INDICATIONS FOR DISCUSSION, CONSULTATION AND TRANSFER OF CARE

As a primary caregiver, the midwife is responsible for decision-making, together with the client. The midwife is responsible for writing orders and carrying them out or delegating them to an appropriate regulated health professional in accordance with CMBC standards.

The midwife discusses care of a client, consults, and/or transfers primary care responsibility according to the *Indications for Discussion, Consultation and Transfer of Care.* The responsibility to consult with a family physician/general practitioner, obstetrician, pediatrician, other specialist physician or a nurse practitioner[1] lies with the midwife. It is also the midwife's responsibility to initiate a consultation within an appropriate time period after detecting an indication for consultation. The severity of the condition and the availability of a physician will influence these decisions.

CMBC expects members to use their professional judgement in making decisions to consult or transfer care. This includes making a decision at an initial visit to assess if a client is appropriate for midwifery care. The list is not exhaustive. Other circumstances may arise where the midwife believes consultation or transfer of care is necessary. The informed choice agreement between the midwife and client should outline the extent of midwifery care, so that the client is aware of the scope and limitations of midwifery care. The midwife should review the *Indications for Discussion, Consultation and Transfer of Care* with the client.

DEFINITIONS

Discussion with a Midwife, a Physician or another regulated health practitioner[2]

It is the midwife's responsibility to initiate a discussion with, or provide information to, another midwife, a physician or another regulated health practitioner in order to create an appropriate plan of care. It is also expected that the midwife will conduct regularly scheduled reviews of client charts with her colleagues to assist in planning care. Discussion should be documented by the midwife in the client record.

[1] During the antepartum or postpartum period, a midwife may consult with a nurse practitioner (with a Family, Adult or Pediatric specialty), as appropriate to the nurse practitioners' scope of practice. Nurse practitioners do not provide primary care in the intrapartum period.

[2] Discussion should occur with a physician, or with another primary care provider such as a nurse practitioner, where another midwife is not available.

Consultation with a Physician[3] or another regulated health practitioner[4]
It is the midwife's responsibility to initiate a consultation in accordance with CMBC standards and to communicate clearly to the consultant that a consultation is requested and why. In requesting a consultation, a midwife uses professional knowledge of the client and requests the opinion of a physician or another regulated health practitioner qualified to give advice in the area of clinical concern. A midwife may also seek a consultation when another opinion is requested by the client. The midwife must document each consultation in the client record in accordance with CMBC standards.

The midwife should expect the consultant to address the problem described in the consultation request, conduct an in-person assessment(s) of the client, and promptly communicate findings and recommendations to the client and to the referring midwife. Discussion will then normally occur between the midwife and the consultant regarding the future plan of care for the client.

Where urgency, distance or climatic conditions do not allow the client to see a physician or another regulated health practitioner for an in-person consultation visit, the midwife should seek advice from the consultant by phone or other similar means. The consultant 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, in accordance with CMBC standards, and discuss the advice received with the client.

A consultation can involve the physician or another regulated health practitioner providing advice and information, and/or providing therapy to the client/newborn, or recommending therapy for the client/newborn to the midwife to provide within the midwifery scope of practice.

After consultation with a physician or another regulated health practitioner, primary care of the client and responsibility for decision-making, with the informed consent of the client, may:

a) continue with the midwife;
b) be shared between the midwife, nurse practitioner[5] and/or physician[6]; or
c) be transferred to the physician.

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.

Shared primary care
In a shared care arrangement the consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within the scope of practice, or vice versa. Areas of involvement in client care and the plan for communication between care providers are clearly agreed upon and documented by the midwife and the consultant.

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[3] In this document, consultation with a physician means consultation with a physician licensed by the College of Physicians and Surgeons of BC unless otherwise specifically indicated.
[4] As appropriate to the individual's scope of practice.
[5] Only for the antenatal and/or postpartum period.
[6] In a shared primary care arrangement, the physician, midwife and client agree on which aspects of care each provider is assuming responsibility for and have a written plan in place for communicating with each other to coordinate that care.

It is recommended that one health professional take responsibility for coordinating the client's care. This arrangement should be clearly communicated to the client and documented in the records. Responsibility can be transferred temporarily from one health professional to another, or be shared between health professionals, according to the client's preferences and needs for care or expertise. Transfer of care or an arrangement for sharing care should be discussed with the client, and agreed to between the midwife, client and consultant(s), and documented in the client record.

Shared primary care arrangements may vary depending on community and on the experience and comfort levels of the care providers involved. Midwives who gain more skills and abilities and experience over time may be able to manage more complex care within their scope of practice in collaboration with their physician colleagues.

Transfer to a physician for primary care
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.

When primary care is transferred to a physician, the midwife may continue to provide supportive care with the client's consent. The midwife may provide care within the midwifery scope of practice as arranged with the physician who has assumed the primary care role.

INDICATIONS: Initial History and Physical Examination

Discussion:

- adverse socio-economic conditions
- age less than 17 years or over 40 years
- cigarette smoking
- grand multipara (5 or more previous births)
- history of infant over 4,500 g
- history of one late miscarriage (after 14 weeks) or pre-term birth
- history of one small for gestational age infant
- history of serious psychological problems
- less than 12 months from last delivery to present due date
- obesity
- poor nutrition
- previous antepartum hemorrhage
- previous postpartum hemorrhage
- one documented previous low-segment cesarean section
- history of hypertensive disorders of pregnancy
- known uterine malformations or fibroids
- history of trauma or sexual abuse

Consultation:

- current medical conditions that may affect pregnancy or are exacerbated due to pregnancy family history of genetic disorders, hereditary disease or significant congenital anomalies
- history of cervical cerclage
- history of three or more first-trimester spontaneous abortions
- history of more than one second-trimester spontaneous abortion
- history of more than one preterm birth, or one preterm birth less than 34 weeks

- history of more than one small for gestational age infant
- history of eclampsia
- history of significant medical illness
- previous myomectomy, hysterotomy or cesarean section other than one documented previous low-segment cesarean section
- previous neonatal mortality or stillbirth
- significant use of drugs, alcohol or other toxic substances
- age less than 14 years
- history of postpartum hemorrhage requiring transfusion
- HIV positive status

Transfer:

- 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)

INDICATIONS: Prenatal Care

Discussion:

- presentation other than cephalic at 36 weeks gestation
- no prenatal care before 28 weeks gestation
- uncertain expected date of delivery

Consultation:

- anemia (unresponsive to therapy)[7]
- documented post-term pregnancy (≥ 42 completed weeks)
- suspected or diagnosed fetal anomaly that may require physician management during or immediately after delivery
- intrauterine fetal demise that may require medical intervention during or immediately after delivery
- inappropriate uterine growth
- medical conditions arising during prenatal care, for example: endocrine disorders, renal disease, suspected or confirmed significant infection including H1N1[8], hyperemesis unresponsive to pharmacologic therapy
- asymptomatic placenta previa persisting into third trimester
- vasa previa
- polyhydramnios or oligohydramnios
- gestational hypertension
- isoimmunization, haemoglobinopathies, blood dyscrasia
- thrombophlebitis or suspected thromboembolism
- mental health concerns presenting or worsening during pregnancy[9]
- pain which persists, worsens and/or is unresponsive to therapy within the midwife's scope of practice
- sexually transmitted infection requiring treatment[10]
- urinary tract infection unresponsive to pharmacologic therapy

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[7] Consultation may be with a physician or another regulated healthcare practitioner.

[8] Consultation with a physician is required for all cases of H1N1 infection; co-management or transfer of care may be necessary based on the physician's assessment.

[9] Consultation may be with a physician, clinical psychologist, mental health worker, or nurse practitioner.

[10] Consultation may be with a physician or a nurse practitioner.

- twins[11]
- repeated vaginal bleeding other than transient spotting or uncomplicated spontaneous abortion less than 14 weeks
- presentation other than cephalic at 37 weeks
- insulin treated gestational diabetes

Transfer:

- molar pregnancy
- cardiac or renal disease with failure
- multiple pregnancy (other than twins)
- severe hypertension, pre-eclampsia[12], eclampsia or HELLP syndrome
- symptomatic placental abruption or previa

INDICATIONS: During Labour and Delivery

Discussion:

- no prenatal care

Consultation:

- breech presentation[13]
- pre-term labour or preterm prelabour rupture of membranes (PPROM) between (34+0 – 36+6 weeks)
- labour dystocia unresponsive to therapy
- suspected placenta abruption and/or previa
- retained placenta
- third- or fourth-degree tear
- twins[11]
- unengaged head in active labour in nullipara
- meconium[14],[15]
- temperature of 38°C or greater on more than one occasion

Transfer:

- active genital herpes at time of labour or rupture of membranes
- pre-term labour or PPROM (less than 34+0 weeks)
- abnormal presentation (other than breech)

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[11] In many settings the management of a twin pregnancy will involve shared or transfer of care to an obstetrician. Responsibility can be transferred temporarily from one health professional to another, or be shared between health professionals, according to the client's preferences and needs for care or expertise.

[12] As defined by SOGC Clinical Practice Guideline No. 206 Diagnosis, Evaluation, and Management of the Hypertensive Disorders of Pregnancy March 2008.

[13] While many of these deliveries may become transfers of care, breech presentation and twins are listed as indications for consultation. Where a spontaneous birth is anticipated, a midwife may conduct the delivery under the direct supervision of an obstetrician. In a remote area, the availability of an experienced midwife who has the confidence of obstetrical colleagues can prevent a client from having to leave family and community. Midwives may also gain important hands-on experience under obstetrical supervision. Responsibility can be transferred temporarily from one health professional to another, or be shared between health professionals, according to the client's preferences and needs for care or expertise.

[14] In hospitals where pediatricians are available on-call, it is recommended that a pediatrician be consulted and in attendance at the birth. The midwife should initiate appropriate surveillance of fetal well-being (see *Guideline for Fetal Health Surveillance in Labour*) and consult with a physician in hospital. Indicators such as normal or abnormal fetal heart rate pattern will affect whether or not transfer of care during labour is indicated.

[15] Whenever meconium is present where the membranes rupture so close to the time of birth that transport from home to hospital would be unsafe and a timely consult is not possible, the midwife in attendance must always be prepared to intubate any non-vigorous newborn as per the Neonatal Resuscitation Program.

- multiple pregnancy (other than twins)
- severe hypertension, severe pre-eclampsia, eclampsia or HELLP syndrome
- prolapsed cord
- placenta abruption, placenta previa or vasa previa
- abnormal fetal heart rate pattern unresponsive to therapy
- suspected embolus
- uterine rupture
- uterine inversion
- hemorrhage unresponsive to therapy
- obstetric shock

INDICATIONS: Postpartum (Maternal)

Consultation:

- breast infection unresponsive to therapy[16]
- wound infection[16]
- uterine infection[16]
- uterine prolapse
- cervical prolapse[17]
- signs of urinary tract infection unresponsive to therapy[16]
- temperature over 38°C on more than one occasion[16]
- persistent or new onset hypertension
- thrombophlebitis or thromboembolism
- persistent bladder or rectal dysfunction[17]
- mental health concerns presenting or worsening during postpartum[18]
- pain which persists, worsens and/or is unresponsive to therapy within the midwife's scope of practice

Transfer:

- hemorrhage unresponsive to therapy
- eclampsia
- postpartum psychosis[19]

INDICATIONS: Postpartum (Infant)

Discussion:

- feeding problems[20]
- excessive moulding
- cephalohematoma

Consultation:

- suspicion of or significant risk of neonatal infection
- 34 to 36+6 weeks gestational age[21]

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[16] Consultation may be with a physician or a nurse practitioner.
[17] Consultation may be with a physician or a physiotherapist.
[18] Consultation may be with a physician, clinical psychologist, mental health worker, or nurse practitioner.
[19] Transfer of care may be with a mental health care specialist. The midwife shall remain in the role of primary obstetrical care provider, within the midwifery scope of practice.
[20] Discussion may be with another midwife, a physician, a nurse practitioner or a lactation consultant.
[21] Consultation may be with a physician or a nurse practitioner.

- in utero exposure to significant drugs, alcohol, or other substances with known or suspected teratogenicity
- prolonged PPV or significant resuscitation
- infant less than 2500 g
- less 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
- 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
- suspected pathological jaundice after 24 hours
- temperature less than 36°C unresponsive to therapy
- temperature of 38°C or more unresponsive to therapy
- temperature instability
- vomiting or diarrhoea[21]
- infection of umbilical stump site[21]
- Infant at or less than 5th percentile in weight for gestational age
- persistent weight loss unresponsive to therapy
- 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