Guideline

Risk assessment and criteria for referral for obstetric-led care (or obstetric opinion) by midwives

Audit standards

1. All women with the defined high risk factors at booking should be referred at booking for obstetric-led care in pregnancy.
2. All women with the high risk factors presenting antenatally should be referred for an obstetric opinion in pregnancy.
3. All women with the high risk factors presenting during labour/ intrapartum or immediate postpartum should be referred for an obstetric opinion.
4. The lead professional should at all times be clearly identifiable from the hospital notes, in particular:
   - in pregnancy, on the hand held notes and on the pink divider sheet in the hospital notes.
   - in labour, in the hospital notes.
5. At any stage of pregnancy, or during the intrapartum or postnatal periods, when risk factors are identified:
   - the process of referral should follow that defined in this guideline and in low risk antenatal guideline LR1.1 responsibility for care, and other relevant specific guidelines, where relevant
   - an individualised plan of care following referral and review must be documented by the receiving clinician.
6. When an opinion is sought by a midwife from an obstetrican and referral back to MLC is appropriate, then it should be stated in the notes by the obstetrician that the women is now suitable for MLC.

1 Scope

This guideline is applicable in Maternity Services for use by all professional staff, particularly midwives, both within hospital and the community.

2 Purpose

- To guide health professionals in the assessment of risk of the pregnant women, in relation to the antenatal, intrapartum and postnatal periods.
- To assist midwives in the initial contact with the pregnant woman, and subsequently during the maternal care episode.
- To allocate her to the correct pathway for her antenatal, intrapartum and/ or postnatal care.
- To define:
    - criteria, based upon risk factors, requiring referral from midwifery-led to obstetric-led care (or an opinion from an obstetrician)
    - the process of referral from midwifery-led to obstetric-led care (or an opinion)
    - the process for referral back to midwifery-led care.

This document does not include the process whereby midwives may make direct referral to another health professional eg to the anaesthetic clinic or the psychiatric services.

3 Abbreviations used

BP	blood pressure
CTG	cardiotocograph
DU	Delivery Unit
EFM	electronic fetal monitoring
HELLP	haemolysis, elevated liver enzymes, low platelets
HIV	human immunodeficiency virus
LSCS	lower segment caesarean secton
MFAU	Maternal-Fetal Assessment Unit
MLC	midwifery-led care
PPH	postpartum haemorrhage
VBAC	vaginal birth after caesarean secton
VTE	venous thromboembolism

4 Introduction

The primary purpose of risk assessment is to classify individual women into different categories (high and low risk) for which specific actions are recommended. It is a form of screening, although the benefits of such assessments lack evidence and harm has rarely been addressed. It is therefore important that care is individualised and based upon the unique needs of each woman.

An assessment of risk should be performed at booking and reviewed regularly throughout pregnancy and labour in order to indicate:

- the most appropriate lead professional
- where referral/ liaison with other health professionals is required
- low risk (midwifery led) or high risk (consultant led) care
- the most appropriate place of admission for the woman during antenatal, intrapartum and postnatal periods.

The lead professional should be clearly identified on the woman's hand held maternity records and on the pink obstetric divider sheet in her hospital notes. Any referral to an obstetrician must be followed by a clear individualised management plan. ✓

If, following review, an obstetrican feels that the women may be transferred back to midwifery-led care during any stage of the pregnancy, labour or postnatal period then any plan for the woman's care should be clearly documented in the notes and it clearly stated that the midwife may resume being the lead professional. ✓

5 High risk factors

The following high risk factors indicate that a referral for obstetric-led care, or opinion, should be made.

5.1 High risk factors at booking

High risk factors at booking are:

- age at booking ≥40 years (nulliparae) or ≥45 years (multiparae)
- body mass index <18.5 or ≥35
- booking blood pressure ≥ 150/90
- religious/ cultural reason for obstetric-led care eg Jehovah's Witness
- women with previous care in this pregnancy in a non-English speaking country
- poor past obstetric history:
    - severe pre-eclampsia or eclampsia, HELLP syndrome
    - rhesus antibodies
    - uterine surgery including:
        - complicated caesarean section (for one previous **uncomplicated** LSCS, women should be referred only to the midwife-led VBAC clinic for review at around 20/40 gestation)
        - myomectomy
        - hysterotomy
        - uterine rupture
        - 2+ LLETZ
    - antepartum haemorrhage or PPH on more than two occasions
    - major primary PPH requiring treatment

    - placental abruption with adverse outcome
    - previous shoulder dystocia
    - puerperal psychosis
    - grand multiparity (para 5 or more)
    - stillbirth/ neonatal death
    - children born with:
        - low birth weight (< 2.5 kgs) or
        - high birthweight (> 4.5 kgs)
    - retained placenta on two or more occasions
    - children born with congenital/ genetic or chromosomal abnormality
    - previous pre-term birth under <36 weeks
- major medical conditions that might complicate pregnancy or anaesthesia:
    - booking BP ≥150/90 or a history of BP problems
    - haemoglobinopathies (sickle cell or thalassaemia)
    - renal impairment/ disease
    - cardiac disease or hypertension
    - respiratory disease including severe asthma requiring current specialist care
    - endocrine disorders or diabetes
    - autoimmune disease
    - herpes: first episode in current pregnancy
    - epilepsy requiring anticonvulsant drugs
    - malignancy
    - haematological disorders
    - strong family history of thromboembolism (first degree relative)
    - anticoagulant therapy
    - HIV, hepatitis B or hepatitis C positive
    - neurological disorders
- risk factors following an antenatal VTE risk assessment (ie score ≥3) which suggest the need for thromboprophylxis (clexane or stockings) (see high risk intrapartum guideline HR2.28 obstetric thromboprophylaxis: pre-conceptual/ antenatal/ post-delivery).
- psychiatric history:
    - major episode past/ present
    - medication for mental illness
    - currently/ previously under psychiatrist
    - history of drug or alcohol abuse.

5.1.1 Process for assessment and referral at booking

The process for risk assesment at booking involves the use of the booking form, which lists the above criteria requiring referral for obstetric-led care, and completion of the hand held maternity notes. The booking form and hand held notes should indicate the lead professional and type of care (consultant led or midwifery-led care). Whilst ideally women should be

referred using the booking form, in some circumstances, it may not be appropriate to use this, for example:

- women referred from another unit for tertiary care
- 'late' bookers
- women recently moved to the area
- certain 'high' risk women, eg those with diabetes, blood borne virus.

Midwives who wish to seek any advice regarding referral criteria may either telephone the antenatal clinic sister, or contact the on-call 'hot week' obstetric consultant during the working week on the DU.

5.2 High risk factors presenting antenatally

High risk factors presenting antenatally are:

- confirmed intrauterine death
- multiple pregnancy
- high risk maternal screening test results or ultrasonic abnormalities
- recurrent antepartum haemorrhage
- fetal growth restriction
- persistent anaemia despite iron (haemoglobin <9.0 g/dl)
- small for gestational age (<fifth centile or reduced growth velocity)
- polyhydramnios or oligohydramnios
- breech presentation, oblique or transverse lie >36/40
- reduced fetal movements >26/40, in line with the reduced fetal movements guideline (see high risk antenatal guideline HR1.40: management of reduced fetal movements)
- placenta praevia
- diastolic BP ≥95 mmHg or proteinuria ≥1+, or systolic >160mmHg
- onset of gestational diabetes
- vulnerable women:
    - teenagers (ie <16yrs)
    - asylum seekers
    - late bookers (ie > 20 weeks).

5.2.1 Process for assessment and referral in pregnancy

High risk factors developing antenatally, listed above, should be referred, or discussed with an obstetrician, using the most appropriate referral pathway.

This could be either via:

- the antenatal clinic – this process is defined in LR1.1 responsibility for care guideline
- the MFAU – for the assessment of problems in pregnancy requiring urgent and/or immediate assessment – see HR1.15: referrals to MFAU

- the on-call 'hot week' obstetric consultant who may provide telephone advice during the working week – this is described in HR2.1 multi-professional communication in Maternity Services and staff handovers
- The Ultrasound Department, followed by appropriate obstetric follow-up if required eg breech presentation (see HR1.12 referrals for ultrasound scans in pregnancy after 24 weeks protocol).

Midwives should use their clinical judgement and consider the urgency of the referral when deciding who, or where, to refer individual women.

5.3 High risk factors presenting during labour / intrapartum or immediate postpartum

- unbooked women
- low platelet count (<100) and/or Hb <8.5 g/dl
- preterm labour <37/40
- suspicious/ pathological CTG
- pyrexia (38.0°C once or 37.5°C on two occasions two hours apart)
- undiagnosed malpresentation
- intrapartum haemorrhage
- absence of fetal heart
- raised diastolic blood pressure (over 90mmHg) or raised systolic blood pressure (over 140mmHg) on two consecutive readings taken 30 minutes apart
- delay in first or second stage labour, as defined in the low risk intrapartum guidelines:
  - 2.7: assessing progress in labour
  - 2.9: second stage of labour - low risk women
- absence of labour following spontaneous rupture of the membranes >24-48 hours and/or requiring induction of labour
- cord prolapse
- **significant** meconium stained liquor (that is, dark green or black amniotic fluid that is thick or tenacious, or any meconium-stained amniotic fluid containing lumps of meconium)
- indications for continuous EFM following abnormalities of the fetal heart on intermittent auscultation
- epidural
- retained placenta
- primary postpartum haemorrhage
- third or fourth degree tear

- post term pregnancy (>42 weeks)
- induction of labour for high risk reasons
- risk factors following a postnatal VTE risk assessment which suggest the need for thromboprophylxis (clexane or stockings) (see high risk intrapartum guideline HR 2.28 obstetric thromboprophylaxis: pre-conceptual/ antenatal/ post-delivery)
- heavy vaginal bleeding suggesting secondary PPH
- **significant** postpartum complications which require urgent or emergency action and which in the midwife's opinion are not appropriate for GP action (see LR3.1 postnatal framework).

5.3.1 Process for assessment and referral intrapartum / immediate postpartum

The process for assessment in the intrapartum period commences when the woman telephones a midwife when in labour. An assessment is undertaken using the telephone assessment tool which assists in directing the woman to the most appropriate place for care (ie DU or Birth Centre) and the timing of admission.

Following admission in labour, a further detailed assessment should be undertaken by a midwife; this should normally be recorded in the intrapartum notes on the admission assessment tool document. If the tool is not used, there should be evidence of an assessment of maternal and obstetric history recorded in the notes. Any risk factors identified should trigger referral to, or discussion with, an obstetrician. An individualised management plan should be documented for all women.

If referral is required to an obstetrician, midwives should refer directly to at least an obstetric SpR (ST 3-5 or equivalent); this process is defined in HR2.1 multi-professional communication in Maternity Services and staff handovers and LR1.1 responsibility for care. For home births, midwives should also refer to LR2.13 home birth.

The on-call 'hot week' obstetric consultant may also be accessed to provide telephone advice during the working week.

6 Monitoring compliance with and the effectiveness of the guideline

The use and effectiveness of this guideline is monitored continuously by the following processes:

The antenatal clinic midwives review each booking form upon receipt to the clinic to assess the suitability of the assessment and the referral for care.

Change are made if required to the lead professional and discussed with obstetric staff if required.

Referrals in pregnancy and during labour from midwife-led to obstetric-led care are monitored continuously using the telephone assessment tool and admission assessment tool, and via peer case review.

In addition, the Obstetric Risk Manager will collect incident forms relating to any adverse incdient involign inappropriate referal in pregnancy, or during the intrapartum or post-natal period. Any significant incidents will be investigated according to the Perinatal Services incident reporting and investigation procedure and then reported to the Head of Midwifery and/ or Clinical Director, and subsequently to the Perinatal Clinical Governance Committee in a quarterly report. The Perinatal Clinical Governance Committee will be responsible for reviewing incident data, and for identifying and monitoring any actions required.

Any agreed action will be taken by the nominated person(s) within midwifery. Any change to the guidleine will be be facilitatd by the the Research and Development Midwife and/or author.

7 References

CEMD (2007) *Why Mothers Die 2003-2005. The Confidential Enquiries into Maternal Deaths in the United Kingdom* RCOG Press, London.

NICE (2007) *Antenatal Care: Routine Care for the Healthy Pregnant Woman* National Institute for Health and Clinical Excellence RCOG Press, London.

8 Associated documents

- LR1.1 responsibility for care guideline
- LR2.1 criteria for the Rosie Hospital Birth Centre guideline
- LR2.2 admission assessment and general principles for the care of (low-risk) women in labour guideline
- LR2.7 assessing progress in labour guideline
- LR2.9 second stage of labour - low risk women guideline
- LR2.13 home birth guideline
- LR3.1 postnatal framework guideline
- HR1.12 referrals for ultrasound scans in pregnancy after 24 weeks
- HR1.15 referrals to Maternal-Fetal Assessment Unit (MFAU) guideline
- HR 2.1 multi-professional communication in Maternity Services and staff handovers
- HR 2.28 obstetric thromboprophylaxis: pre-conceptual/ antenatal/ post-delivery guideline
- HR1.40 management of reduced fetal movements guideline
- Perinatal Services incident reporting and investigation procedure

Equality and diversity statement

This document complies with the Cambridge University Hospitals NHS Foundation Trust service equality and diversity statement.

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Document management

Document control/change history

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Draft	J Ford	As above	Aug 2004		
Draft 3	V Dekker & J Ford	As above	Dec 2007	DU Forum; Maternity Risk Management Group; Polices & Procedures Group (Maternity); Obstetric Divisional Group	Revised in line with CEMD (2007) and NICE (2007). Title changed from 'Risk Assessment'.
Draft 4 Version 1	As above	As above	Feb 2008	Polices & Procedures Group (Maternity); Obstetric Divisional Group	Inclusion of 'vulnerable' women considered again following rejection of guideline at divisional in February; now included
Draft Version 2	J Ford	As above	Feb 2010	Policies & Procedures Group (Maternity); Perinatal Services Management Group	Some changes for CNST added inc. process for referral antenatally, intrapartum and post-natally and individualised management plan.
Draft 6 Version 3	J Ford	As above	March 2011	H Morrison, ANC Sister; Policies & Procedures Group (Maternity); Perinatal Services Management Group	Age criteria, preterm birth <36/40 and LLETZ added. Amended herpes to first episode, severe asthma to include that requiring specialist care and previous uncomplicated CS to include midwife-led VBAC clinic.

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