

TITLE

CRITERIA TO SUPPORT APPROPRIATE LEVEL OF OBSTETRICAL CARESCOPE

Provincial: Acute Care

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NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To promote proactive obstetrical care planning decisions that are supported by the assessment and identification of maternal and fetal risk factors, communication between involved **health care professionals** and obstetrical triage scoring.
- To enable access to the appropriate level of obstetrical care to support optimal outcomes for mother and infant.

PRINCIPLES

- Early identification of high risk pregnancies and deliveries, including having an established planned place for birth during antenatal care, is crucial in minimizing the risk and need for intrapartum transfer.
- High risk pregnancies and deliveries require consultation. This applies with or without transfer to obstetrical and/or neonatal care specialists.
- Decision to transfer an obstetrical or neonatal **patient** to a higher level of care in an alternate facility, follows consultation between **most responsible health practitioner** (MRHP) and the **consultant** and is based on the assessment of risk factors for the mother, fetus or neonate, labour progress, and potential for delivery on route.
- Decisions related to transportation are the result of team communication and collaboration between sending and receiving physicians (consultant), Registered Nurses, and Emergency Medical Services (EMS) staff.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

1. Points of Emphasis

- 1.1 It is recognized that distance, weather and road conditions may make the goal of transferring the intrapartum **patient** who presents in active labour from a level 1A hospital to any higher level hospital within a thirty minute target unachievable. (See Appendix A: *Service delivery model by level of hospital*).
- 1.2 The Obstetrical Triage Assessment Scoring (OTAS) system may assist in timely assessment and determination of acuity.
- 1.3 Ideally, the appropriate hospital for birth will have been selected prior to the pregnant woman presenting to the hospital. In a situation where a woman presents to a hospital that does not have the resources to provide the level of intervention necessary, the hospital and health care professionals shall respond in the same way as they would for any unexpected medical emergency.
- 1.4 When antenatal transfers are necessary, the needs and requirements of mother and fetus as well as the capacity of local resources and facilities should be considered in order to determine the most appropriate birthing hospital.
- 1.5 Transferring a woman and fetus is preferable to neonatal transport and should be the primary goal. The reason for transport may be related to the woman, or fetus, or both.
- 1.6 When pre-labour complications are anticipated, early consultation with or without transfer of care to the appropriate hospital is recommended. It is preferable to avoid emergency maternal transport, if possible.
- 1.7 Transport is indicated when, after assessment and consultation, it is determined that the woman and/or the fetus requires the advanced resources and skilled health care professionals at a hospital that provides a higher level of care such as specialized obstetrical and surgical care and/or specialized neonatal care (see Appendix A: *Service delivery model by level of hospital* and Appendix B: *Obstetrical Transport Decision tree*).

2. Appropriate Induction of Labour

- 2.1 Medical induction of labour by oxytocin is not recommended at a level 1A hospital, unless the following circumstances, recognized to be conducive to a favourable outcome, exist:

- a) gestational age of greater than 38 weeks;
 - (i) primipara (primip); or
 - (ii) multipara (multip) with previous uncomplicated vaginal delivery.
- b) singleton fetus;
- c) Bishop Score of equal to or greater than six (6);
- d) a low antepartum risk score;
- e) a back-up plan has been established with a level 1B or higher hospital;
- f) the patient understands the risks associated with induction of labour and there is documented informed consent.

Note: Membrane sweeping, cervical ripening by cervidil or prostaglandin gel, insertion of cervical balloon and augmentation of already established labour is not included in the description of induction in this document.

3. Preterm Birth

- 3.1 Preterm infants have unique medical and nursing needs that require the specialized services available within a hospital with a neonatal intensive care unit (NICU) appropriate to gestational age. Presentation of the women at risk for preterm birth within a level 1A, 1B, or 1C hospital, requires consultation between MRHP at that hospital and the consultant at the referral hospital.
- 3.2 Early Preterm Birth is defined as gestational age between 22^{0/7} and 31^{6/7} weeks.
 - a) Gestational age between 22^{0/7} and 29^{6/7} weeks are to be transferred to a level three (3) NICU.
 - b) Gestational age between 30^{0/7} and 31^{6/7} weeks may be transferred to a level two (2) NICU if no level three (3) NICU beds are available or accessible.
- 3.3 Preterm Birth is defined as a gestational age between 32^{0/7} and 33^{6/7} weeks. Consultation and transfer of care to a facility with any level NICU is required.
- 3.4 Late Preterm Birth is defined as a gestational age between 34^{0/7} and 36^{6/7} weeks.
 - a) Gestational age between 34^{0/7} and 34^{6/7} weeks are to be transferred to a level two (2) NICU.
 - b) Gestational age between 35^{0/7} and 36^{6/7} weeks may be transferred to level two (2) NICU following consultation between the MRHP at level one

(1) hospital and neonatal/pediatric consultant at referral hospital. This population is at high risk for readmission if not cared for in a NICU.

- 3.5 Care of the late preterm infant is not recommended at a level 1A, 1B, 1C hospital without NICU support, unless the following circumstances, recognized to be conducive to a favourable outcome, exist:
- a) Consultation with pediatric/neonatal specialist in higher level of care hospital.
 - b) The mother and infant are provided with dedicated nursing staff who have appropriate competency and access to resources to ensure enhanced monitoring and care of the late preterm infant.
 - (i) Appropriate competency for nursing staff required to care for a late preterm infant in a hospital without access to NICU includes:
 - current Neonatal Resuscitation Provider (NRP) certification;
 - familiarity and access to the Acute Care of at-Risk Newborns (ACoRN) reference manual;
 - health care professional indicates that they are skilled and confident to provide the appropriate care for the late preterm infant;
 - approval and agreement of local manager; and
 - late preterm infant special needs have been discussed with the parent and documented informed consent to remain in the hospital without access to NICU has been received.
 - c) There is a minimum mother and infant hospital stay of 72 hours. Prior to discharge the infant demonstrates effective:
 - (i) feeding;
 - (ii) respiratory;
 - (iii) thermoregulation;
 - (iv) gastrointestinal; and
 - (v) endocrine functioning.
- 3.6 Cervical insufficiency generally presents between 16 and 24 weeks gestation. A level three (3) facility should be considered for the performance of a rescue or emergency cerclage at 22-23 weeks gestation to support timely and appropriate early preterm neonatal care if needed.

- 3.7 In communities where there are both level two (2) and level three (3) NICUs available- pre-counselling the patient regarding the most appropriate hospital to access based on number of weeks gestation will facilitate optimal access to required level of care and minimize transfers between sites within that community.

Summary of Recommended Care Locations by Gestational Age

Gestational Age (weeks)	Level 1A Hospital	Level 1B Hospital	Level 1C Hospital	Level 2 Hospital	Level 3 Hospital	Level 2 NICU	Level 3 NICU
22 ^{0/7} to 29 ^{6/7}							✓
30 ^{0/7} to 31 ^{6/7}						2 nd Choice	1 st Choice
32 ^{0/7} to 33 ^{6/7}				✓	✓	✓	✓
34 ^{0/7} to 34 ^{6/7}				✓	✓	✓	✓
35 ^{0/7} to 36 ^{6/7}	With special considerations			✓	✓	✓	✓
37 ^{0/7} to 40 +	✓			✓	✓	✓	✓

4. Supporting Transfer

- 4.1 The decision to transport a woman and fetus, and/or neonate shall include (see Appendix B: *Obstetrical Transport Decision Tree*):
- a) team collaboration including:
 - (i) mother and family;
 - (ii) sending hospital Physician;
 - (iii) receiving hospital Physician;
 - (iv) Referral, Access, Advice, Placement, Information & Destination (RAAPID);
 - (v) EMS staff; and
 - (vi) nursing staff from sending and receiving hospital.
 - b) ensuring that transport personnel have the appropriate expertise, technical skills, clinical judgment and equipment to provide proficient care for any emergency that may arise during transport; and
 - c) completion of cervical exam.
- 4.2 Contraindications to woman, fetus and/or neonate transport include but are not limited to:
- a) woman or fetus' condition is unstable or threatening to deteriorate rapidly;

- b) birth is imminent;
 - c) lack of attendants with necessary skills;
 - d) weather conditions are unsuitable for travel; or
 - e) risk of travel outweighs the risk of delivery at a level one (1) hospital.
- 4.3 Once decision to transport has been made, using *Transport Decision Tree* (Appendix B) and accessing RAAPID, effective communication shall be established between sending and receiving health care professionals.
- a) The MRHP at the sending site shall communicate with the MRHP who will be accepting care at the receiving site.
 - b) The MRHP at the sending site shall ensure that the nurse supervisor on duty at the receiving site is aware of the patient's expected time of arrival and condition upon transfer.
- 4.4 Health care professionals involved in transport shall have the ability to:
- a) monitor woman, fetus and neonatal vital signs;
 - b) assess and respond to changing conditions of the woman and fetus;
 - c) perform neonatal resuscitation including cardiopulmonary resuscitation (CPR);
 - d) initiate and administer intravenous (IV) therapy; and
 - e) conduct an emergency birth.
- 4.5 Stabilize patient for transfer:
- a) establish IV line;
 - b) administer medications as needed:
 - (i) antibiotics;
 - (ii) steroids (betamethasone);
 - (iii) tocolytic;
 - (iv) anti-hypertensive; and
 - (v) magnesium sulfate (MgSO₄).
- 4.6 Complete Obstetrical Transfer Record:
- a) photocopy of prenatal record;

- b) ultrasound;
- c) prenatal lab results;
- d) current lab results;
- e) electronic fetal monitoring tracing;
- f) triage notes; and
- g) pertinent documents.

DEFINITIONS

Consultant means Obstetrician, Neonatologist, Pediatrician or other obstetrical or neonatal specialist that has been requested to provide advice regarding the care of a patient(s).

Health care professional means an individual who is a member of a regulated health discipline, as defined by the *Health Disciplines Act* (Alberta) or the *Health Professions Act* (Alberta), and who practises within scope and role.

Most responsible health practitioner means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by AHS to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of their practice.

Patient means an adult or child who receives or has requested health care or services from Alberta Health Services and its health care professionals or individuals authorized to act on behalf of Alberta Health Services. This term is inclusive of residents, clients and outpatients.

REFERENCES

- Appendix A - *Service Delivery Model by Level of Hospital*
- Appendix B - *Obstetrical Transport Decision Tree*

Version Control

Date	Action Taken
March 27, 2020	Revised
Click here to enter a date	Optional: Choose an item

APPENDIX A

Service Delivery Model by Level of Hospital

- Level 0 Hospital = hospital that does not routinely provide obstetrical support
- Level 1 A Hospital = hospital with no operating room capability
- Level 1 B Hospital = hospital with 24/7 Operating Room (OR) and Cesarean section capability
- Level 1 C Hospital = hospital with 24/7 OR plus obstetrical specialist
- Level 2 Hospital = hospital with full obstetrics, surgical and pediatric services including L2 NICU
- Level 3 Hospital = hospital with full obstetrics, surgical and neonatal services including L2 & 3 NICU

Community and Rural Maternal Services Intrapartum Pathway for **Planned Birth**

Indicators	Level 1A Home or birth center No OR	Level 1B 24/7 OR	Level 1C OR + OB/GYN	Level 2 OR + OB/Gyn +L2 NICU	Level 3 Tertiary L3 NICU
Average risk obstetrics 37 to 40 or greater weeks gestation	Home, Birth Center, L1A, 1B, 1C, 2 or 3				
Planned Low Risk Induction gestation of 38 weeks or greater, multip, Bishop score of 6 or greater, established back up plan with referral hospital and patient consent	L1A, 1B, 1C, 2 or 3				
Planned caesarean of 39 weeks or greater gestation	L1B, 1C, 2 or 3				
Planned induction of labour 37 weeks or greater gestation with medical indication	L1B, 1C, 2 or 3				
Women presents to hospital in labour at assessment/triage area: Professional judgement is used to assess maternal risk and need for consult and/or transfer to appropriate level of care facility.					
Consider consultation: Abnormal presentation, atypical or abnormal fetal heart, dystocia	L1B, 1C, 2 or 3				
Consultation and possible transfer Maternal tachycardia, maternal hypertension, urine protein 2+, pyrexia, significant vaginal blood loss	L1 C, 2 or 3				
Consultation and transfer Preterm labour, caesarean less than 37 weeks, rupture of membranes greater than 24 hours, non-labour pain with other risks, multiple fetuses, intrauterine growth restriction, macrosomia, oligohydramnios or polyhydramnios.	L2 or 3				
Transfer- Preterm labour- Between 22 and 30 weeks gestation	L3				
If any of the factors above are observed but birth is imminent, assess whether birth in the current location is preferable to transferring the woman to alternate level site. Consider need for neonatal transport. Any plan for transport to be preceded by cervical exam and discussion with the health care team and EMS to determine risk of on route delivery					

APPENDIX B

Obstetrical Transport Decision Tree

