MIDWIFERY REGULATORY COUNCIL OF NOVA SCOTIA

INDICATIONS FOR DISCUSSION, CONSULTATION AND TRANSFER OF CARE

Introduction

As primary care providers, midwives are fully responsible for clinical assessment, planning of care and decision-making together with their clients during pregnancy, birth, and the postpartum period. In accordance with Section 31 of the *Midwifery Act*, this includes the responsibility to:

a) identify conditions in a mother and her baby that necessitate consultation or referral to a physician or other health care professional, in accordance with standards approved by the Council;

b) consult with a physician regarding any deviations from the normal course of pregnancy, labour, delivery and the postpartum period, in accordance with standards approved by the Council;

c) transfer primary responsibility for care if the consultation under clause (b) determines that management by a physician is required, in accordance with standards approved by the Council; and

d) continue to provide midwifery care in collaboration with a physician when primary responsibility for care is transferred under clause (c), to the extent that is agreed to by the physician, the midwife and the mother.

This policy sets out clinical indications that require 1) review or discussion with care team members, 2) consultation with a physician or other appropriate care provider, and/or 3) transfer of care to a physician. The list of indications in each of these categories does not preclude other possible circumstances in which consultation and/or transfer of care may be necessary. Midwives are expected to use their professional judgment in making decisions regarding discussion, consultation, and transfer of care including what care providers are the most appropriate to consult with depending on the clinical situation.

It is the midwife's responsibility to consult appropriately and in a timely manner. The client must be made aware of the scope and limitations of midwifery care and the reasons the midwife is recommending a consultation and/or transfer of care. If a client requests a consultation or transfer to another provider, the midwife must facilitate this and document accordingly. Should a client decline a consultation and the indication could require care outside the scope of practice for the midwife, the midwife should refer to the policy on Client Requests Outside of Standards (2022).

DEFINITIONS

1) <u>Discussion</u>

The midwife reviews information pertinent to the clinical situation or indication with at least one other midwife or multidisciplinary team member in order to plan the client's care appropriately.

NSH/IWK midwifery sites may have established protocols or procedures for management of clinical indications in this category. In such cases, the midwife may follow site protocols and document accordingly in the client's record. Following an established protocol can replace a team discussion.

2) <u>Consultation with a Physician or Other Appropriate Care Provider</u>

Consultation with another provider must first start with an informed choice discussion with the client where consent has been given to initiate the consultation. The consultation should include the client's clinical situation and request for advice on management of the indication. The midwife must document the consultation request in the client's record, in accordance with MRCNS standards.

A consultation usually involves in-person assessment of the client, with prompt communication by the consultant to the referring midwife of their findings and recommendations. If urgency, distance, weather, or other circumstances preclude an in-person consultation, advice may be transmitted by other appropriate means (telephone, fax, email). The form of communication and the consultant's findings and recommendations should be documented by the midwife in the client's record.

Following the consultation, the midwife either continues as the primary care provider with responsibility for decision-making together with the client, or transfers care of the client to a physician. The consultant may provide advice and/or therapy directly to the client/newborn, or may recommend a plan of care and/or therapy that the midwife may carry out.

Once a consultation has taken place and the consultant's findings, opinions and recommendations have been communicated to the midwife, the midwife must discuss these with the client. If the client declines the recommended consultation, advice and/or therapy, this must be clearly documented in the client's record.

In certain circumstances the consultant may provide, and be responsible for, a discrete aspect of care that the client needs, while the midwife continues as the primary care

provider and maintains overall responsibility for the course of care within their scope of practice. Consultant involvement in discrete areas of client care must be clearly agreed upon and documented by the midwife.

The above notwithstanding, only one person can be the most responsible care provider at any one time, as stated in the *CMPA/HIROC Joint Statement on Liability Protection for Midwives and Physicians*.[1] The most responsible provider, and the subsequent plan of care, including roles and responsibilities of the primary care providers involved, must be clearly communicated and agreed upon with the client and all care team members and documented in the client's record. Responsibility can be transferred temporarily from one health provider to another, according to the client's preferences and needs for care or expertise.

[1] https://www.hiroc.com/system/files/resource/files/2018-10/CMPA-HIROC-2016-Joint-Statement-EN.pdf

4) <u>Transfer of care to a physician</u>

When primary care is transferred permanently or temporarily from the midwife to a physician, the physician assumes full responsibility for subsequent decision-making, together with the client. A transfer of care from midwife to physician may be temporary (e.g. for a specific medical intervention such as cesarean section) or permanent (i.e. for the remaining course of care). In a temporary transfer, the midwife resumes primary responsibility for care when the condition of the client or newborn warrants and their care is again within the midwife's scope of practice. Transfer of care back to the midwife must be clearly agreed upon and documented by both the midwife and physician.

When the physician assumes primary responsibility for care of a midwifery client, the midwife may continue to provide discrete aspects of care within their scope of practice, in collaboration with the physician and the client.

Once a transfer has taken place, the midwife must ensure that the client understands this transfer and which health professional has primary care responsibility. The midwife must also clearly document the transfer in the client's record.

In situations where the client's care is transferred, the midwife may continue to provide primary care for the well newborn. Similarly, if the newborn's care is transferred, the midwife may remain the primary care provider for the well client. The physician may also transfer either the client's care or the newborn's care back to the midwife, as appropriate.

INDICATIONS: INITIAL HISTORY AND PHYSICAL EXAMINATION

DISCUSSION:

- history of significant medical or mental health conditions
- age less than 17 years or over 40 years
- grand multipara (5 or more previous births)
- history of substance use (including nicotine and cannabis)
- history of infant over 4,500 g
- history of shoulder dystocia
- history of one late miscarriage (after 14 weeks)
- history of one late pre-term birth (34 - 36+6)
- history of one small for gestational age infant
- less than 12 months from last delivery to present due date
- low or high BMI
- previous antepartum hemorrhage
- previous postpartum hemorrhage
- one documented previous uncomplicated low-segment cesarean section
- history of hypertensive disorders of pregnancy
- known uterine malformations or fibroids
- history of trauma or sexual abuse
- current eating disorder or nutritional concerns
- poor obstetric history with potential risk of recurrence in current pregnancy

CONSULTATION

- Current medical and mental health conditions that may affect pregnancy or may be exacerbated by pregnancy
- Significant use of drugs, alcohol, or other substances with known or suspected teratogenicity or risk of associated complication
- Previous pelvic organ injury, or uterine surgery other than one documented uncomplicated low-segment C-section.
- History of cervical cerclage or incompetent cervix
- History of severe uterine malformation

- History of more than one second trimester spontaneous abortion
- History of three or more consecutive first trimester spontaneous abortions
- History of >1 late preterm birth, or preterm birth less than 34 weeks
- History of more than one small for gestational age infant
- Previous stillbirth or neonatal mortality which likely impacts pregnancy
- History of severe pre-eclampsia, eclampsia or HELLP syndrome
- History of postpartum hemorrhage requiring transfusion and/or surgical intervention

TRANSFER

- Current medical condition(s) that may adversely affect or are exacerbated by pregnancy that require specialized medical care (common examples include: cardiac or renal disease, pre-existing Insulin dependent diabetes mellitus)

INDICATIONS: PRENATAL CARE

DISCUSSION:

- no prenatal care before 28 weeks gestation
- uncertain expected date of delivery

CONSULTATION:

- Medical conditions arising during prenatal care including but not limited to hyperemesis unresponsive to pharmacologic therapy, endocrine disorders, renal disease and suspected or confirmed viral or bacterial infection that require treatment outside of midwifery scope
- Non-cephalic presentation (e.g. breech) at 36 weeks
- Documented post-term pregnancy (≥42 wks)
- Abnormal cervical cytology requiring further evaluation
- Suspected or diagnosed fetal anomaly that may require immediate medical management after delivery
- Anemia (unresponsive to therapy)
- Persistent significant vaginal bleeding
- Thrombophlebitis or suspected thromboembolism
- Isoimmunization, hemoglobinopathies or blood dyscrasia

- Abnormal findings during ultrasound that require management outside of midwifery scope (including but not limited to abnormal BPP, oligohydramnios, polyhydramnios, vasa previa, abnormal fetal growth)
- Gestational diabetes mellitus
- Intrauterine fetal demise
- Twins **
- Substance use during pregnancy
- Declining all blood products
- Spontaneous abortion at or after 14 weeks
- Severe psychological problems or severe psychiatric illness

**While some of these births may become shared care or transfers of care, twins and breech presentation are listed as indications for consultation to allow an obstetrical consultant discretion in having the RM manage such a delivery, where a spontaneous birth is reasonably anticipated. RMs may also gain important hands-on experience with obstetrical guidance.

TRANSFER

- Cardiac or renal disease with failure
- Multiple pregnancy (other than twins)
- Gestational Diabetes Mellitus requiring medication
- Pre eclampsia, eclampsia, HELLP syndrome
- Placenta previa confirmed by third trimester ultrasound

INDICATIONS: LABOUR AND DELIVERY

DISCUSSION:

- no prenatal care

CONSULTATION:

- Late preterm labour or pre-labour rupture of membranes (34+0 to 36+6 weeks gestation)
- Significant vaginal bleeding
- Meconium stained amniotic fluid*
- Twins **

• Breech or other malpresentation with the potential to be delivered vaginally**

• Persistent hypertension

• Suspected chorioamnionitis

• Active genital herpes at onset of labour or rupture of membranes

• Labour dystocia unresponsive to therapy

• Atypical or abnormal fetal heart rate pattern unresponsive to therapy

• Lacerations involving the anus, anal sphincter, rectum, urethra

• Retained placenta

* Consult may be at the time of birth following current NRP standards (meaning 2 skilled providers including one with intubation skills). Hospitals may have their own community standards for this scenario.

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TRANSFER OF CARE:

* Severe hypertension, preeclampsia, eclampsia or HELLP syndrome

• Prolapsed cord

• Preterm labor or PPROM less than 34+0 weeks

* Multiple pregnancy other than twins

* Abnormal presentation other than breech

* Placental abruption, placenta previa or vasa previa

* Uterine rupture

* Uterine inversion

* Suspected embolus

* Hemorrhage unresponsive to therapy

* Obstetric shock

INDICATIONS: POST-PARTUM MATERNAL

CONSULTATION:

* Breast infection unresponsive to pharmacologic therapy
* Urinary tract infection unresponsive to pharmacologic therapy
• Uterine prolapse
• Persistent bladder or rectal dysfunction
• Wound infection
* Uterine infection
• Persistent temp >38 degrees
* Persistent or new onset hypertension
* Thromboembolitis or thrombophlebitis
* Secondary postpartum hemorrhage
• Serious mental health concerns presenting or worsening during postpartum

TRANSFER OF CARE:

* Hemorrhage unresponsive to therapy
* Postpartum eclampsia
* Postpartum psychosis

INDICATIONS: POST-PARTUM INFANT

DISCUSSION:

• Feeding problems
• excessive moulding
• cephalohematoma

CONSULTATION:

• suspicion of or significant risk of neonatal infection
• 34 to 36+6 weeks gestational age
• prolonged PPV or significant resuscitation
• Infant at or less than 5th percentile in weight for gestational age

• fewer than 3 vessels in umbilical cord
• excessive bruising, abrasions, unusual pigmentation and/or lesions
• birth injury requiring investigation
* congenital abnormalities, for example: cleft lip or palate, developmental dysplasia of the hip, ambiguous genitalia
* abnormal heart rate pattern or persistent/symptomatic murmur
* any other abnormal findings on physical exam
* Hyperbilirubinemia requiring medical treatment
* Infant born to client with active genital herpes, HIV positive or hepatitis positive
* persistent poor suck, poor feeding, lethargy, hypotonia or abnormal cry
* persistent abnormal respiratory rate and/or pattern
* persistent cyanosis, pallor or jitteriness
* jaundice in first 24 hours
* failure to pass urine or meconium within 36 hours of birth
* temperature less than 36°C or greater than 37.9°C unresponsive to thermoregulation techniques
• vomiting or diarrhea
• infection of umbilical stump site
• persistent weight loss unresponsive to therapy
• failure to regain birth weight in 3 weeks
• failure to thrive
• In utero exposure to significant drugs, alcohol or other substances with known or suspected teratogenicity or other associated complications

TRANSFER OF CARE:

* Apgar score lower than 7 at 10 minutes
* suspected seizure activity
* significant congenital anomaly requiring immediate medical intervention, for example: omphalocele, myelomeningocele

References

College of Midwives of Newfoundland and Labrador. (2018). Consultation, Shared Primary Care and Transfer of Care Midwifery Practice Guidelines. Retrieved at: http://www.cmnl.ca/pdf/66CMNL-Consultation-and-Transfer-Guidelines-Final-July-18-2018.pdf

College of Nurses and Midwives of British Columbia. (2021). Indications for discussion, consultation and transfer of care. Retrieved at: https://www.bccnm.ca/Documents/standards_practice/rm/RM_Indications_for_Discussion_Consultation_and_Transfer_of_Care.pdf

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