points

- Identify woman who presents antenatally with risk factors requiring referral to antenatal obstetric anaesthetic clinic as outlined in above tables
- Refer as early as possible after 20 weeks gestation, referral accepted from midwives, obstetric doctors or obstetric physicians
- Complete a referral/consult form, which must include the name of the obstetrician whom the woman is booked under and the specific reason for referral
- Advise the woman to take referral/consult form to clerks at antenatal clinic reception and book into Friday morning antenatal obstetric anaesthetic clinic
- Review woman in the antenatal obstetric anaesthetic clinic by consultant anaesthetist, or senior registrar who will document consultation in electronic Medical Record (eMR) and copy to obstetric care plan in eMaternity
- Communicate special requirements such as the need for cardiac monitoring with the MFM team and or request an MDT meeting for very high complexity women
- Communicate requests for perioperative consults with chronic pain or other teams verbally and in eMR

- Re-refer woman back to antenatal obstetric anaesthetic clinic if there is a change in her condition or a definitive birth plan made
- Re-refer to the CS-PAC for final review, consent and pathology collection within two weeks if scheduled for elective CS

3.2 Documentation

- Medical record
- eMaternity
- Antenatal card

3.3 Education Notes

- The above tables are not exhaustive, if questions arise as to whether review is needed, please call Anaesthetics to discuss.
- Antenatal Obstetric Anaesthesia Clinic (AOAC) description
    - This clinic is held in the Antenatal Outpatients Department on Friday mornings 0830-1230 for a max of 5 patients.
    - Appointments are 45 minutes and, where feasible, in-person to allow the anaesthetist to conduct an appropriate history, examination, risk assessment, discussion of care plans, counselling and cross team coordination.
    - Women referred to the AOAC may or may not also be subsequently scheduled for Caesarean Birth. In the event they are scheduled for a Caesarean, these women are either returned to the AOAC or they also booked into the CS-PAC in the two weeks prior to their scheduled OT date, having a clear management plan.
- Pre-anaesthesia Caesarean Section Clinic (CS-PAC) description
    - This clinic is held in the Antenatal Outpatients Department on Monday afternoons 1300-1700 (Max 8 patients) and Friday mornings 0830-1230 (Max 6 patients).
    - All women booked for elective CS are also booked to have a telephone consultation in CS-PAC within two weeks of the scheduled date of surgery.
- The women should have been screened as low complexity prior to booking. Women are advised to be available for a phone call anytime during the session. For time keeping, 30 minutes is allocated per patient.
- The focus of the consult is consent, psychological preparation and instructions for fasting, medication management etc. Additionally, women should be instructed to attend SEALS Pathology at POW not more than 72 hours pre op for G&H. The pathology request forms are sent to SEALS by the JMOs. including pathology collection.
- Documentation should be entered into eMR Powerchart either through direct text entry (PAC Medical consult) OR by scanning the completed paperchart to ones networked email address and uploading to eMR.

3.4 Related Policies/procedures

- Epidural Analgesia
- Obesity and Weight gain in Pregnancy, Labour and Postpartum
- Twin Pregnancy – Antenatal Care
- Twin Pregnancy – Intrapartum Vaginal Birth
- Caesarean Birth- maternal preparation and receiving of the newborn

3.5 References

- N/A

4 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal Liaison Officers, health workers or other culturally specific services

5 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters.

6 NATIONAL STANDARDS

- Standard 2 – Partnering with Consumers
- Standard 5 – Comprehensive Care
- Standard 6 – Communicating for Safety

7 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
4/2/2025	V1	Dr Leonie Watterson
7/4/2025	V1	Dr Leonie Watterson

12/5/2025	V1	Transcribed to new template