

STANDARD FOR DISCUSSION, CONSULTATION AND TRANSFER OF CARE

BACKGROUND

A midwife is a primary caregiver and provides care within her scope of practice. In providing care, a midwife is responsible for recognizing conditions which require consultation with or transfer of care to a physician* and to initiate a consultation within an appropriate period of time.

PURPOSE OF THE STANDARD

The purpose of the Standard is to describe the process for discussion, consultation and transfer of care and to list in which situations a midwife must consult or transfer care.

The Standard applies to all settings. It is not intended to be exhaustive; other circumstances may arise where the midwife determines consultation or transfer of care is necessary.

The category of mandatory consultation refers to situations in which a midwife must initiate consultation with a physician. It is the midwife's responsibility to initiate a consultation and to communicate clearly to the consultant that she is seeking a consultation.

The category of indications for discussion refers to situations where a midwife must initiate a discussion with, or provide information to, another midwife, physician or another appropriate care provider in order to plan care appropriately. The midwife must document the discussion and plan for care in her records.

The Standard will be reviewed by the College of Midwives every three years. Changes will be based on research, experience and ongoing evaluation of midwifery practice to ensure the relevance of the Standard to safe and effective midwifery care.

*Physician may include an obstetrician, neonatologist, paediatrician, anaesthesiologist, internist, psychiatrist, family physician, etc.

DISCUSSION

The category of indications for *discussion* refers to situations in which a midwife must initiate a discussion with, or provide information to, another midwife or appropriate health care provider in order to plan care appropriately. This plan may include a consultation with a physician competent to give advice in this field. The midwife in her records must document the discussion and plan for care.

CONSULTATION

A *consultation* refers to the situation where a midwife, in light of her professional knowledge of the client and in accordance with the standards of practice of the College of Midwives, or where another opinion is requested by the client, requests the opinion of a consultant competent to give advice in this field.

The midwife must inform the client of the indication for consultation and discuss the options with them as early as possible in the process of care. A timely consultation may benefit the midwife and enhance the care of the client.

If a consultation is requested, the consultation should be specific, i.e., requesting the consultant to address one or several specific issues in the care of that client. Consultation does not imply automatic transfer of care unless stated. In the former, the consultant's responsibilities pertain to one specific area of care, usually in the form of recommendations for action, with occasional expectations that this action is to be carried out by the consultant. In the latter, the consultant takes on total care and becomes the primary, responsible care provider. The level of consultation required should be established and mutually agreed to by dialogue between the referring midwife and the consultant. If the referring midwife wishes to transfer care of the client, this should be made clear on the consultation form.

Documentation for the consultation should include the following:

- Date and time:
 - Of the consultation request,
 - The consultant was informed of the consultation, and
 - The response occurred,
- Specific questions to be answered,
- Consultant's response including:
 - Assessment of the client, and
 - Recommendations, and
- Identification of the role of the midwife and that of the consultant in the ongoing care of the patient.

The role of the referring midwife is to:

- Consider requesting a consultation before an urgent situation becomes emergent,
- Advise the client with respect to the reasons for consultation and steps involved,
- Provide a summary of the client's history, physical examination, laboratory findings and any other pertinent information,

- Document the reasons for the consultation and specific issues to be addressed by the consultant, and
- Specify whether the consultation is for:
 - One time only request,
 - Collaborative care, or
 - Transfer of care.

The consultation can involve the consultant providing advice and information and/or providing therapy to the woman/newborn or prescribing therapy to the midwife for the woman or the newborn.

Once a consultation has taken place and the consultant findings, opinion and recommendations are communicated to the client and the midwife, the midwife must discuss the consultant recommendations with the client and ensure the client understands which health professional will have responsibility for primary care.

Where urgency, distance or climatic conditions make an in-person consultation with a consultant not possible, the midwife should seek advice from the consultant by phone or similar means. The midwife should document this request for advice in her records, and discuss with the client the advice received.

The consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within her scope of practice. Areas of involvement in client care must be clearly agreed upon and documented by the midwife and the consultant.

TRANSFER OF CARE

When primary care is *transferred*, permanently or temporarily, from the midwife to a physician, the physician, together with the client, assumes full responsibility for subsequent decision-making. The midwife may continue to provide supportive care. Cooperation in the care of a woman/newborn will be enhanced by mutual recognition of respective professional roles. Care may be transferred back to the midwife in situations where the woman's/newborn's condition returns to the normal scope of practice of the midwife.

INITIAL INTERVIEW (CLIENT HISTORY)

Indications for Discussion

- Grand multipara (para 5 or greater)
- History of genital herpes
- History of infant over 4500 grams
- History of one infant weighing less than 2500 grams
- History of psychological problems
- Poor nutrition
- Previous antepartum haemorrhage
- Previous postpartum haemorrhage
- One documented previous lower segment Caesarean section

Indications for Mandatory Consultation

- History of medical conditions that may be exacerbated by pregnancy or affect labour + birth
- History of >1 low birth weight infant (less than 2500 grams)
- History of >1 lower segment Caesarean section
- Previous reconstructive bladder surgery
- Previous uterine surgery excluding 1 lower segment Caesarean section
- Previous vaginal surgery excluding episiotomy or laceration repair
- History of >one late miscarriage (after 14 weeks)
- History of one preterm birth
- History of intrauterine growth restriction
- Previous stillbirth or neonatal loss
- Congenital defect(s) of the reproductive organs
- Psychiatric illness requiring hospitalization and/or psychotropic drugs
- Postpartum psychosis
- Severe mental disability
- History of severe pregnancy induced hypertension or eclampsia during previous pregnancy
- Marked skeletal abnormalities in the pregnant woman
- BMI >40
- Family history of genetic disorders, hereditary disease or significant congenital anomalies (genetic screening should be offered)
- History of ≥ 3 consecutive spontaneous abortions
- History of back or pelvic surgery
- History of cervical cerclage or incompetent cervix

Indications for Transfer of Care

- Serious, chronic or acute medical conditions

PRENATAL CARE

Indications for Discussion

- Uncertain estimated date of birth
- No prenatal care before 28 weeks
- Presentation other than cephalic at 36 weeks
- Severe varicosities of the lower extremities

Indications for Mandatory Consultation

- Rubella during the 1st trimester of pregnancy
- Abnormal pap smear
- Known HIV positive
- Acute pyelonephritis
- Hepatic disease
- Symptomatic sexually transmitted infection not referred to in Schedule B Part I #1
- Exposure to known teratogens (e.g. chemicals, infections)
- Persistent abuse of alcohol or drugs
- Hyperemesis Gravidarum
- Development of serious medical conditions
- Severe persistent abdominal pain
- Vaginal bleeding (other than transient spotting)
- Abdominal surgery after 24 weeks gestation
- Abnormal glucose tolerance test
- RH isoimmunization or other positive antibody screen
- Persistent anaemia (i.e. Hb. less than 90 g/l) unresponsive to therapy
- UTI not responsive to therapy
- Abnormal fetal growth pattern
- Abnormal fundal growth pattern
- Pregnancy induced hypertension
- Antepartum fetal death
- Severe varicosities of the vulva
- Polyhydramnios
- Oligohydramnios
- Confirmed Abnormal Placenta Location/Placental Abnormalities
- Suspected or diagnosed fetal anomaly that may require immediate medical management after delivery
- Twins
- Breech presentation at term *

* While many of these births may become transfers of care, twins and breech presentation are listed as indications for consultation to allow an obstetrical consultant discretion in deciding if a midwife may manage such a delivery, where a spontaneous birth is reasonably anticipated. In a remote area, the availability of an experienced midwife may prevent a woman from having to leave her family and community. Midwives may also gain important hands-on experience under obstetrical supervision.

PRENATAL CARE Continued...

Indications for Mandatory Consultation Continued...

- Presentation other than cephalic at 37 weeks
- Prolonged rupture of membranes (greater than 24 hours without onset of labour)
- Documented pregnancy greater than 42 weeks gestation
- History or presence of severe uterine prolapse
- Evidence of change in fetal status

Indications for Transfer of Care

- Serious medical conditions which develop during pregnancy (e.g. diabetes, cardiac disease, renal disease)
- Missed or incomplete abortion
- Molar pregnancy
- Extra-uterine pregnancy
- Severe pregnancy induced hypertension
- Placenta previa
- Multiple pregnancy (other than twins)
- Oligohydramnios
- Thromboembolic disease
- Preterm rupture of membranes < 35 weeks gestation
- Signs of placental abruption

DURING LABOUR AND BIRTH

Indications for Discussion

- No prenatal care

Indications for Mandatory Consultation

- Active genital herpes
- Preterm Labour (35+0 to 36+6 weeks)
- Vaginal bleeding, continued or repeated
- Twins*
- Breech presentation*
- Hypertension
- Failure to progress, which may include dystocia, non-dilatation, non-descent of the presenting part with or without dilatation of the cervix (Prolonged active Phase, prolonged second stage)
- Thick or particulate meconium at any time during labour
- Unexpected sudden or severe abdominal pain
- Maternal request for epidural anaesthesia/narcotic analgesia
- Lacerations involving the anus, anal sphincter, rectum, urethra

Indications for Transfer of Care

- Preterm labour less than 35 weeks
- Uterine rupture
- Abnormal fetal heart rate pattern unresponsive to therapy
- Cord prolapse
- Persistent fever greater than 38 C
- Abnormal presentation other than breech
- Eclampsia
- Multiple pregnancy other than twins

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POSTPARTUM (MATERNAL)

Indications for Mandatory Consultation

- Retained placenta with or without bleeding
- Persistent uterine atony
- Severe Uterine Prolapse
- Vulvar haematoma not stabilizing
- Persistent bladder dysfunction
- Persistent temp $>38^{\circ}\text{C}$
- Pregnancy induced hypertension
- Secondary postpartum haemorrhage
- UTI not responsive to therapy.
- Subinvolution of the uterus with signs and symptoms of uterine infection
- Suspected superficial or deep vein thrombosis
- Breast infection unresponsive to treatment
- Unexplained persistent chest pain or dyspnea
- Serious psychological problems

Indications for Transfer of Care

- Haemorrhage unresponsive to treatment
- Inversion of the uterus
- Postpartum eclampsia
- Thromboembolic disease

POSTPARTUM (INFANT)

Indications for Discussion

- Infant above the 95th percentile for weight, length or head circumference
- Abnormal finding on physical exam
- Presence of persistent rash
- Failure of infant to regain birth weight within 14 days

Indications for Mandatory Consultation

- Preterm baby (35+0 to 36+6 weeks gestation)
- Apgar score less than seven at five minutes
- Infant below the 5th percentile for weight, length or head circumference
- Persistent mottling of skin
- Persistent pallor, cyanosis, hypotonia or jitteriness
- Excessive bruising, abrasions, unusual pigmentation or lesions
- Generalized bruising
- Generalized petechiae
- Abnormally flushed or ruddy color
- Weight less than 2500 grams
- Signs and symptoms of hypoglycaemia
- Postmaturity syndrome
- Shrill or abnormal cry
- Abnormal movement of any extremity
- Congenital abnormalities
- Ambiguous genitalia
- Abnormal heart rate pattern
- Persistent quiet tachypnea >4hrs of age
- Persistent abnormal respiratory rate and/or pattern
- Infant born to a mother with active genital herpes
- Infant born to a mother who is Hepatitis positive
- Suspicion of neonatal infection
- Infant born to a mother with current significant drug or alcohol abuse
- Infant born to a mother who is HIV positive
- Single umbilical artery
- Does not pass meconium within 24 hours
- Does not urinate within 24 hours
- Jaundice within 24 hours
- Suspected pathological jaundice after 24 hours

POSTPARTUM (INFANT) continued...

**Indications for Mandatory Consultation
continued...**

- Presence of vesicles on skin or mucous membranes
- Fever or persistent low temperature unresponsive to therapy
- Abnormal vomiting or diarrhea
- Infection of the umbilical stump site
- Weight loss in infant greater than 10% of birth weight that is unresponsive to adaptation in feeding plan.
- Feeding intolerance
- Failure of infant to regain birth weight within 21 days
- Infant born to a mother with serious medical complications which may affect the newborn

Indications for Transfer of Care

- Infant <35+0 weeks gestation
- Respiratory distress
- Central cyanosis
- Lethargic, flaccid or unresponsive to stimulation
- Significant congenital anomaly requiring immediate medical intervention
- Heart rate less than 100/minute with activity or greater than 160/minute at rest, or any abnormal sounds noted
- Signs and symptoms of oomphalitis
- Suspected seizure activities
- Bilious vomiting