Midwives' Association of Washington State
INDICATIONS FOR DISCUSSION, CONSULTATION, AND TRANSFER OF CARE IN A HOME OR BIRTH CENTER MIDWIFERY PRACTICE

1. INTRODUCTION:

Professional members of the Midwives' Association of Washington State (MAWS) include Licensed Midwives (LMs)[1] and Certified Nurse Midwives (CNMs). In the home or birth center setting LMs and CNMs (herein referred to as 'Midwives') work interdependently with one another and with other health care practitioners to promote the optimal health and safety of low-risk mothers and babies during the normal childbearing cycle. Midwives engage in an ongoing risk screening process that begins at the initial visit and continues through the completion of care. In providing care, midwives take into account their clinical judgment and expertise, a client's own values and informed choice, relevant state laws and regulations, the standards for practice and core competencies for basic midwifery care provided by their professional organizations, relevant midwifery and medical literature, the settings in which they practice, the collaborative relationships they have with other health care practitioners and area hospitals, and their philosophy of care.

During pregnancy, labor, or postpartum, risk factors or complications can develop. This document provides a list of conditions that a midwife may encounter in practice for which discussion, consultation, or transfer of care is indicated. The list is representative but not exhaustive. Other circumstances may arise where the licensed midwife believes discussion, consultation, or transfer of care to be necessary.

Professional members of the Midwives' Association of Washington State are advised to discuss, consult, and/or transfer care of their clients according to this document and in accordance with the MAWS document Position Statement: Shared Decision-Making. MAWS recognizes that there are variations in practice specialty and professional members may hold different licenses or qualifications which hold them to a different standard of care than those outlined in this document. (These practitioners may include but are not limited to CNMs, ARNPs, and NDs). In addition, new clinical procedures may be undertaken in accordance with the MAWS document Mechanism for Introducing Expanded Clinical Procedures into Midwifery Practice. MAWS members should discuss the scope and limitations of midwifery care with clients and refer to these documents as necessary.

This document should be used as a screening tool to distinguish between low-risk and higher-risk maternal and newborn clients. Its purpose is to enhance safety and promote midwives' accountability to their clients, to one another, to other health care practitioners, and to the general public. MAWS reviews this document periodically and revises it as necessary in order to reflect the most current evidence available and to insure that the parameters identified promote the safety of mother and newborn without unduly restricting midwifery practice.

[1] Licensed midwifery, as defined in RCW 18.50, is an autonomous profession. When there are significant deviations from normal during the pregnancy, labor, or postpartum period, licensed midwives are required by law in Washington State (RCW 18.50.010) to consult with a physician regarding the client's care.

2. DEFINITIONS:

2.1 DISCUSSION WITH ANOTHER MIDWIFE, AN ARNP, OR A PHYSICIAN

A discussion refers to a situation in which the midwife seeks information from a colleague about a clinical situation, presenting a management plan for feedback.[2]

2.1.1 It is the midwife's responsibility to initiate a discussion with and provide accurate and complete clinical information to another midwife, a nurse practitioner, or a physician in order to plan care appropriately. This discussion can take place between midwives in the same practice.

2.1.2 Discussion should occur in a timely manner soon after the clinical situation is discovered.

2.1.3 Discussion may occur in person, by phone, fax, or e-mail.

2.1.4 Discussion may include review of relevant patient records.

2.1.5 Discussion may include request for prescriptive medication based on signs or symptoms and/or laboratory results.

2.1.6 Discussion should be documented by the midwife in her records. Documentation of discussion should refer only to practitioner type without specifying the name of the practitioner contacted. Documentation should also include the midwife's management plan.

2.1.7 Discussion need not occur if the midwife has previously encountered a particular situation, discussed it with a colleague, developed a management plan, and is currently managing the same clinical presentation. In this case, documentation of the management plan and discussion with the client of the management plan is sufficient.

2.3 CONSULTATION WITH A PHYSICIAN

A consultation refers to a situation in which the midwife, using her professional knowledge of the client and in accordance with this document, or by client request, seeks the opinion of a physician competent to give advice in the relevant field. The consultant will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that led to the consultation.

2.2.1 It is the midwife's responsibility to initiate a consultation and to communicate clearly to the consultant that the midwife is seeking a consultation.

2.2.2 A consultation can involve the physician providing advice and information, and/or providing care to the woman/newborn, and/or prescribing treatment for the woman or newborn.

[2] A MAWS member who has additional credentials (i.e.: CNM, ND) that allow for a broader scope of practice need not discuss conditions that are within her scope of practice.

2.2.3 In the case of an in-person consultation, the midwife should expect that the consultant will promptly communicate findings and recommendations to the client and the referring midwife after the consultation has taken place.

2.2.4 Where urgency, distance, or climatic conditions do not allow an in-person consultation with a physician when it would otherwise be appropriate, the midwife should seek advice from a physician by phone or other similar means. The midwife should document this request for advice in her records and discuss the consultant's advice with the client.

2.2.5 It is the midwife's responsibility to provide all relevant medical records to the consultant, including a written summary of the client's history and presenting problem, as appropriate.

2.2.6 Consultation should be fully documented by the midwife in her records, including the consultant's name, date of referral, and the consultant's findings, opinions, and recommendations. The midwife should then discuss the consultant's recommendations with the client.

2.2.7 After consultation with a physician, care of the client and responsibility for decision-making, with the informed consent of the client, either continues with the midwife, is shared collaboratively by the midwife and the consultant,[3] or transfers completely to the consultant. Transfer or sharing of care should occur only after dialogue and agreement among the client, the midwife, and the consultant.

2.4 TRANSFER TO A PHYSICIAN OR OTHER QUALIFIED HOSPITAL-BASED PROVIDER

When care is transferred permanently or temporarily from the midwife to a qualified hospital-based provider, the receiving practitioner assumes full responsibility for subsequent decision-making, together with the client. For guidance about intrapartum transfers, see also the MAWS document Planned Out-of-Hospital Birth Transport Guideline.

[3] During such collaborative care the consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within her scope of practice. It is the midwife's responsibility to maintain explicitly clear communication between all parties regarding which health professional has primary responsibility for which aspects of the client's care. In addition to any verbal dialogue regarding client care, the dialogue and plan of care should be documented in the client's chart.

3.1 PRE-EXISTING CONDITIONS AND INITIAL HISTORY

Discussion:

- family history of significant genetic disorders, hereditary disease, or congenital anomalies
- history of pre-term birth (<36 weeks)
- history of IUGR
- history of severe postpartum hemorrhage
- history of severe pre-eclampsia or HELLP
- history of gestational diabetes requiring oral hypoglycemic or insulin
- no prenatal care prior to third trimester
- BMI > 35
- history of lap band, gastroplasty or other bariatric (weight loss) surgery
- previous unexplained neonatal mortality or stillbirth

Consultation:

- absent prenatal care at term
- history of seizure disorder in adulthood
- history of HELLP
- history of uterine surgery, including myomectomy
- one prior cesarean birth with low transverse incision
- significant history of or current cardiovascular, renal, hepatic, neurological or severe gastrointestinal disorder or disease
- significant history of or current endocrine disorder (excluding controlled mild hypothyroidism)
- pulmonary disease/active tuberculosis/severe asthma
- collagen vascular diseases
- significant hematological disorders
- current or recent diagnosis of cancer requiring chemotherapy
- history of cervical cerclage
- history of 3 consecutive spontaneous abortions (excluding clients who present to care with viable pregnancy at gestation >14wks and beyond previous miscarriage)
- significant uterine anomalies
- essential hypertension
- history of eclampsia
- history of postpartum hemorrhage requiring transfusion
- current severe psychiatric illness
- current seizure disorder

Transfer:

- any serious medical condition associated with increased risk status for mother or fetus, for example: cardiac disease, renal disease with failure, insulin-dependent diabetes mellitus, uncontrolled asthma, or maternal HIV infection
- isoimmunization with an antibody known to cause hemolytic disease of the

newborn
- prior cesarean with incision other than low transverse (e.g. classical)
- two or more prior cesareans with low transverse incision

3.2 ANTEPARTUM CONDITIONS

Discussion:

- urinary tract infection unresponsive to treatment
- significant abnormal ultrasound finding
- significant abnormal laboratory finding
- unresolved size/dates discrepancies
- 42 completed weeks with reassuring fetal surveillance including AFI and BPP with NST

Consultation:

- reportable sexually transmitted infection
- significant abnormal Pap
- significant abnormal breast lump
- pyelonephritis
- thrombosis
- fetal demise after 14 weeks gestation
- anemia unresponsive to treatment
- primary herpes infection
- significant vaginal bleeding
- hemoglobinopathies
- platelets ≤ 105,000/μL
- persistent abnormal fetal heart rate or rhythm
- non-reassuring fetal surveillance
- significant placental abnormalities
- significant or unresolved polyhydramnios or oligohydramnios
- presentation other than cephalic at 37 weeks
- multiple gestation if co-managing prenatal care (transfer if not co-managing)
- significant infection the treatment of which is beyond the midwife's scope of practice

Transfer:

- ectopic pregnancy
- molar pregnancy
- premature pre-labor rupture of membranes (PPROM)
- documented persistent/unresolved intrauterine growth restriction (IUGR)
- multiple gestation if not co-managing prenatal care
- eclampsia, HELLP, pre-eclampsia, or persistent hypertension
- placenta previa at term
- isoimmunization with an antibody known to cause hemolytic disease of the newborn

- clinically significant placental abruption
- deep vein thrombosis
- cardiac or renal disease with failure
- gestational diabetes requiring management with medication; consultation in lieu of transfer if co-managing metformin with physician
- known fetal anomaly or condition that requires physician management during or immediately after delivery
- 43 weeks completed gestation

3.3 INTRAPARTUM CONDITIONS

In certain intrapartum situations, the midwife may need to act immediately and transport may not be the most prudent course of action in that moment. It is expected that the midwife will use her clinical judgment and expertise in such situations, access 9-1-1 and emergency services as appropriate, and transport as able.

Discussion:

- >8 hours of active labor pattern without significant change in cervix and/or station and/or position
- >3 hours of active pushing without significant change
- prolonged rupture of membranes (>48 hours without active labor)

Transfer:

- active labor before 37 completed weeks
- undiagnosed non-cephalic presentation including breech, transverse lie, oblique lie, or compound presentation at onset of labor
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- undiagnosed multiple gestation
- maternal fever (≥100.4 F) that persists >1 hour
- findings indicative of chorioamnionitis including, but not limited to, maternal tachycardia, fetal tachycardia, temperature ≥100.4 F, uterine tenderness, purulent or malodorous amniotic fluid.
- thick meconium
- persistent non-reassuring fetal heart rate pattern
- maternal exhaustion unresponsive to rest/hydration
- abnormal bleeding during labor
- suspected placental abruption
- suspected uterine rupture
- hypertension (≥140 systolic or 90 diastolic twice 1 hour apart)
- suspected pre-eclampsia (hypertension and proteinuria)
- maternal seizure
- ROM > 72 hours
- ROM > 18 hours with GBS status unknown and no prophylactic antibiotics, or GBS+ and no prophylactic antibiotics
- prolapsed cord or cord presentation
- significant allergic response

- active genital herpes in vaginal, perineal or vulvar area in labor or after ROM
- client's stated desire for transfer to hospital-based care

3.4 POSTPARTUM CONDITIONS

Consultation:

- urinary tract infection unresponsive to treatment
- mastitis (including breast abscess) unresponsive to treatment
- reportable sexually transmitted infections
- retained products/unresolved subinvolution/prolonged or excessive lochia
- hypertension presenting beyond 72 hours postpartum
- significant abnormal Pap
- significant postpartum depression

Transfer:

- significant postpartum hemorrhage unresponsive to treatment, with or without sustained maternal vital sign instability or shock
- retained placenta (>1 hour or active bleeding and manual removal unsuccessful)
- lacerations beyond midwife's ability to repair
- unusual or unexplained significant pain or dyspnea
- significant, enlarging hematoma
- endometritis
- maternal seizure
- anaphylaxis
- persistent uterine prolapse or inversion
- maternal fever (≥ 100.4 F) that persists > 1 hour within the first 72 hours postpartum
- persistent hypertension in the first 72 hours postpartum (≥ 140 systolic or 90 diastolic twice 1 hour apart)
- postpartum psychosis

3.5 NEWBORN CONDITIONS

It is recommended that parents establish a relationship with a pediatric provider before the baby is born. It is strongly recommended that all parents be advised to establish care with a pediatric provider by 2 weeks of age. The following conditions warrant contact sooner.

Consultation:

- low birth weight newborn (< 2500 gm = 5 lbs 8 oz)
- loss of greater than 10% of birth weight
- prolonged asymptomatic jaundice
- persistent cardiac arrhythmias or murmurs
- significant clinical evidence of prematurity
- failure to thrive
- hypoglycemia
- significant or symptomatic jaundice beyond the first 24 hours
- positive critical congenital heart disease screening (CCHD)

Transfer:

- seizure
- jaundice in the first 24 hours
- persistent respiratory distress
- persistent central cyanosis or pallor
- persistent temperature instability
- persistent hypoglycemia
- significant bruising, petechiae or purpura
- Apgar score 6 or less at ten minutes of age
- major congenital anomalies affecting well-being
- birth injury requiring medical attention