

INDICATIONS FOR MULTIDISCIPLINARY TEAM REVIEW, CONSULTATION AND TRANSFER OF CARE

Introduction:

As a primary caregiver, the midwife is fully responsible for decision-making, together with the client. The midwife is responsible for writing orders and carrying them out or delegating them in accordance with the standards of the Midwifery Regulatory Council of Nova Scotia. Midwives practice as part of a multidisciplinary team. Team members are available for discussion/review, consultation, or transfer of care as appropriate.

There will be circumstances in which consultation is necessary when care required by the client is beyond the midwife's scope of practice. In those circumstances the midwife discusses care of the client, consults and/or transfers primary care responsibility according to the *Indications for Multidisciplinary Team Review, Consultation and Transfer of Care*. This document is not exhaustive and is not intended to outline the core competencies of the midwife nor does it describe the midwife's scope of practice.

The Midwifery Regulatory Council expects that members will use their professional judgment in making decisions regarding consultation and transfer of care. Consultation may be with a family physician, nurse practitioner, neonatologist, obstetrician or other specialist physician. It is the midwife's responsibility to consult appropriately and in a timely fashion. The client should be aware of the scope and limitations of midwifery care and understand fully why consultation or transfer of care is being recommended. If, at any time, the client requests either consultation with a physician or transfer of care to a physician, these wishes must be respected.

Definitions:

Multidisciplinary Review

It is the midwife's responsibility to initiate review with members of a multidisciplinary team. This team may include physicians, nurses, midwives, physiotherapist, lactation consultants, dieticians, nurse practitioners, social workers, mental health workers and others where appropriate. Each midwifery practice will need to establish the composition of the multidisciplinary team.

When review by the team is indicated, it may include any or all members of the team and this will be dictated by the nature of the clinical issue. Discussion with the team and the recommendations made should be clearly documented in the client's records.

Consultation with a Physician or Nurse Practitioner

It is the midwife's responsibility to initiate a consultation and to communicate clearly to the consultant that she is seeking a consultation. A consultation refers to the situation where a midwife, using her professional knowledge of the client and in accordance with the standards of the Midwifery Regulatory Council of Nova Scotia, requests the opinion of a physician or nurse practitioner competent to give advice in the relevant field. While this is often an obstetrician or neonatologist, it may also be a specialist in another field (for example, psychiatry, dermatology, hematology). A midwife may also seek a consultation when another opinion is requested by the client. Consultation must be documented by the midwife in her records in accordance with the standards of the Midwifery Regulatory Council of Nova Scotia. The midwife should expect that the consultation will be conducted in person unless urgency, distance or climatic conditions preclude this. In these situations, advice may be received by other means (telephone, fax, email) and this communication and the consultant's recommendations should be documented by the midwife in the record. If the consultant has seen the client in person, the midwife should expect prompt communication regarding findings and recommendations.

After consultation with a physician/nurse practitioner, primary care of the client and responsibility for decision-making, with the informed consent of the client, either:

- a) continues with the midwife, or
- b) is transferred to a consultant

Once a consultation has taken place and the consultant's findings, opinions and recommendations have been 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 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. If the client declines the recommended consultation or the treatment recommendations made, this should be clearly documented in her records.

Only one health professional has overall responsibility for a client at any one time, and the client's care should be coordinated by that person. The identity of

the primary caregiver should be clearly known to all of those involved and documented in the records of the referring health professional and the consultant. Responsibility could be transferred temporarily to another health professional, or be shared between health professionals, according to the client's best interests and optimal care; however, transfer or sharing of care should occur only after discussion and agreement among the client, the referring health professional and the consultant(s).

Transfer to a physician who will then assume primary responsibility for care.

When primary care and responsibility for the client has been transferred permanently from the midwife to a physician, the physician assumes full responsibility for subsequent decision-making, together with the client. When primary responsibility is transferred to a physician, the midwife may provide supportive care within her scope of practice, in collaboration with the physician and the client. The physician may decide to transfer primary care back to the midwife when the woman's or her newborn's condition is such that their care again falls within the midwife's scope of practice. Care of the mother and the newborn may be transferred independently and similarly primary responsibility for care of the mother or the newborn may be returned to the midwife independently.

INDICATIONS: Initial History and Physical Examination

Review with multidisciplinary team:

- Age 14-17
- Age \geq 40
- Grand multipara (5 or more prior deliveries)
- History of preterm birth \geq 32 weeks
- History of severe psychological problems
- Less than 12 months from last delivery to present due date
- BMI < 18
- BMI > 30 but < 40
- History of genital herpes
- History of low birth weight infant (defined as less than 5th percentile for gestational age)
- Previous APH (in previous pregnancy)
- Previous PPH not requiring surgical intervention or transfusion
- History of stable essential hypertension
- History of previous PIH with onset after 36 weeks GA
- Known uterine fibroids
- Known minor uterine malformations

- One documented uncomplicated Lower Segment Transverse Cesarean Section (LSTCS)
- Current eating disorder

Consultation: History and Physical Examination

- Current medical conditions – cardiovascular, pulmonary, endocrine disorders, (including gestational diabetes mellitus), hepatic disease, neurologic disease, severe gastrointestinal disease
- Family history of genetic disorders, hereditary disease or significant congenital anomalies¹
- History of late miscarriage (≥ 14 weeks)
- History of cervical cerclage or incompetent cervix
- History of PTB < 32 weeks
- History of more than one PTB (any gestational age prior to 37 weeks)
- History of severe psychiatric illness including post partum psychosis (i.e., requiring hospitalization or psychotropic drugs)
- BMI ≥ 40
- History of severe preeclampsia or eclampsia
- History of significant medical illness
- Previous myomectomy, hysterotomy
- Previous complicated lower segment cesarean section
- Any c/s other than lower segment (i.e., classical, inverted T)
- More than one previous c/s (regardless of type of incision)
- History of genital mutilation
- Recurrent genital herpes
- Rh isoimmunization
- Known hemoglobinopathy
- Known HIV positive
- Previous operation or injuries to bladder, uterus, or vagina (other than previous cesarean section or episiotomy)
- History of ≥ 3 spontaneous abortions
- Previous neonatal mortality or intrauterine fetal demise (IUFD)
- Significant infection in first trimester of pregnancy (i.e. rubella, varicella)
- History of parvovirus or toxoplasmosis infection at any time in pregnancy
- History of untreated syphilis at any time during the pregnancy
- Significant use of drugs, alcohol or other toxic substances
- Age < 14 yrs or ≥ 43
- History of PPH requiring transfusion or surgical procedure (e.g. B-Lynch, artery ligation)
- History of severe uterine malformation (septate uterus, uterine didelphus)
- History of previous thromboembolic event (DVT, PE)

¹ Consultation with Medical Genetics may be appropriate

Transfer:

- Any serious medical condition (cardiac or renal disease, severe autoimmune disease such as SLE, antiphospholipid syndrome)
- Insulin Dependent Diabetes Mellitus (IDDM)

INDICATIONS: Prenatal Care

Review with multidisciplinary team:

- No prenatal care before 28 weeks
- Unknown expected date of confinement

Consultation:

- Noncephalic presentation at 36 weeks
- Anemia (Hgb < 100) unresponsive to treatment
- Confirmed IUFD
- Documented post term pregnancy ($\geq 42^0$ weeks)
- Abnormal biophysical profile
- Abnormal Pap test requiring further investigation
- Known HIV positive
- Ovarian cysts or pelvic masses
- Concerns on ultrasound about appropriate fetal growth
- Medical conditions arising during prenatal care (for example, abnormal glucose tolerance test, hypertension, renal disease, endocrine disorders, suspected significant infection, hyperemesis)
- Suspected or diagnosed fetal anomaly that may require physician management during or immediately after delivery
- Exposure to known teratogens (infectious or chemical)
- Complete Placenta Previa with no active bleeding, less than 24 weeks gestational age
- Low lying placenta (less than 2 cm from the internal cervical os) at greater than 32 weeks
- Pregnancy-induced hypertension²

² Society of Obstetricians & Gynaecologists of Canada. (2008). Diagnosis, Evaluation and Management of the Hypertensive Disorders of Pregnancy. *JOGC*, 30(3), supplement 1, pp1-52.

- Polyhydramnios or oligohydramnios
- Isoimmunization, hemoglobinopathies or blood dyscrasia
- Severe psychological problems or severe psychiatric illness
- Twins
- Repeated vaginal bleeds other than transient spotting
- Prior or recurrent genital herpes during pregnancy

Transfer:

- Cardiac or renal disease with failure
- Insulin Dependent Diabetes Mellitus (IDDM)
- Multiple pregnancy (other than twins)
- Proteinuric hypertension or eclampsia
- Suspected placental abruption
- Complete placenta previa with no vaginal bleeding at greater than 24 weeks
- Complete placenta previa with history of vaginal bleeding at any gestational age

INDICATIONS: During Labour and Delivery

Review with Multidisciplinary Team:

- No prenatal care
- Thin, non-particulate meconium³

Consultation:

- Breech presentation⁴
- Pre-term labour (35⁰ to 36⁶)
- Prolonged active phase
- Prolonged rupture of membranes⁵
- Atypical heart rate patterns unresponsive to therapy⁶

³ Whenever meconium is present, the midwife in attendance must be prepared to intubate the newborn.

⁴ While many of these deliveries may become transfers of care, breech presentation and twins are listed as indications for consultation to allow the obstetrical consultant discretion in deciding if a midwife may manage such a delivery, where a spontaneous birth is reasonably anticipated. Circumstances may make delivery by the midwife necessary and unavoidable and, in these instances, previous hands-on experience under the supervision of an obstetrician would be beneficial.

⁵ Consultation with an obstetrician should be undertaken if membranes are ruptured for 24 hours without onset of labour, in a woman who is GBS (-). Approach to women who are GBS (+) with ruptured membranes should be in accordance with the hospital policies and SOGC guidelines.

- Prolonged second stage
- Suspected placental abruption and/or previa
- Retained placenta
- Third or fourth degree tear⁷
- Twins
- Unengaged head in active labour in primigravida
- Thick or particulate meconium⁸
- Temperature over 38 degrees Celsius on more than one occasion
- Need for epidural analgesia⁹
- Need for narcotics and/or sedatives¹⁰

Transfer:

- Active genital herpes at time of labour
- Pre-term labour at less than 35⁰ weeks
- Abnormal presentation (other than breech)
- Multiple pregnancy (other than twins)
- Proteinuric pre-eclampsia or eclampsia
- Prolapsed cord
- Placental abruption and/or previa
- Severe hypertension
- Abnormal fetal heart rate patterns unresponsive to therapy
- Uterine rupture
- Uterine inversion
- Hemorrhage unresponsive to therapy
- Obstetric shock

INDICATIONS: Postpartum (Maternal)

⁶ Society of Obstetricians & Gynaecologists of Canada. (2007). Fetal Health Surveillance: Antepartum and Intrapartum Consensus Guideline. *JOGC*, 29(9), supplement 4, pp. 1-60.

⁷ If the perineal laceration is not third or fourth degree but is felt to be complex (i.e., large labial or periurethral lacerations), consultation might be considered.

⁸ Delivery in hospital is indicated if thick or particulate meconium has been identified. If membranes rupture immediately prior to delivery such that transfer is unsafe, the midwife must be prepared to intubate and suction the neonate. Once meconium has been identified, appropriate fetal surveillance should be initiated and consultation with an obstetrician undertaken. It is recommended that, if possible, a pediatrician/care provider with advanced resuscitation skills also be consulted to attend the birth.

⁹ Consultation with an anesthetist might be the most appropriate clinician

¹⁰ Consultation for a prescription for these medications could be with either a family physician or an obstetrician

Review With Multidisciplinary Team

- Breast infection unresponsive to standard pharmacologic therapy
- Urinary tract infection unresponsive to standard pharmacologic therapy

Consultation:

- Wound infection
- Uterine infection
- Temperature over 38 degrees Celsius on more than one occasion
- Persistent hypertension
- Preeclampsia (postpartum onset)
- Serious psychological problems or severe psychiatric illness

Transfer:

- Hemorrhage unresponsive to therapy
- Postpartum eclampsia
- Thrombophlebitis or thromboembolism
- Uterine inversion

INDICATIONS: Postpartum (Infant)

Multidisciplinary Review:

- Feeding problems

Consultation:

- Suspicion of, or significant risk of, neonatal infection
- 35-37 weeks gestational age
- Infant less than 2500 gm
- Two vessels identified in the umbilical cord
- Abnormal findings on physical examination
- Excessive moulding and cephalohematoma
- Excessive bruising, abrasions, unusual pigmentation and /or lesions
- Birth injury requiring investigation
- Congenital abnormalities, for example: cleft lip/palate, congenital dislocation of hip, ambiguous genitalia
- Abnormal heart rate or pattern
- Persistent poor suck, hypotonia or abnormal cry

- Persistent abnormal respiratory rate and/or pattern
- Persistent cyanosis, pallor or jitteriness
- Bilirubin in the high intermediate or high zone with neonatal screening (either with bilirubin meter or blood testing)
- Jaundice within the first 24 hours
- Failure to pass urine or meconium within 24 hours of birth
- Suspected pathological jaundice after 24 hours
- Born to a mother with active genital herpes
- Mother known to be hepatitis positive
- Mother known to be HIV positive
- Maternal history of significant alcohol or drug use during pregnancy
- Temperature less than 36 degrees C or greater than 37.9 degrees unresponsive to thermoregulation techniques
- Vomiting or diarrhea
- Infection of the umbilical stump site
- Significant weight loss (more than 10% of body weight)
- Failure to regain birth weight in 3 weeks
- Failure to thrive

Transfer

- Apgar score lower than 7 at 10 minutes
- Suspected seizure activity
- Significant congenital anomaly requiring immediate medical intervention (for example, omphalocele, myelomeningocele)
- Temperature instability

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