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 document sets out clinical indications or situations 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 is not exhaustive and 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.

It is the midwife's responsibility to consult appropriately and in a timely manner. The client must be informed of the scope and limitations of midwifery care and the reasons the midwife is recommending a consultation and/or transfer of care. If, at any time, the client requests a consultation with a physician or transfer of care to a physician, the midwife must respect these wishes.

DEFINITIONS

1) Discussion

The midwife discusses and shares 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. Team members may include physicians, nurse practitioners, nurses, lactation consultants, physiotherapists, dieticians, social workers, mental health workers and other health care professionals, as appropriate. The midwife must document the discussion and care plan in the client's records.

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

2) Consultation with a Physician or Other Appropriate Care Provider

The midwife explicitly requests the professional opinion of a physician or other appropriate health care provider with the expertise to advise on management of the clinical situation or indication(s). While the consultant is often an obstetrician, neonatologist or family physician, s/he may also be a specialist in another field (e.g. psychiatry, dermatology or hematology).

It is the responsibility of the midwife to initiate a consultation and communicate clearly to the consultant that she is seeking a consultation. The midwife must document the consultation request in the client's record, in accordance with MRCNS standards. The midwife may also initiate a consultation when the client is requesting another opinion.

A consultation usually involves in-person assessment of the client, with prompt communication by the consultant to the referring midwife of his/her 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 woman or the newborn, or 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 records.

In certain circumstances the consultant may provide, and be responsible for, a discrete aspect of care that the client needs, with the midwife continuing as the primary care provider and maintaining overall responsibility for the course of care within her scope of practice. Consultant involvement in discrete areas of client care must be clearly agreed upon and documented by the midwife and the consultant.

In other circumstances the consultant and midwife may share care of the client on an ongoing basis, in keeping with the client's best interests and optimal care. However, 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*, care providers sharing care must have an agreement about who is the most responsible care provider at any given time, and what the division of responsibilities is at any given time.[1] The most responsible provider must be clearly identified to all persons involved, including the client, and documented by the midwife and the consultant in the client's records.

3) Transfer of care to a physician

The midwife transfers care of the client to a physician who then assumes full responsibility for clinical decision-making and treatment. 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 woman or newborn warrants and her/his 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 supportive care or discrete aspects of care within her scope of practice, in collaboration with the physician and the client.

In situations where the mother'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 remains the primary care provider for the well mother. The physician may also transfer either the mother's care or the newborn's care back to the midwife, as appropriate.

[1] http://www.canadianmidwives.org/DATA/DOCUMENT/JSLiability_ENG200706.pdf

INDICATIONS: Initial History and Physical Examination

Discussion:

- Age 14-17
- Age ≥ 40[2]
- Grand multipara (5 or more prior deliveries)
- Less than 12 months from last delivery to present due date
- History of stable essential hypertension
- Gestational hypertension without preeclampsia, or preeclampsia with onset after 36 weeks gestational age
- Previous APH (in previous pregnancy)
- Previous PPH not requiring surgical intervention or transfusion
- Uterine fibroid
- Known minor uterine malformations
- One documented uncomplicated Lower Segment Transverse Cesarean Section (LSTCS)
- History of preterm birth ≥32 weeks
- History of low birth weight infant (<2500g)
- History of infant over 4500g
- Current eating disorder
- BMI < 18
- BMI > 30 but < 40

Consultation: History and Physical Examination

- Age < 14 yrs
- Current medical conditions – cardiovascular, pulmonary, endocrine disorders, hepatic disease, neurologic disease, severe gastrointestinal disease
- History of previous thromboembolic event (DVT, PE)
- History of significant medical illness that could impact pregnancy
- History of severe psychiatric illness including post partum psychosis (i.e., requiring hospitalization or psychotropic drugs)
- BMI ≥ 40
- Family history of genetic disorders, hereditary disease or significant congenital anomalies[3]
- Previous myomectomy, hysterotomy

[2] Offer Early Pregnancy Review at IWK as per provincial protocol
[3] Consultation with Medical Genetics may be appropriate

- History of genital mutilation
- Previous operation or injuries to bladder, uterus, or vagina (other than previous cesarean section or episiotomy)
- History of severe uterine malformation (septate uterus, uterine didelphus)
- History of ≥ 3 spontaneous abortions[4]
- History of fetal demise at ≥ 14 weeks' gestational age
- Previous stillbirth or neonatal mortality
- History of cervical cerclage or incompetent cervix
- History of preterm birth < 32 weeks
- History of more than one preterm birth (any gestational age prior to 37 weeks)
- History of severe preeclampsia or eclampsia
- Previous complicated lower segment cesarean section
- Any c/s other than lower segment (i.e., classical, inverted T)
- More than one previous cesarean section (regardless of type of incision)
- History of postpartum hemorrhage requiring transfusion or surgical procedure (e.g. B-Lynch, artery ligation)
- Rh isoimmunization
- Known hemoglobinopathy
- Known HIV positive
- History of parvovirus, toxoplasmosis or varicella infection at any time in pregnancy
- History of untreated syphilis at any time during the pregnancy
- Primary genital herpes outbreak in current pregnancy
- Significant use of drugs, alcohol or other toxic substances
- Poor obstetric history with high risk of recurrence in current pregnancy

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

Discussion:

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

[4] If a client is first seen after 20 weeks' gestation, a consultation is not required unless otherwise clinically indicated. If a consultation has already occurred for this in a prior pregnancy, a further consultation is not required.

Consultation:

- Significant infection in first trimester of pregnancy (ie rubella, varicella)
- Exposure to known teratogens (infectious or chemical)
- Isoimmunization, hemoglobinopathies or blood dyscrasia
- Abnormal Pap test requiring further investigation
- Known HIV positive
- Anemia (Hgb < 100) unresponsive to treatment
- Suspected or diagnosed fetal anomaly that may require physician management during or immediately after delivery
- Twins
- 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
- Repeated vaginal bleeds other than transient spotting
- Medical conditions arising during prenatal care (for example, hypertension, renal disease, endocrine disorders, suspected significant infection, hyperemesis)
- Active sexually transmitted disease
- Severe psychological problems or severe psychiatric illness
- Gestational hypertension[5]
- Gestational diabetes mellitus[6]
- Concerns on ultrasound about appropriate fetal growth
- Polyhydramnios or oligohydramnios
- Noncephalic presentation at 36 weeks
- Abnormal biophysical profile
- Confirmed intrauterine fetal demise
- Documented post term pregnancy (≥ 42^{o} weeks)

Transfer:

- Cardiac or renal disease with failure
- Multiple pregnancy (other than twins)
- Insulin Dependent Gestational Diabetes Mellitus
- Pre eclampsia, eclampsia, HELLP syndrome
- Suspected placental abruption

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

[6] Current guidelines require referral to a dietician (Jillian Coolen, State of the Art- Changes in Screening for Gestational Diabetes mellitus, *Diabetes Care in Nova Scotia,* July 2013, Vol 23, Number 1). Consultation with an obstetrician is required for gestational diabetes not controlled by diet alone)

- 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

Discussion:

- No prenatal care
- Meconium[7]

Consultation:

- Pre-term labour (35^0 to 36^6)
- Twins
- Suspected placental abruption and/or previa
- Breech presentation[8] or other malpresentation
- Prolonged rupture of membranes[9]
- Atypical heart rate patterns unresponsive to therapy[10]
- Unengaged head in active labour in primigravida
- Need for epidural analgesia[11]
- Temperature over 38 degrees Celsius on more than one occasion
- Prolonged active phase
- Prolonged second stage
- Retained placenta
- Third or fourth degree tear[12]

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[7] Delivery in hospital is indicated if 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. It is recommended that, if possible, a pediatrician/care provider with advanced resuscitation skills also be consulted to attend the birth.

[8] 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.

[9] 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.

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

[11] Consultation with an anesthetist might be the most appropriate clinician

[12] 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.

Transfer:

- Pre-term labour at less than 35^0 weeks
- Multiple pregnancy (other than twins)
- Abnormal presentation (other than breech)
- Active genital herpes at time of labour
- Pre-eclampsia, eclampsia or HELLP syndrome
- Severe hypertension
- Prolapsed cord
- Placental abruption and/or previa
- Abnormal fetal heart rate patterns unresponsive to therapy
- Uterine rupture
- Uterine inversion
- Hemorrhage unresponsive to therapy
- Obstetric shock

INDICATIONS: Postpartum (Maternal)

Consultation:

- Suspected endometritis or wound infection whether abdominal or perineal
- Breast infection unresponsive to standard pharmacologic therapy
- Urinary tract infection unresponsive to standard pharmacologic therapy
- Persistent hypertension
- Preeclampsia (postpartum onset)
- Serious psychological problems or severe psychiatric illness

Transfer:

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

INDICATIONS: Postpartum (Infant)

Discussion:

- Feeding problems

Consultation:

- 35-36 +6 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
- Suspicion of, or significant risk of, neonatal infection
- Persistent poor suck, hypotonia or abnormal cry
- Persistent abnormal respiratory rate and/or pattern
- Persistent cyanosis, pallor or jitteriness
- Bilirubin level requiring treatment according to the decision guide for total serum bilirubin screening – RCP 2009[13]
- Jaundice within the first 24 hours
- Suspected pathological jaundice after 24 hours
- Failure to pass urine or meconium within 24 hours of birth
- 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
- Weight loss in infant greater than 10% of birth weight that is unresponsive to adaptation in feeding plan.
- 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, omphalocoele, myelomingocele)
- Temperature instability

[13] Reproductive Care Program of Nova Scotia, Hyperbilirubinemia Screening, revised May 2010, http://rcp.nshealth.ca/clinical-practice-guidelines/hyperbilirubinemia-screening

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