Saskatchewan College of Midwives

Subject: **Mandatory Discussion, Consultation And Transfer of Care**

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GUIDELINE

PREAMBLE

Midwives are primary caregivers who are fully responsible for clinical decisions and the management of care within their scope of practice with primary consideration to the best interest of the woman and her fetus/newborn. In providing care, a midwife is responsible for recognizing conditions, which require discussion with, consultation with, or transfer of care to a physician or another appropriate health care professional and to initiate discussion and/or consultation within an appropriate period of time.

PURPOSE

The purpose of this policy is to describe the process for discussion, consultation and transfer of care and to list which situations a midwife should discuss, consult or transfer care.

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

This policy will be reviewed by the Saskatchewan College of Midwives at a minimum, every 24 months. Changes will be based on research, experience and ongoing evaluation of midwifery practice to ensure the relevance of the Policy to safe and effective midwifery care.

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. The midwife in her records must document the discussion and plan for care. This may include consultation with a physician or other health care provider or transfer of care to a physician.

CONSULTATION

A *consultation* refers to the situation where a midwife, using her professional knowledge of the client and in accordance with the standards of practice of the Saskatchewan College of Midwives, requests the opinion of a physician or health practitioner (hereinafter referred to as consultant), competent to give advice in this field. A midwife may also seek a consultation when the client requests another opinion.

The midwife must inform the client of the indication for consultation and discuss the options with her as early as possible in the process of care. The midwife should attempt to acquire a consultation in a timely manner to benefit the midwife and the care of the client.

The midwife should request that the consultation address the problem that led to the referral, an in-person assessment of the client, and the prompt communication of the findings and recommendations to the client and the midwife.

Following the assessment of the client by the consultant(s), discussion may occur between the midwife and consultant regarding future client care, and a written report will be provided by the consultant.

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

After consultation with a physician, primary care of the client and/or newborn and responsibility for decision-making together with the client either:

a) Continues with the midwife, or
b) Is transferred to a physician

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

The consultant may be involved in, and responsible for, a discrete area of the client's and/or newborn'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. The consultant may recommend transfer of care whether or not requested by the referring midwife.

Documentation of the consultation may include the following:

- Reason for the consultation
- Date and time of the consultation request
- Date and time the response occurred
- Consultant's assessment of the client
- Consultant's recommendations
- Identification of the role of the midwife and that of the consultant in the ongoing care of the client.

The role of the referring midwife is to:

- Request a consultation as soon as the indication appears
- 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 to the consultant
- Document the reasons for the consultation and specific issues to be addressed by the consultant
- Specify whether the consultation is intended for:
    - One time only request
    - Collaborative care, or
    - Transfer of 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 the records, and discuss with the client the advice received.

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 Mandatory Discussion

- Grand multipara (para 5 or greater)
- History of infant over 4500 grams
- History of psychological problems
- Poor nutrition
- Previous antepartum haemorrhage
- Previous postpartum haemorrhage
- Age less than 16 years or more than 40 years

Indications for Mandatory Consultation

- Any prior anomaly
- History of genital herpes
- History of medical or surgical conditions that may be exacerbated by pregnancy or affect labour and birth
- History of any low birth weight infant or less than 10th percentile for the gestational age
- History of pre-term birth =/< 36 6/7 weeks
- History of more than one lower segment Caesarean section
- Previous uterine surgery or vaginal surgery excluding episiotomy or laceration repair
- History of one or more late miscarriages (after 14 weeks)
- Previous stillbirth or neonatal loss
- Known uterine malformations or significant fibroids
- Previous history of postpartum psychosis
- Problematic substance use
- History of gestational hypertension which is considered severe by the most current guidelines
- BMI over 40
- History of 3 or more consecutive first trimester spontaneous abortions
- History of cervical cerclage or incompetent cervix
- HIV positive client

Indications for Transfer of Care

- Serious, chronic or acute medical conditions
- History of venous thrombosis

PRENATAL CARE

Indications for Mandatory Discussion

- Uncertain estimated date of birth
- No prenatal care before 28 weeks
- Severe varicosities of the lower extremities

Indications for Mandatory Consultation

- Rubella or Varicella or Parvovirus at any stage during the pregnancy
- HIV positive
- Abnormal Pap smear
- Pelvic Inflammatory Disease or Tubo-ovarian abscess
- Exposure to known teratogens
- Persistent abuse of alcohol or drugs
- Hyperemesis Gravidarum
- Development of serious medical and/or surgical conditions
- Vaginal bleeding (other than transient spotting) after 16 weeks
- Gestational Diabetes Mellitus (GDM) on diet
- RH isoimmunization or other positive antibody screen
- Persistent anaemia unresponsive to therapy
- UTI not responsive to therapy
- Fetal Growth Restriction where EFW < 10th centile for gestational age
- Fetal Macrosomia where EFW > 90th centile for gestational age"
- Abnormal fetal growth pattern
- Gestational hypertension
- Antepartum fetal death
- Severe varicosities of the vulva
- Polyhydramnios
- Oligohydramnios
- Low lying placenta at =/> 28 weeks
- Suspected or diagnosed fetal anomaly
- Twins *
- Breech presentation at term *
- Presentation other than cephalic at =/> 34 weeks
- Uncomplicated rupture of membranes at term (greater than 48 hours without a plan to deliver)
- Documented pregnancy greater than 42 weeks gestation
- History or presence of severe uterine prolapse
- Evidence of change in fetal status

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* 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.

Indications for Transfer of Care

- Serious medical conditions which develop during pregnancy
- Missed or incomplete abortion
- Molar pregnancy
- Extra-uterine pregnancy
- Gestational hypertension which is considered severe by the most current guidelines
- Placenta previa at more than 28 weeks
- Twins with discordant growth and/or twin to twin transfusion syndrome and/or other significant increased risk
- High Order Multiple Pregnancy
- Thromboembolic disease
- Preterm rupture of membranes less than 35 weeks gestation
- Placental abruption

DURING LABOUR AND BIRTH

Indications for Mandatory Discussion

- No prenatal care

Indications for Mandatory Consultation

- Preterm labour (35+0 to 36+6 weeks to a doctor for the baby)
- Vaginal bleeding, continued or repeated
- Twins [*]
- Stillbirth
- Breech presentation [*]
- Gestational hypertension
- Failure to progress, after appropriate use of oxytocin
- Meconium during labour
- Sudden or severe abdominal pain
- Maternal indication for or request for epidural anaesthesia/narcotic analgesia
- Lacerations involving the anus, anal sphincter, rectum, urethra
- Persistent fever greater than 38^{0} C after treatment
- Malpresentation/Abnormal presentation other than breech (transfer of care if feasible)
- HIV positive (transfer of care if unsuppressed or unknown viral load)

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Indications for Transfer of Care

- Preterm labour less than 35 weeks
- Breech presentation (if feasible)
- Active genital herpes
- Uterine rupture
- Abnormal fetal heart rate pattern unresponsive to therapy
- Cord prolapse
- Malpresentation/Abnormal presentation other than breech (transfer of care if feasible)
- Eclampsia
- Gestational hypertension which is considered severe by the most current guidelines
- HIV positive (if viral load unsuppressed or unknown)

POSTPARTUM (MATERNAL)

Indications for Mandatory Consultation

- Retained placenta with or without bleeding (transfer of care if feasible)
- Persistent uterine atony
- Severe uterine prolapse
- Vulvar haematoma not stabilizing
- Persistent bladder dysfunction
- Persistent temp greater than 38°C
- Secondary postpartum haemorrhage
- UTI not responsive to therapy
- Subinvolution of the uterus with signs and symptoms of uterine infection
- Suspected deep vein thrombosis
- Gestational hypertension
- Breast infection unresponsive to treatment
- Serious psychological problems
- Request for immediate postpartum tubal occlusion

Indications for Transfer of Care

- Haemorrhage unresponsive to treatment
- Gestational hypertension which is considered severe by the most current guidelines
- Unexplained persistent chest pain or dyspnea
- Inversion of the uterus (if feasible)
- Postpartum eclampsia
- Thromboembolic disease

POSTPARTUM (INFANT)

Indications for Mandatory Discussion

- Infant above the 95th percentile for weight, length or head circumference
- Abnormal finding on physical exam
- Presence of persistent rash
- Does not pass meconium within 24 hours
- Does not urinate within 24 hours
- Generalized bruising

Indications for Mandatory Consultation

- Preterm baby (35+0 to 36+6 weeks gestation)
- Apgar score less than 7 at five minutes
- Infant below the 5th percentile for weight, length or head circumference
- Persistent mottling of skin, pallor and cyanosis and/or abnormally flushed or ruddy colour
- Hypotonia or jitteriness
- Excessive bruising, abrasions, unusual pigmentation or lesions or generalized petechiae
- Postmaturity syndrome
- Abnormal cry
- Abnormal movement of any extremity
- Congenital abnormalities
- Abnormal heart rate and/or pattern
- 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
- Infant born to a mother who is HIV positive
- Suspicion of neonatal infection, local or systemic
- Infant born to a mother with current significant substance abuse
- Single umbilical artery
- Jaundice within 24 hours
- Diagnosed pathological jaundice
- Fever (greater than 37.9 °C) or persistent low temperature (less than 36°C) unresponsive to therapy
- Abnormal vomiting or diarrhea
- 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
- Infant born to diabetic mother who is =/> than the 90th percentile

Indications for Transfer of Care

- Infant below 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 that 160/minute at rest, or any abnormal sounds noted
- Signs and symptoms of omphalitis
- Suspected seizure activities
- Bilious vomiting

NOTE

Patients are autonomous and may refuse any form of consultation and/or transfer of care. The midwife shall make reasonable endeavours to persuade the client to accept a consultation and/or transfer of care as is evidenced by best practice. Midwives are expected to document instances where the exercise of patient autonomy is specifically contrary to the advice that has been given.