

Standard:	Consultation and Transfer of Care
Approved by:	Council
Date Approved:	May 28, 2014
Date to be Reviewed:	July 2017
Revision date(s):	November 19, 2015
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Attachments:	none



## CONSULTATION AND TRANSFER OF CARE

According to the midwifery model of care, the midwife works in partnership with the client. As a provider of primary healthcare, the midwife is fully responsible for the clinical assessment, planning and delivery of care for each client. The client remains the primary decision-maker regarding her own care, and that of her newborn.<sup>1</sup>

Throughout the antepartum, intrapartum and postpartum periods, clinical situations may arise in which the midwife will need to initiate involvement of other health care providers in the care of a client or her newborn. According to the requirements of this Standard, she will:

1. **Consult** with a physician, or the most appropriate available health care provider, or
2. **Transfer responsibility for primary care** to a physician

### Definitions

#### Consultation with a Physician, or other appropriate health care provider

- Consultation is an explicit request from a midwife of a physician, or other appropriate health care provider, to give advice on a plan of care and participate in the care as appropriate.
- It is the midwife's responsibility to decide when and with whom to consult and to initiate consultations.
- Consultation may result in the physician, or other health care provider, giving advice, information and/or therapy to the woman/newborn directly or recommending a plan of care and/or therapy to be carried out by the midwife.
- After consultation with a physician, the role of most responsible provider either remains with the midwife or is transferred to the consulting physician.
- Consultation may be initiated at the client's request.

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<sup>1</sup> CMO Standard on *Informed Choice*

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## Transfer of Care to a Physician

- Transfer of care occurs when the primary care responsibilities required for the appropriate care of the client fall outside of the midwife's scope of practice.
- A transfer of care may be permanent or temporary.
- When primary care is transferred from the midwife to a physician, the physician assumes full responsibility for the subsequent planning and delivery of care to the client.
- The client remains the primary decision-maker regarding her care and the care of her newborn.
- After a transfer of care has taken place the midwife shall remain involved as a member of the health care team and provide supportive care to the client within the scope of midwifery.<sup>2</sup>
- If the condition for which the transfer of care was initiated is resolved, the midwife may resume primary responsibility for the care of the mother and/or newborn.

## Midwife's Responsibilities

In all instances where another health care provider is required in the care of a midwife's client or her newborn, the midwife shall:

- Review the *Consultation and Transfer of Care Standard* with the client as part of an informed choice discussion.
- Respect the principles of informed choice, and support the client decision making process.
- Ensure that a client's decision not to pursue a consultation with another health care provider is clearly documented in the client's health record, in accord with the standards of the College of Midwives.<sup>3</sup>
- Ensure that a client's decision not to follow a consultant's recommendation, once it is communicated to the midwife, is documented in the client's health record, in accord with the standards of the College of Midwives.
- Involve the other health care provider within an appropriate time frame.

<sup>2</sup> Refer to the CMO *Interprofessional Collaboration Standard* for additional information

<sup>3</sup> CMO Standard *When a Client Chooses Care Outside the Midwifery Standards of Practice*

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- Ensure that the request for a consultation or transfer of care are both clearly articulated to the other health care provider and the client, and documented in the client's health record.<sup>4</sup>
- Ensure, where possible, that a consultation includes an in-person evaluation of the client or her newborn and that a consultation is initiated by phone where urgency, distance or climatic conditions make an in-person consultation impossible.
- Ensure that the subsequent plan of care, including the roles and responsibilities of the primary care providers involved, are communicated to the clinicians, and to the client and documented in the client's health record.
- Remain accountable for the care they have provided whether working collaboratively or independently.

Throughout the course of care other indications not specifically referenced in this Standard may arise which require the involvement of other health care providers. Notwithstanding the indications listed in this Standard, midwives are expected to use their best clinical judgment supported by the highest quality available evidence and relevant guidelines, to determine when the involvement of other health care practitioners is warranted.

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<sup>4</sup> See CMO Record Keeping Policy Suite

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## Initial History and Physical Exam

### Consultation:

- Significant current medical conditions that may affect pregnancy or are exacerbated due to pregnancy
- Significant use of drugs, alcohol or other substances with known or suspected teratogenicity or risk of associated complications
- Previous uterine surgery other than one documented low-segment cesarean section
- History of cervical cerclage
- History of more than one second-trimester spontaneous abortion
- History of three or more consecutive first-trimester spontaneous abortions
- History of more than one preterm birth, or preterm birth less than 34+ 0 weeks in most recent pregnancy
- History of more than one small for gestational age infant
- History of severe hypertension or pre-eclampsia, eclampsia or HELLP syndrome
- Previous neonatal mortality or stillbirth which likely impacts current pregnancy

### Transfer of Care

- Cardiac disease
- Renal disease
- Insulin-dependent diabetes mellitus
- HIV positive status

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## Prenatal Care

### Consultation

- Significant mental health concerns presenting or worsening during pregnancy
- Persistent or severe anemia unresponsive to therapy
- Severe hyperemesis unresponsive to pharmacologic therapy
- Abnormal cervical cytology requiring further evaluation
- Significant non-obstetrical or obstetrical medical conditions arising during pregnancy
- Sexually transmitted infection requiring treatment
- Gestational diabetes unresponsive to dietary treatment
- Urinary tract infection unresponsive to pharmacologic therapy
- Persistent vaginal bleeding other than uncomplicated spontaneous abortion less than 14+0 weeks
- Fetal anomaly that may require immediate postpartum management
- Evidence of intrauterine growth restriction
- Oligohydramnios or polyhydramnios
- Twin pregnancy
- Isoimmunization
- Persistent thrombocytopenia
- Thrombophlebitis or suspected thromboembolism
- Gestational hypertension
- Vasa previa
- Asymptomatic placenta previa persistent into third trimester
- Presentation other than cephalic, unresponsive to therapy, at or near 38+0 weeks
- Intrauterine fetal demise
- Evidence of uteroplacental insufficiency
- Uterine malformation or significant fibroids with potential impact on pregnancy

### Transfer of Care:

- Molar pregnancy
- Multiple pregnancy (other than twins)
- Severe hypertension or pre-eclampsia, eclampsia or HELLP syndrome
- Placental abruption or symptomatic previa

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- Cardiac or renal disease
- Gestational diabetes requiring pharmacologic treatment

### Labour, Birth and Immediate Post Partum

#### Consultation:

- Preterm prelabour rupture of membranes (PPROM) between 34 +0 and 36 +6 weeks
- Twin pregnancy
- Breech or other malpresentation with potential to be delivered vaginally
- Hypertension presenting during the course of labour
- Abnormal fetal heart rate pattern
- Suspected intraamniotic infection
- Labour dystocia unresponsive to therapy
- Intrauterine fetal demise
- Retained placenta
- Third or fourth degree laceration
- Periurethral laceration requiring repair

#### Transfer of Care:

- Active genital herpes at time of labour or rupture of membranes
- HIV positive status
- Preterm labour or PPRM less than 34 +0 weeks
- Fetal presentation that cannot be delivered vaginally
- Multiple pregnancy (other than twins)
- Prolapsed or presenting cord
- Placental abruption, placenta previa or vasa previa
- Severe hypertension or pre-eclampsia, eclampsia or HELLP syndrome
- Suspected embolus
- Uterine rupture
- Uterine inversion
- Hemorrhage unresponsive to therapy

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## Post Partum

### Consultation:

- Breast or urinary tract infection unresponsive to pharmacologic therapy
- Suspected endometritis
- Abdominal or perineal wound infection unresponsive to non pharmacologic treatment
- Persistent or new onset hypertension
- Significant post-anesthesia complication
- Thrombophlebitis or suspected thromboembolism
- Significant mental health concerns including postpartum depression and signs or symptoms of postpartum psychosis
- Persistent bladder or rectal dysfunction
- Secondary postpartum hemorrhage
- Uterine prolapse
- Abnormal cervical cytology requiring treatment

### Transfer of Care:

- Postpartum eclampsia
- Postpartum psychosis<sup>5</sup>

## Infant

### Consultation:

- 34 +0 to 36 +6 weeks gestational age
- Suspected neonatal infection
- In utero exposure to significant drugs, alcohol, or other substances with known or suspected teratogenicity or other associated complications
- Findings on prenatal ultrasound that warrant postpartum follow up
- Prolonged PPV or significant resuscitation
- Failure to pass urine or meconium within 36 hours of birth
- Suspected clinical dehydration
- Feeding difficulties not resolved with usual midwifery care

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<sup>5</sup> Transfer of care to a mental health care specialist. The midwife shall remain the primary obstetric care provider, within her scope of practice, given it is possible to do so.

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- Significant weight loss unresponsive to interventions or adaptation in feeding plan
- Failure to regain birth weight by three weeks of age
- Infant at or less than 5<sup>th</sup> percentile in weight for gestational age
- Single umbilical artery not consulted for prenatally
- Congenital anomalies or suspected syndromes
- Worsening cephalhematoma
- Excessive bruising, abrasions, unusual pigmentation and/or lesions
- Significant birth trauma
- Abnormal heart rate, pattern or significant murmur
- Hypoglycemia unresponsive to initial treatment
- Hyperglycemia
- Suspected neurological abnormality
- Persistent respiratory distress
- Persistent cyanosis or pallor
- Fever, hypothermia or temperature instability
- Vomiting or diarrhea
- Evidence of localized or systemic infection
- Jaundice within the first 24 hours
- Hyperbilirubinemia unresponsive to phototherapy
- Suspected seizure activity

Transfer of Care:

- Major congenital anomaly requiring immediate intervention