Practice Directive

Collaborative Care & Indications for Consultation and Transfer of Care

Prince Edward Island College of Nursing and Midwifery

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PEICNM
PRINCE EDWARD ISLAND COLLEGE OF NURSING AND MIDWIFERY

Introduction

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 given to the best interests of the client and their fetus or newborn. In providing care to clients and their families, RMs may need to collaborate with other health care professionals. Collaborative practice involves two or more autonomous health care providers working together toward a common goal.

RMs are responsible for recognizing conditions that require case review with another RM, consultation with a physician or another appropriate health care professional, or transfer of care. The purpose of this practice directive is to support and promote collaborative practice between midwives and other health care providers. RMs are autonomous practitioners responsible not only for providing care that supports normal childbearing but also for identifying situations that warrant consultation or transfer of care.

This practice directive applies in all settings. It is not exhaustive; other circumstances may arise in which either the RM or the client determines that consultation or transfer of care is necessary.

Collaboration may take place in the form of:

- Consultation
- Referral
- Transfer of care

Consultation

A consultation occurs when a Registered Midwife (RM), based on their professional assessment and in accordance with legislation, regulations, and PEICNM policies and practice directives, seeks the opinion or advice of a physician or another health care provider with appropriate expertise. A consultation may also be initiated when a client requests another opinion.

The RM should explain to the client why a consultation is being recommended and discuss available options as early as possible. Consultations should be arranged in a timely manner and may take place either in person or virtually.

After the consultation, the RM and the consulting provider should discuss the ongoing plan of care for the client and/or newborn and determine which provider will be the Most Responsible Provider (MRP).

Together a decision should be made for the care to:

1. Continue with the RM

2. Be collaborative between the RM and consultant, where both are managing separate and agreed upon aspects of care.

The consultant may assume responsibility for a specific aspect of the client's and/or newborn's care, while the RM continues to hold overall responsibility within their scope of practice. The roles and areas of involvement for both the RM and the consultant must be clearly agreed upon and documented.
Only one provider can be the Most Responsible Provider (MRP) at any given time. The RM and the consultant must establish and document who the MRP is and clarify the division of responsibilities. The identified MRP must be clearly communicated to everyone involved in the client's care, including the client.

3. Be transferred to a physician or nurse practitioner

Once the consultant has assessed the client, the findings, opinions and/or recommendations should be communicated to the client and the RM. The RM should discuss the consultant's recommendations with the client and ensure that the client understands which health professional will have responsibility for primary care.

Indications for Consultation

Initial History and Physical Exam	1. Significant medical conditions that may affect pregnancy or may be exacerbated by pregnancy 2. Significant use of drugs, alcohol, or other substances with known or suspected teratogenicity or risk of associated complication 3. Previous uterine surgery other than one documented low-segment Caesarean section 4. History of cervical cerclage 5. History of more than one second trimester spontaneous abortion 6. History of three or more consecutive first trimester spontaneous abortions 7. History of more than one preterm birth, or preterm birth less than 34 weeks 8. History of more than one intrauterine growth restricted infant 9. Previous stillbirth or neonatal mortality which likely impacts pregnancy 10. History of severe eclampsia, pre-eclampsia or HELLP syndrome
Prenatal Care	1. Significant mental health concerns presenting during pregnancy 2. Significant medical conditions presenting during pregnancy 3. Abnormal cervical cytology requiring further evaluation 4. Pregnancy complication outside of RM's scope of practice (ex: gestational hypertension, severe hyperemesis, severe anemia, or UTI unresponsive to pharmacologic therapy) 5. Persistent significant vaginal bleeding 6. Thrombophlebitis or suspected thromboembolism 7. Oligohydramnios or polyhydramnios

	8. Evidence of intrauterine growth restriction 9. Insulin treated gestational diabetes 10. Intrauterine fetal demise that may require medical intervention during or immediately after delivery 11. Asymptomatic placenta previa persistent into third trimester 12. Vasa previa 13. Suspected or diagnosed fetal anomaly that may require immediate medical management after delivery 14. Twin pregnancy ** 15. Non-cephalic presentation at 38 weeks **
During Labour and Birth	1. Active genital herpes at onset of labour or rupture of membranes 2. Late preterm labour or pre-labour rupture of membranes (PPROM) between 34+0 and 36+6 weeks of gestation 3. Significant vaginal bleeding 4. Twin pregnancy ** 5. Breech or other malpresentation with the potential to be delivered vaginally** 6. Significant hypertension 7. Labour dystocia unresponsive to therapy 8. Abnormal fetal heart rate pattern unresponsive to therapy 9. Lacerations involving the anus, anal sphincter, rectum, or urethra 10. Retained placenta with or without bleeding
Postpartum Maternal	1. Breast infection unresponsive to pharmacologic therapy 2. Urinary tract infection unresponsive to pharmacologic therapy 3. Severe uterine prolapse 4. Persistent bladder or rectal dysfunction 5. Wound infection 6. Uterine infection 7. Persistent temperature greater than 38 degrees Celsius 8. Persistent or new onset hypertension 9. Secondary postpartum hemorrhage 10. Thrombophlebitis or suspected thromboembolism
Postpartum Infant	1. Suspicion or significant risk of neonatal infection 2. Apgar Score less than 7 at five minutes 3. Prolonged PPV or significant resuscitation 4. Late preterm baby (34+0 to 36+6 weeks) 5. In utero exposure to significant drugs, alcohol, or other substances with known or suspected teratogenicity or other associated complications 6. Persistent pallor, cyanosis, hypotonia or jitteriness 7. Excessive bruising, abrasions, unusual pigmentation or lesions 8. Hypoglycemia unresponsive to initial treatment 9. Suspected neurological abnormality or seizure activity

	10. Congenital anomalies or suspected syndromes, ambiguous genitalia 11. Abnormal heart rate, pattern or symptomatic murmur 12. Persistent abnormal respiratory rate and/or pattern 13. Infant at or less than 5th percentile in weight for gestational age 14. Feeding issues not resolved with usual midwifery care 15. Significant birth trauma 16. Infant born to an individual with active genital herpes 17. Infant born to a mother who is Hepatitis B or C positive 18. Infant born to a mother who is HIV positive 19. Single umbilical artery not consulted for prenatally 20. Failure to pass urine or meconium within 24 hours 21. Hyperbilirubinemia unresponsive to phototherapy 22. Fever or hypothermia, temperature instability unresponsive to therapy 23. Abnormal vomiting or diarrhea 24. Evidence of localized or systemic infection 25. Significant weight loss unresponsive to interventions or adaptation in feeding plan 26. Failure of infant to regain birth weight within 21 days

**While some of these births may become transfers of care, twins and non-cephalic 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.

Referral

The RM may refer a part of the client's or infant's care to another health care providers to either take over care of that aspect or to provide management advice to the client and the RM. For example, referral to the primary care provider for an abnormal blood test result that is not within the scope of care of the RM.

Transfer of Care

When care is transferred from the RM to a physician/NP, the physician/NP assumes full responsibility for subsequent decision-making. Care may be temporarily or permanently transferred. The RM may continue to provide the supportive care aspects of the RM's scope of practice, which may include education, advocacy, labour support and breastfeeding support. Physical assessments, diagnostic tests and interventions are the responsibility of the physician/NP accepting care. Care may be transferred back to the RM in situations where the client's or newborn's condition returns within the scope of practice of the RM.

Indications for Transfer of Care

Initial History and Physical Exam	1. Serious, chronic or acute medical conditions. Ex: cardiac or renal disease. 2. Pre-existing Insulin dependent diabetes mellitus
Prenatal Care	1. Molar pregnancy 2. Severe hypertension or pre-eclampsia, eclampsia or HELLP syndrome 3. Multiple pregnancy (other than twins) 4. Thromboembolic disease 5. Placental abruption or symptomatic placenta previa
During Labour and Birth	1. Severe hypertension, severe pre-eclampsia, eclampsia, or HELLP syndrome 2. Prolapsed or presenting cord 3. Preterm labour or PPROM less than 34+0 weeks 4. Multiple pregnancy (other than twins) 5. Abnormal presentation other than breech 6. Placental abruption, placental previa or vasa previa 7. Uterine rupture 8. Uterine inversion 9. Suspected embolus 10. Hemorrhage unresponsive to therapy
Postpartum Maternal	1. Hemorrhage unresponsive to treatment 2. Postpartum eclampsia 3. Postpartum psychosis
Postpartum Infant	1. Significant congenital anomaly requiring immediate medical intervention 2. Suspected seizure activities