STANDARD FOR CONSULTATION AND TRANSFER OF CARE

BACKGROUND

A midwife is a primary caregiver and provides care within their 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 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.

There are circumstances that are not listed in this Standard where a referral to another health care professional is indicated. This list is specific to indications for consultation and transfer of care to an appropriate primary care provider, usually a physician. In some hospitals the appropriate consultant may be a specialist primary health care provider who is not a physician.

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 provide safe and effective midwifery care.

CONSULTATION

A *consultation* refers to the situation where a midwife requests the opinion of a consultant competent to give advice regarding the issue. Consultations are mandatory in the situations outlined in this standard and are also initiated upon request of the client or at the midwife's discretion. In most cases the consultation is made upon learning of the condition.

The category of consultation refers to situations in which a midwife must initiate consultation with an appropriate primary care provider. It is the midwife’s responsibility to initiate a consultation and to communicate clearly to the consultant that they are seeking a consultation.

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 transfer of care unless stated. A consultation can result in the consultant providing advice and information, and/or providing therapy to the client. The physician may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within their scope of practice and experience. Areas of involvement in client care

must be clearly agreed upon and documented by the midwife and the consultant. In some situations, the consultant may recommend transfer of care.

TRANSFER OF CARE

When primary care is *transferred*, permanently or temporarily, from the midwife to another primary care provider, the other primary care provider becomes the most responsible care provider. The midwife may continue to provide supportive care or may provide care within the midwifery scope of practice as arranged with the physician who has assumed the role of most responsible care provider. Care may be transferred back to the midwife in situations where the client's/newborn's condition returns to the scope of practice of the midwife.

PROCESS

The midwife must inform the client of the indication for consultation or transfer and discuss the options and steps involved with them as early as possible. A timely consultation or transfer may enhance the plan of care for the client. If a client declines consultation or transfer, or declines to follow the recommendations of the consultant, this must be documented, and where appropriate the midwife must consult the *Policy on When a Client Requests Care Outside the Midwifery Standards of Practice*

Where urgency, distance or climatic conditions do not allow the client to see a physician in-person, the midwife should seek advice from the physician by phone or other similar means. The physician may use alternative means of communication (e.g. via Telehealth) to assess the client as available and appropriate. The midwife should document such requests for advice in client records, and discuss the advice received with the client.

DOCUMENTATION FOR THE CONSULTATION AND TRANSFER SHOULD INCLUDE:

1. Date and time:
    a. Of the request
    b. The response occurred
2. A summary of the client's history, physical examination, laboratory findings and any other pertinent information
3. Specific question(s) to be answered
4. Consultant's response including:
    a. Assessment of the client
    b. Recommendations
5. Identify the role of the midwife and that of the consultant in the ongoing care of the client.

Once a consultation or transfer has taken place then the physician's findings, opinion and recommendations are communicated to the client and the midwife, the midwife must discuss these recommendations with the client. If a transfer of care takes place, the midwife ensures the client understands which health professional will have primary responsibility for their care.

INITIAL INTERVIEW (CLIENT HISTORY)

Indications for Consultation

1. Significant current medical conditions that may affect pregnancy, labour, birth, fetus or newborn, or are exacerbated due to pregnancy
2. History of 3 or more consecutive spontaneous abortions
3. Family history of genetic disorders, hereditary disease or significant congenital anomalies (genetic screening should be offered)
4. History of >one late miscarriage (after 14 weeks)
5. History of cervical cerclage or incompetent cervix
6. History of hypertensive disorder of pregnancy
7. History of more than 1 small for gestational age (SGA) newborn (less than 3rd percentile)
8. History of more than1 lower segment Caesarean section
9. Previous uterine surgery excluding 1 lower segment Caesarean section
10. History of more than one preterm birth or preterm birth of less than 34 weeks
11. Previous stillbirth or neonatal loss which likely impacts current pregnancy
12. History of significant mental health concerns presenting or worsening during pregnancy or the postpartum period

Indications for Transfer of Care

1. Current medical conditions that may adversely affect or are exacerbated by pregnancy that require specialized medical care (common examples include cardiac disease, renal disease, pre-existing insulin-dependent diabetes mellitus)

PRENATAL CARE

Indications for Consultation

1. Abnormal cervical cytology requiring further evaluation
2. Uterine malformation/disorders or significant fibroids with potential impact on pregnancy
3. Significant non-obstetrical or obstetrical medical conditions arising during pregnancy
4. Isoimmunization, haemoglobinopathies, blood dyscrasia
5. Persistent vaginal bleeding other than uncomplicated spontaneous abortion less than 14+0 weeks
6. Severe hyperemesis unresponsive to pharmacologic therapy
7. Urinary tract infection unresponsive to pharmacologic therapy
8. Persistent or severe anemia unresponsive to therapy
9. Sexually transmitted and blood borne infection requiring treatments that are not within the scope of midwifery practice
10. Maternal infection that may cause congenital infection of the fetus requiring treatments that are not within the scope of midwifery practice
11. Significant mental health concerns presenting or worsening during pregnancy
12. Suspected or diagnosed fetal anomaly that may require physician management during or immediately after delivery
13. Inappropriate/Abnormal uterine/fetal growth
14. Abnormal fetal assessment
15. Gestational diabetes unresponsive to diet/lifestyle changes
16. Hypertensive disorders of pregnancy
17. Asymptomatic placenta previa or low-lying placenta persistent into third trimester
18. Vasa previa
19. Oligohydramnios or polyhydramnios
20. Thrombophlebitis or suspected thromboembolism
21. Twin pregnancy
22. Intrauterine fetal demise
23. Presentation other than cephalic at 37 weeks
24. Documented post-term pregnancy (42 weeks)

Indications for Transfer of Care

1. Molar pregnancy
2. Cardiac or renal disease
3. Multiple pregnancy (other than twins)
4. Gestational diabetes requiring pharmacologic treatment
5. Severe hypertension or pre-eclampsia, eclampsia or HELLP syndrome
6. Placental abruption or symptomatic previa

DURING LABOUR AND BIRTH

Indications for Consultation

1. Active genital herpes
2. Preterm labour or preterm premature rupture of membranes (PPROM) between (35+0 and 36+6 weeks)
3. Twin pregnancy
4. Breech presentation
5. Suspected placental abruption and/or previa
6. Hypertension
7. Labour dystocia
8. Maternal request for analgesia that is not within the scope of midwifery practice
9. Suspected intra-amniotic infection
10. Intrauterine fetal demise

Indications for Transfer of Care

1. Preterm labour or PPROM less than 35+0 weeks
2. Placental abruption, placenta previa or vasa previa
3. Severe hypertension, severe pre-eclampsia, eclampsia or HELLP syndrome
4. Uterine rupture
5. Abnormal fetal heart rate pattern unresponsive to therapy
6. Prolapsed or presenting cord
7. Suspected embolus
8. Hypovolemic shock
9. Abnormal presentation (other than breech)
10. Multiple pregnancy (other than twins)

POSTPARTUM MATERNAL

Indications for Consultation

1. Retained placenta
2. Lacerations involving the anus, anal sphincter, rectum, urethra
3. Significant post-anesthesia complication
4. Thrombophlebitis or suspected thromboembolism
5. Unexplained persistent chest pain or dyspnea
6. Uterine prolapse
7. Subinvolution of the uterus with signs and symptoms of uterine infection
8. Breast or urinary tract infection unresponsive to pharmacologic therapy
9. Wound infection
10. Uterine infection
11. Persistent bladder or rectal dysfunction
12. Persistent or new onset hypertension
13. Secondary postpartum haemorrhage
14. Significant mental health concerns presenting or worsening during postpartum
15. Abnormal cervical cytology requiring treatment

Indications for Transfer of Care

1. Haemorrhage unresponsive to treatment
2. Hypovolemic shock
3. Inversion of the uterus
4. Postpartum eclampsia
5. Postpartum psychosis
6. Thromboembolic disease

POSTPARTUM INFANT

Indications for Consultation

1. Prolonged PPV or significant resuscitation
2. 35+0 to 36+6 weeks gestation
3. Infant below the 5th percentile for weight or head circumference
4. Weight less than 2500 grams
5. Persistent pallor, cyanosis, hypotonia or jitteriness, poor suck, poor feeding, lethargy, or abnormal cry
6. Birth injury requiring investigation
7. Excessive bruising, abrasions, unusual pigmentation/coloration or lesions
8. Signs and symptoms of hypoglycaemia unresponsive to treatment
9. Congenital anomalies or suspected syndromes
10. Abnormal heart rate pattern or persistent/symptomatic murmur
11. Persistent abnormal respiratory rate and/or pattern
12. Suspicion of neonatal infection
13. Infant born to an individual with current significant drug or alcohol use in utero, exposure to significant drugs, alcohol, or other substances with known or suspected teratogenicity
14. Infant born to an individual who is HIV or syphilis positive or who has active genital herpes at the time of birth
15. Abnormal number of umbilical vessels not consulted for prenatally
16. Worsening cephalohematoma
17. Does not pass meconium within 36 hours
18. Does not urinate within 36 hours
19. Suspected clinical dehydration
20. Jaundice within the first 24 hours
21. Hyperbilirubinemia unresponsive to phototherapy
22. Hyperthermia, hypothermia or temperature instability
23. Vomiting or diarrhea
24. Infection of the umbilical stump site
25. Abnormal weight gain pattern unresponsive to interventions or adaptation in feeding plan

Indications for Transfer of Care

1. Less than 35+0 weeks gestation
2. Apgar score less than seven at ten minutes
3. Significant congenital anomaly requiring immediate intervention
4. Suspected seizure activity