Standard:	Consultation, Shared Primary Care and Transfer of Care
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Consultation, Shared Primary Care and Transfer of Care Midwifery Practice Guidelines

According to the midwifery model of care, the Registered Midwife (RM) works in partnership with the client. As a provider of primary healthcare, the RM is fully responsible for the clinical assessment, planning and delivery of care for each client. The client remains the primary decision-maker regarding their own care and that of their newborn.

Throughout the antepartum, intrapartum, and postpartum periods, clinical situations may arise in which the RM will need to initiate involvement of other health care providers in the care of a client or the newborn. A consultation can involve a physician or another regulated health practitioner, and the RM 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 RM.

After consultation with a physician, primary care of the client and responsibility for decision-making, with the agreement of the consultant and the informed consent of the client may:

a) Continue with the RM as lead primary provider
b) Be shared between the midwife and a physician
c) Be transferred to the physician as lead primary provider

Definitions

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

- Consultation is an explicit request from the RM to 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 RM'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 client/newborn directly, or recommending therapy for the client /newborn to the RM to provide within the midwifery scope of practice.
- Consultation may be initiated at the client's request.

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 RM maintaining overall responsibility within her scope of practice, or vice versa.
- Areas of involvement in client/newborn care and the plan for communication between care providers are clearly agreed upon and documented by the RM and consultant.
- Ideally, one health professional takes 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 best interests and optimal care.
- Shared primary care arrangements may vary depending on community and the experience and comfort levels of the care provider involved. RMs with specialized skills and abilities may be able to manage more complex care within their scope of practice in collaboration with their physician colleagues.

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 RM's scope of practice.
- A transfer of care may be permanent or temporary.
- When primary care is transferred from the RM 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 their care and the care of their newborn.
- After the transfer of care has taken place the RM shall remain involved as a member of the health care team and provide supportive care to the client within the scope of midwifery.
- If the condition for which the transfer of care was initiated is resolved, the RM may resume primary responsibility for the care of the mother and/or newborn.

Registered Midwife's Responsibilities

In all instances where another health care provider is required in the care of the RM's client or their newborn, the RM 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 discussion making process.
- Involve the other health care provider and the client within an appropriate time frame.
- Ensure that the request for a consultation or a transfer of care are both clearly articulated to the other health care provider and the client, and documented in the client's health record.
- Ensure, where possible, that a consultation includes an in-person evaluation of the client or their 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.
- Ensure that a client's decision not to pursue a consultation or to follow a consultant's recommendation is clearly documented in the client's health record.

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, the RM is expected to use their best clinical judgment, taking in account relevant guidelines and hospital policies, to determine when the involvement of other health care practitioners is warranted.

INITIAL HISTORY and PHYSICAL EXAM	
Consultation	**Transfer of Care**
• Significant medical conditions that may affect pregnancy or may be exacerbated by pregnancy • Significant use of drugs, alcohol or other substances with known or suspected teratogenicity or risk of associated complication • Previous uterine surgery other than one documented low-segment C-section. • History of cervical cerclage • History of more than one second-trimester spontaneous abortion • History of ≥3 or more consecutive first trimester spontaneous abortions • History of >1 preterm birth, or preterm birth less than 34 weeks • History of more than one small for gestational age infant • Previous stillbirth or neonatal mortality which likely impacts pregnancy • History of severe eclampsia, pre-eclampsia or HELLP syndrome	• Serious, chronic or acute medical conditions, e.g. Cardiac or Renal disease • Pre-existing Insulin dependent diabetes mellitus

PRENATAL CARE	
Consultation	**Transfer of Care**
• Significant mental health concerns presenting during pregnancy • Significant medical conditions presenting during pregnancy • Abnormal cervical cytology requiring further evaluation • Pregnancy complication outside of RM's scope of practice (e.g. gestational hypertension, severe hyperemesis, severe anemia or Urinary Tract infection unresponsive to pharmacologic therapy) • Persistent significant vaginal bleeding • Thrombophlebitis or suspected thromboembolism • Oligohydramnios or polyhydramnios • Evidence of intrauterine growth restriction • Insulin treated gestational diabetes • Intrauterine fetal demise that may require medical intervention during or immediately after delivery • Asymptomatic placenta previa persistent into the third trimester • Vasa previa • Suspected or diagnosed fetal anomaly that may require immediate medical management after delivery	• Molar pregnancy • Severe hypertension or pre-eclampsia, eclampsia or HELLP syndrome • Multiple pregnancy (other than twins) • Thromboembolic disease • Placental abruption or symptomatic placenta previa

• Twins ** • Non-cephalic presentation (e.g. breech) at 38 weeks** **While some of these births may become shared care or 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.	

DURING LABOUR and BIRTH	
Consultation	**Transfer of Care**
• Active genital herpes at onset of labour or rupture of membranes • Late preterm labour or pre-labour rupture of membranes (34+0 to 36+6 weeks gestation) • Significant vaginal bleeding • Twins ** • Breech or other malpresentation with the potential to be delivered vaginally** • Significant hypertension • Labour dystocia unresponsive to therapy • Abnormal fetal heart rate pattern unresponsive to therapy	• Severe hypertension, preeclampsia, eclampsia or HELLP syndrome • Prolapsed cord or cord presentation • Preterm labor or PPROM less than 34 weeks • Multiple pregnancy other than twins • Abnormal presentation other than breech • Placental abruption, placenta previa or vasa previa • Uterine rupture • Uterine inversion • Suspected embolus • Hemorrhage unresponsive to therapy

• Lacerations involving the anus, anal sphincter, rectum, urethra • Retained placenta with or without bleeding ** 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.	

POSTPARTUM – [MOTHER]	
Consultation	**Transfer of Care**
• Breast infection unresponsive to pharmacologic therapy • Urinary tract infection unresponsive to pharmacologic therapy • Severe uterine prolapse • Persistent bladder or rectal dysfunction • Wound infection • Uterine infection • Persistent temp >38 degrees C • Persistent or new onset hypertension • Secondary postpartum hemorrhage • Thrombophlebitis or suspected thromboembolism	• Hemorrhage unresponsive to therapy • Postpartum eclampsia • Postpartum psychosis

• Serious mental health problems including postpartum depression and signs or symptoms of postpartum psychosis	

POSTPARTUM - INFANT	
Consultation	**Transfer of Care**
• Suspicion or significant risk of neonatal infection • Apgar score less than seven at five minutes • Prolonged PPV or significant resuscitation • Late preterm baby (34+0 to 36+6 weeks) • In utero exposure to significant drugs, alcohol or other substances with known or suspected teratogenicity or other associated complications • Persistent pallor, cyanosis, hypotonia or jitteriness • Excessive bruising, abrasions, unusual pigmentation or lesions • Hypoglycemia unresponsive to initial treatment • Suspected neurological abnormality or seizure activity • Congenital abnormalities or suspected syndromes, ambiguous genitalia • Abnormal heart rate, pattern or significant murmur	• Significant congenital anomaly requiring immediate medical intervention • Suspected seizure activities

• Persistent abnormal respiratory rate and/or pattern • Infant <2500 grams • Feeding issues not resolved with usual midwifery care • Significant birth trauma • Infant born to a mother with active genital herpes • Infant born to a mother who is Hepatitis B or C positive • Infant born to a mother who is HIV positive • Single umbilical artery not consulted for prenatally • Failure to pass urine or meconium within 24hours • Hyperbilirubinemia requiring medical treatment • Fever or hypothermia, temperature instability unresponsive to therapy • Abnormal vomiting or diarrhea • Evidence of localized or systemic Infection • Significant weight loss unresponsive to interventions or adaptation in feeding plan. • Failure of infant to regain birth weight within 21 days	