MATERNITY UNIT

GUIDELINE: Maternity Consultation & Transfer of Care Procedure

SCOPE: This procedure applies to all obstetricians, LMCs with access agreements accessing Tairāwhiti DHB with their clients & employed midwifery staff.

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PURPOSE:
The purpose of this procedural guideline is to:

- Safely manage the primary/secondary interface in the clinical setting by having a clearly documented process defining responsibilities of obstetricians, LMCs and core midwives.
- Ensure the client & all the practitioners involved (LMCs, core midwives & obstetricians) know by use of Maternity Clinical Information System (MCIS) who is responsible for the clinical care at any given time.

DEFINITIONS:
Referral: Referral is made to the secondary maternity service by the Lead Maternity Carer (LMC) as per the referral guidelines for consultation with obstetric & related medical services (referral guidelines).

The Code of Health & Disability Services Consumers Rights (Code of Rights): The health consumer has 10 rights under the Health & Disability Commissioner Act 1994.

Consultation: To liaise with another person or source of information. In this guidance consultation does not indicate transfer of care unless initiated by either party.

Consultation Documentation: The consultation is documented in the MCIS clinical record when a consultation has taken place followed by the outcome.

Transfer: The physical transfer of a woman from a primary birthing unit or home to Hauora Tairāwhiti, either before or during labour or after birth.

Transfer of care: Means a **transfer of clinical responsibility** for the decision-making regarding the woman's care from a primary based LMC to secondary care specialist (or designate). Where the LMC continues to provide midwifery care, ongoing communication about the woman's/baby's progress is of the utmost importance. Following transfer of clinical responsibility to the obstetrician, a decision is made regarding the most appropriate midwife to provide ongoing midwifery care. The ongoing midwifery care is a negotiated process & is clearly documented. A transfer of midwifery care from LMC to core midwife means that the LMC is no longer responsible for providing midwifery care, & has transferred that responsibility to the core midwife & vice versa. The transfer of care is to be documented in

MCIS, followed by the agreed care plan. Transfer of care back to the LMC will be negotiated at the appropriate stage
MCIS is to be used on every occasion where a transfer between primary & secondary midwifery services occurs, or where an LMC transfers over to an LMC colleague.

Support: Means LMC supports the woman & family in a non-clinical capacity, but will not be performing clinical assessments. The LMC's support role is documented clearly in MCIS and the woman informed of this change so that she has a clear understanding of who is caring for her and clinically responsible for decision making with her. It is acknowledged that in an emergency the LMC will become professionally obligated to become clinically involved & document her actions accordingly.

Responsible Midwife: At any time ONLY ONE midwife (LMC or core) is responsible for the care of a woman. This person has full responsibility for all midwifery clinical decision making & midwifery care provision until such time as transfer back occurs, using the MCIS to document the transfer of care. By ensuring one midwife is fully responsible for the midwifery care & decision-making, confusion & assumptions are eliminated & appropriate actions taken.

SBARR: Clinical communication is conveyed by using the SBARR communication tool. All SBARR conversations commence by identifying oneself.

Observation Chart: It is Hauora Tairāwhiti standard that all maternal vital signs & observations are plotted on the MCIS observation charts, for antenatal, intrapartum and postnatal care as well as for epidural and post-operative care under the Maternity Early Warning System (MEWS) observations in MCIS.

Where a consultation or transfer of clinical responsibilities occurs, the woman and whanau must be informed. The woman should know at all times who is responsible for clinical decision-making and midwifery care.

GUIDELINE:
Responsibilities of parties during consultation/handover/transfer of care:
LMC responsibilities

ACTION	RATIONALE
1. LMC refers to the secondary services as per the referral guidelines. Full & complete referrals are to be made including a midwifery assessment informing the maternity referral category, test & scan results & any other applicable information including a GROW chart.	The referral guidelines document is a national guide to be used as a steer to good maternity practice. It is a client's right (Code of Rights: right 4) for providers to cooperate to ensure quality & continuity of services. To this end, full & complete referrals enable efficient processing of referrals to enable women to be seen in a timely manner
2. Referrals to antenatal clinic require a primary midwifery assessment to inform the written referral process. A management plan and risk assessment will	As above

be commenced and updated as the pregnancy progresses by the obstetrician.	
3. Where the LMC's client has been seen antenatally & advised to birth at Puawai Aroha, the LMC is responsible to consult with the O&G team to put a plan in place as appropriate. This should be clearly documented in the woman's clinical records in MCIS.	To ensure the O&G team & Shift Coordinators are aware of the client's needs to enable an appropriate clinical response when required.
4. In urgent situations, the LMC contacts the O&G for a consultation with a view to a transfer of care in certain circumstances. This is normally done verbally in the first instance. The LMC is to communicate the urgency of the woman's condition (based on a midwifery assessment) at the time, using the SBARR communication tool and documenting the telephone call in the communication page in MCIS (MMPO). Alternatively, if it is a core midwife receives the call directly from the LMC or via the O&G, then she is to document the call in the woman's MCIS records. Following the verbal discussion, the LMC provides the relevant & required clinical & administrative information to inform the secondary service.	When the urgency of the woman's condition is communicated the secondary service can plan its resources to appropriately respond on the woman's arrival. Adequate information enables an appropriate clinical & administrative response.
5. If the woman arrives prior to the LMC: • The core midwife will take a full set of maternal observations including temperature, pulse, BP, respirations, urinalysis, palpation, contractions, liquor, state of hydration & bladder. Fetal surveillance will be undertaken. If the woman is in labour the observations are to be recorded on the labour and birth tab of MCIS and in the pregnancy care tab of MCIS if the woman is not labouring. • If the LMC arrives with or prior to the arrival of the woman, the LMC is to notify the shift coordinator at Puawai Aroha of their arrival. a. In the case of an <u>emergency</u>: a core midwife is to be allocated to assist or receive an immediate transfer of care	Establish a baseline assessment in order to enable an early detection of deterioration & timely response.

where appropriate. The emergency response is activated to call for urgent medical assistance. b. In case of a <u>non-emergency</u>: LMC may request a consultation or transfer of care. • If the LMC has not transferred care, she is responsible for recording a full set of maternal observations including temperature, pulse, BP, respirations, urinalysis, palpation, contractions, liquor, state of hydration & bladder. Fetal surveillance will be undertaken. If the woman is in labour the observations are to be recorded in the labour and birth tab of MCIS and in the pregnancy care tab of MCIS if the woman is not labouring.	The shift coordinator is responsible to deploy resources & needs to have a whole picture for planning & allocation of resources.
6. If the O&G has been consulted, ongoing care & responsibilities are to be negotiated by means of a four-way conversation between LMC, obstetrician, woman & core midwife. The consultation/ specialist review is to be documented in the MCIS. The ongoing plan is to be documented in MCIS.	To enable clarification of the ongoing plan of care.
7. Following the outcome of the discussion in No. 6 above, the LMC approaches the shift coordinator. The ongoing midwifery care is then negotiated between LMC, core midwife & woman. Consideration is given to the LMC's role prior to transfer & her responsibilities to her primary care clients in the community or rural service area. The transfer of care in MCIS is to be used if there is a change in who is providing midwifery care.	To enable clarification of the most appropriate midwife to provide ongoing midwifery care.
8. When a transfer of clinical responsibility to the obstetrician has occurred, the LMC can continue to provide midwifery care. Where the LMC wishes to undertake secondary midwifery care, she will remain fully responsible for all midwifery care in ongoing collaboration & information-sharing with the obstetrician & shift coordinator.	Where a handover of responsibility has occurred to the obstetrician, obstetric & midwifery collaboration are key to seamless & safe care

9. Where the LMC wishes to transfer midwifery care to the core midwifery team, a timely notice of this intention is important. When acuity is high then a minimum of 30 minutes' notice is required. The LMC is responsible to keep herself updated of her client's condition.	To enable the secondary service to re-arrange resources.
10. Where the LMC stays in support following a handover, she must clearly communicate with the woman the nature of her support role and utilise the transfer of care section in the MCIS.	Women need to know at all times who their principle carer is.

O&G Responsibilities

ACTION	RATIONALE
1) When the O&G is called to assess a woman, communication should be documented in the communication tab in MCIS to establish the urgency of the situation. The O&G should indicate the likely time of attendance.	Women are to be seen in a timely way & in accordance with the urgency of their condition.
2) The obstetrician assesses the woman considering all factors, including the maternal observations (temperature, pulse, blood pressure, respirations, contractions, liquor, state of hydration, bladder), palpation & vaginal examination (if indicated) & fetal surveillance.	
3) Following assessment, the obstetrician with the woman & her LMC/core midwife will discuss the proposed plan of care. The ongoing care & responsibilities are to be negotiated by a four-way conversation between LMC/core midwife, obstetrician & woman. The outcome of the discussion is documented in MCIS along with a management plan and risk assessment.	To enable clarification of the ongoing plan of care.
4) The outcome of the consultation in No. 3 above is communicated to the shift coordinator and the whiteboard updated.	To enable the team to be fully informed in order to respond to demands & emergencies.
5) Where the obstetrician gives a consultation over the phone or in the corridor, it is required that the midwife initiating the consultation records the	To ensure a full record of all secondary/tertiary maternity care input.

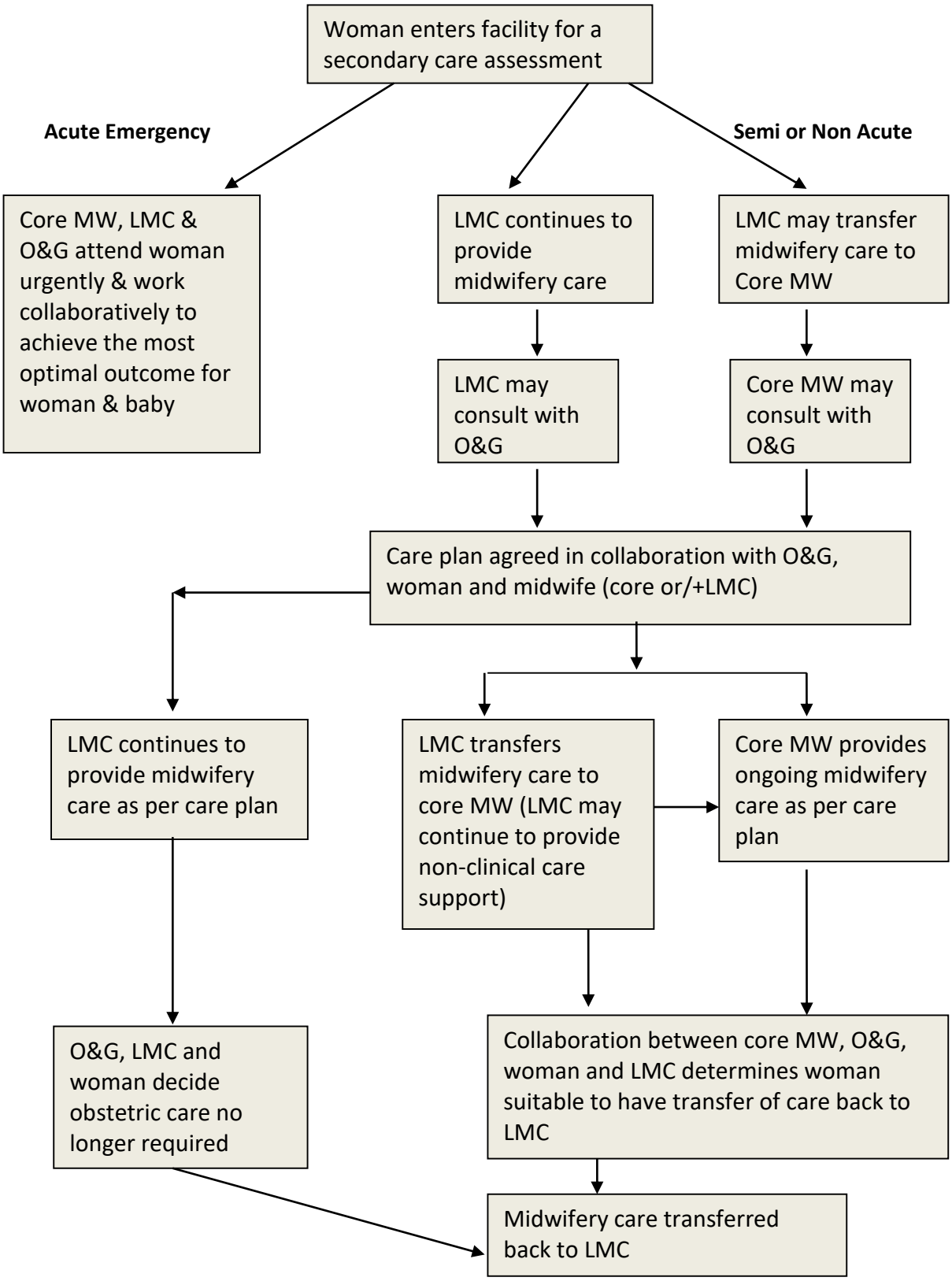
outcome of the consultation in the communication tab of MCIS.	
6) The obstetrician is responsible for timely re-assessments. If a delay is anticipated, then the appropriate back up person needs to be contacted by the obstetrician.	Women who are under the secondary obstetric service are to receive timely & appropriate assessments & corresponding treatment.
7) Where a woman is ready for discharge from secondary services, the planned date of discharge is to be documented in the MCIS.	It is imperative to clarify responsibility & who is accountable for ongoing decision-making.

Core midwifery responsibilities

ACTION	RATIONALE
1) If an urgent situation: a. The on call obstetrician will be notified immediately &; b. The core midwife will prepare labels & 'break glass' in the woman's MCIS records, so they are accessible on arrival of the O&G. In emergency situations, the notification of the expected transfer is to be made to the appropriate person or teams e.g. theatre, paediatrician	To enable the secondary service to prioritise & appropriately respond to urgent situations. To ensure that Laboratory tests can be sent/done without delay. Advance warning to supporting personnel
2) Upon notification of the woman & LMC's arrival the coordinator of the area will enquire about the woman's condition.	Establish a baseline assessment in order to enable an early detection of deterioration.
3) Where a midwifery handover is required the core midwife will take a full set of maternal observations, including temperature, pulse, blood pressure, respirations, contractions, liquor, state of hydration & bladder & an abdominal palpation & vaginal examination (if indicated). Fetal surveillance will be undertaken as per protocol. If the woman is in labour the observations are to be recorded in the labour and birth tab in MCIS and in the pregnancy care tab if the woman is not labouring.	A timely obstetric assessment can occur as indicated. Earlier assessment can be activated based on the maternal & fetal observations.
4) When the LMC approaches the coordinator to negotiate a transfer of midwifery care, the coordinator is responsible to allocate a core midwife to receive the transfer as soon as practicable. If a delay in providing a	To enable the most appropriate midwife to provide ongoing midwifery care.

	midwifery resource, the shift coordinator/LMC will escalate to the CMM. See escalation guideline.	
5)	If transfer of midwifery care occurs, a three-way discussion should take place. Consideration is given to the LMC's role prior to transfer & her responsibilities to her primary care women in the community or rural service area. The transfer of care should be recorded in the MCIS.	To enable clarification of the most appropriate midwife to provide midwifery care.
6)	The LMC should indicate the extent to which she wishes to be updated regarding the woman's condition.	To clarify who is responsible from what time & enable the LMC to negotiate their position.
7)	Midwifery team communicates with LMC regarding transfer of care back to the LMC. The transfer of care should be documented in MCIS.	To clarify who is responsible from what time & enable LMC to negotiate their position Transferring care back with full & relevant information is a client's right.

Transfer of care flow chart



REFERENCES:

- Guidelines for consultation with obstetric & related medical services 2012 (referral guidelines)
- The Health and Disability Commissioner Act, 1994
- Hauora Tairāwhiti Escalation Plan for Maternity, January 2017
- Maternity Service Specifications 2003
- Maternity Clinical Information System (Badgernet) Version 10.0.1., May 2016
- New Zealand College of Midwives Transfer Procedures, 11/09/2008
- Section 88 Notice pursuant to the New Zealand & Public Health & Disability Act 2000
- Waikato (2014) Maternity Consultation and Transfer of Care Procedure Reference 2740. Version: 01

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