

	MIDWIFERY INDICATIONS FOR CONSULTATION AND TRANSFER OF CARE GUIDANCE DOCUMENT
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Background

Registered Midwives (RMs) are primary caregivers who are fully responsible for clinical decisions and the management of care within their scope of practice with primary consideration to the best interest of the client and their fetus/newborn. In providing care, a RM is responsible for recognizing conditions, which require case review with other RMs or consultation with, or transfer of care to a physician or another appropriate health care professional and to initiate this communication within an appropriate period of time.

Purpose

The purpose of this guidance document is to describe the process for consultation and transfer of care and to list situations and/or circumstances where it is appropriate for this communication to take place. And, to educate RMs, consultants, and clients/members of the public about the practice of midwifery and the parameters within which RMs practice.

This guidance document applies to all settings. It is not intended to be exhaustive; other circumstances may arise where the RM or the client determines consultation or transfer of care is necessary.

1.0 Consultation

- 1.1 *A consultation* refers to the situation where a RM, using their professional knowledge of the client and in accordance with legislation and professional practice policies of the College of Registered Nurses and Midwives of PEI, requests the opinion of a physician or another health practitioner (hereinafter referred to as consultant), competent to give advice in this field. A RM may also seek a consultation when the client requests another opinion.
- 1.2 The RM shall inform the client of the indication for consultation and discuss the options with the client as early as possible in the process of care. The RM shall attempt to acquire a consultation in a timely manner.

- 1.3 The RM shall request consultation to address the client matter and seek an assessment of the client by the consultant. The findings and or recommendations shall be communicated to the client and the RM.
- 1.4 Following the assessment of the client by the consultant(s), discussion may occur between the RM and consultant regarding future client care. A written report shall be provided by the consultant to the RM as per standard medical practice.
- 1.5 The consultation can involve the consultant providing advice and information, providing therapy to the client/newborn or prescribing therapy to be administered by the RM for the client/newborn.
- 1.6 After consultation with a consultant, primary care of the client and/or newborn and responsibility for decision-making together with the client either:
 - 1.6.1 continues with the RM,
 - 1.6.2 is collaborative between the RM and consultant where both are managing separate and agreed upon aspects of care (see 1.8 and 1.11) or
 - 1.6.3 is transferred to a physician or in the case of the newborn, may be transferred to a physician or nurse practitioner.
- 1.7 Once a consultation has taken place and the consultant's findings, opinions and recommendations are communicated to the client and the RM, the RM shall discuss the consultant's recommendations with the client and ensure that the client understands which health professional will have responsibility for primary care.
- 1.8 The consultant may be involved in, and responsible for, a specific aspect of the client's and/or newborn's care, with the RM maintaining overall responsibility within their scope of practice. Areas of involvement in client care must be clearly agreed upon and documented by the RM and the consultant. The consultant may recommend transfer of care whether or not requested by the referring RM.

1.9 The role of the referring RM is to:

- 1.9.1 Request a consultation as soon as the indication appears or based on community standards
- 1.9.2 Advise the client with respect to the reasons for consultation and steps involved
- 1.9.3 Provide a summary of the client's history, physical examination, laboratory findings and any other pertinent information to the consultant
- 1.9.4 Document the reasons for the consultation and specific issues to be addressed by the consultant
- 1.9.6 Specify whether the consultation is intended for:
 - one time only request
 - collaborative care, or
 - transfer of care.

1.10 Documentation received from the consultant may include the following:

- 1.10.1 Reason for the consultation
- 1.10.2 Date and time of the consultation request
- 1.10.3 Date and time the response occurred
- 1.10.4 Consultant's assessment of the client
- 1.10.5 Consultant's recommendations
- 1.10.6 Identification of the role of the RM and that of the consultant in the ongoing care of the client.

1.11 In some circumstances the consultant and RM may both continue to care for 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. There must be 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. The most responsible provider must be clearly identified to all persons involved, including the client, and documented by the RM and the consultant in the client's records.

1.12 Where urgency, distance or climatic conditions make an in-person consultation with a consultant not possible, the midwife shall seek advice from the consultant by phone or other means convenient to both. The physician may use alternative means of communication (for example, Telehealth) to assess the client as available and appropriate.

1.13 The RM shall document this request for advice in the client records, and discuss the advice received with the client.

2.0 *Transfer of Care*

2.1 When primary care is *transferred*, permanently or temporarily, from the RM to a physician, the physician, together with the client assumes full responsibility for subsequent decision-making. The RM may continue to provide supportive care.

2.2 Cooperation in the care of a client/newborn will be enhanced by mutual recognition of respective professional roles. Care may be transferred back to the RM in situations where the client's/newborn's condition returns to within the scope of practice of the RM.

3.0 *Indications for Consultation*

3.1 *Initial History and Physical Exam*

- 3.1.1 Significant medical conditions that may affect pregnancy or may be exacerbated by pregnancy
- 3.1.2 Significant use of drugs, alcohol or other substances with known or suspected teratogenicity or risk of associated complication
- 3.1.3 Previous uterine surgery other than one documented low-segment Caesarean section
- 3.1.4 History of cervical cerclage
- 3.1.4 History of more than one second-trimester spontaneous abortion
- 3.1.5 History of \geq three or more consecutive first trimester spontaneous abortions
- 3.1.6 History of more than one preterm birth, or preterm birth less than 34 weeks
- 3.1.7 History of more than one intrauterine growth restricted infant
- 3.1.8 Previous stillbirth or neonatal mortality which likely impacts pregnancy
- 3.1.9 History of severe eclampsia, pre-eclampsia or HELLP syndrome

3.2 Prenatal Care

- 3.2.1 Significant mental health concerns presenting during pregnancy
- 3.2.2 Significant medical conditions presenting during pregnancy
- 3.2.3 Abnormal cervical cytology requiring further evaluation
- 3.2.4 Pregnancy complication outside of RM's scope of practice (for example, gestational hypertension, severe hyperemesis, severe anemia or Urinary Tract infection unresponsive to pharmacologic therapy)
- 3.2.5 Persistent significant vaginal bleeding
- 3.2.6 Thrombophlebitis or suspected thromboembolism
- 3.2.7 Oligohydramnios or polyhydramnios
- 3.2.8 Evidence of intrauterine growth restriction
- 3.2.9 Insulin treated gestational diabetes
- 3.2.10 Intrauterine fetal demise that may require medical intervention during or immediately after delivery
- 3.2.11 Asymptomatic placenta previa persistent into third trimester
- 3.2.12 Vasa previa
- 3.2.13 Suspected or diagnosed fetal anomaly that may require immediate medical management after delivery
- 3.2.14 Twin pregnancy**
- 3.2.15 Non-cephalic presentation (for example, breech) at 38 weeks**

**[While some of these births may become 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 under obstetrical supervision].

3.3 During Labour and Birth

- 3.3.1 Active genital herpes at onset of labour or rupture of membranes

- 3.3.2 Late preterm labour or pre-labour rupture of membranes (PPROM) between (34+0 and 36+6 weeks gestation)
- 3.3.3 Significant vaginal bleeding
- 3.3.4 Twin pregnancy**
- 3.3.5 Breech or other malpresentation with the potential to be delivered vaginally**
- 3.3.6 Significant hypertension
- 3.3.7 Labour dystocia unresponsive to therapy
- 3.3.8 Abnormal fetal heart rate pattern unresponsive to therapy
- 3.3.9 Lacerations involving the anus, anal sphincter, rectum, urethra
- 3.3.10 Retained placenta with or without bleeding

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3.4 Postpartum Maternal

- 3.4.1 Breast infection unresponsive to pharmacologic therapy
- 3.4.2 Urinary tract infection unresponsive to pharmacologic therapy
- 3.4.3 Severe uterine prolapse
- 3.4.4 Persistent bladder or rectal dysfunction
- 3.4.5 Wound infection
- 3.4.6 Uterine infection
- 3.4.7 Persistent temperature >38 degrees C
- 3.4.8 Persistent or new onset hypertension
- 3.4.9 Secondary postpartum haemorrhage
- 3.4.10 Thrombophlebitis or suspected thromboembolism

3.5 Postpartum Infant

- 3.5.1 Suspicion or significant risk of neonatal infection
- 3.5.2 Apgar Score less than seven at five minutes
- 3.5.3 Prolonged PPV or significant resuscitation
- 3.5.4 Late preterm baby (34+0 to 36+6 weeks)
- 3.5.5 In utero exposure to significant drugs, alcohol or other substances with known or suspected teratogenicity or other associated complications
- 3.5.6 Persistent pallor, cyanosis, hypotonia or jitteriness
- 3.5.7 Excessive bruising, abrasions, unusual pigmentation or lesions
- 3.5.8 Hypoglycaemia unresponsive to initial treatment
- 3.5.9 Suspected neurological abnormality or seizure activity
- 3.5.10 Congenital anomalies or suspected syndromes, ambiguous genitalia
- 3.5.11 Abnormal heart rate, pattern or symptomatic murmur
- 3.5.12 Persistent abnormal respiratory rate and/or pattern
- 3.5.13 Infant at or less than 5th percentile in weight for gestational age

- 3.5.14 Feeding issues not resolved with usual midwifery care
- 3.5.15 Significant birth trauma

- 3.5.16 Infant born to an individual with active genital herpes
- 3.5.17 Infant born to a mother who is Hepatitis B or C positive
- 3.5.18 Infant born to a mother who is HIV positive
- 3.5.19 Single umbilical artery not consulted for prenatally
- 3.5.20 Failure to pass urine or meconium within 24 hours
- 3.5.21 Hyperbilirubinemia unresponsive to phototherapy
- 3.5.22 Fever or hypothermia, temperature instability unresponsive to therapy
- 3.5.23 Abnormal vomiting or diarrhea
- 3.5.24 Evidence of localized or systemic infection
- 3.5.25 Significant weight loss unresponsive to interventions or adaptation in feeding plan
- 3.5.26 Failure of infant to regain birth weight within 21 days

4.0 *Indications for Transfer of Care*

4.1 *Initial History and Physical Exam*

- 4.1.1 Serious, chronic or acute medical conditions, examples: include cardiac or renal disease
- 4.1.2 Pre-existing Insulin dependent diabetes mellitus

4.2 *Prenatal Care*

- 4.2.1 Molar pregnancy
- 4.2.2 Severe hypertension or pre-eclampsia, eclampsia or HELLP syndrome
- 4.2.3 Multiple pregnancy (other than twins)
- 4.2.4 Thromboembolic disease
- 4.2.5 Placental abruption or symptomatic placenta previa

4.3 *During Labour and Birth*

- 4.3.1 Severe hypertension, severe pre-eclampsia, eclampsia or HELLP syndrome
- 4.3.2 Prolapsed or presenting cord
- 4.3.3 Preterm labour or PPRM less than 34+0 weeks
- 4.3.4 Multiple pregnancy other than twins
- 4.3.5 Abnormal presentation other than breech
- 4.3.6 Placental abruption, placenta previa or vasa previa
- 4.3.7 Uterine rupture
- 4.3.8 Uterine inversion
- 4.3.9 Suspected embolus
- 4.3.10 Hemorrhage unresponsive to therapy

4.4 *Postpartum Maternal*

- 4.4.1 Haemorrhage unresponsive to treatment
- 4.4.2 Postpartum eclampsia
- 4.4.3 Postpartum psychosis

4.5 *Postpartum Infant*

- 4.5.1 Significant congenital anomaly requiring immediate medical intervention
- 4.5.4 Suspected seizure activities