Transfer of Care from Midwives to Other Health Care Professionals

For Use in:	Maternity Services
By:	Midwives
For:	Midwives and Obstetricians
Division responsible for document:	Women and Children
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Name of document author:	Sue Holland
Job title of document author:	Clinical Effectiveness Midwife
Name of document author's Line Manager:	Kelly Stevens
Job title of author's Line Manager:	Deputy Divisional Director of Midwifery
Supported by:	Stephanie Pease Divisional Midwifery Director
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If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	N/A

A Clinical Guideline

Version and Document Control:

Version Number	Date of Update	Change Description	Author
10	26/11/2021	Removal of alert form. Added in MMAU and links to relevant documents. Amended referral pathway for EPAU.	Sue Holland
10.1	07/03/2022	Appendix 3 amended	Sue Holland
10.2	10/03/2022	Minor changes to page 6	Sue Holland

This is a Controlled Document

Printed copies of this document may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions.

Quick Reference 1 – How and where to transfer patients (see also Quick Reference 3 Early bleeding/pain)

Quick Reference 2 – Guidance for transfer of care to another trust

From Inpatient Wards

From Home

Quick Reference 3 - Early pregnancy bleeding/ pain advice

Appendix 3 Consultant speciality list

Monday (AM) **Ms Beth Revell (BJR)** **Skylark Team & Perinatal Mental Health**	Vulnerable women & FGM: • Learning Difficulties, • Severe Postnatal Depression, • Puperal or Psychosis, • Psychiatric disorders, (mod/severe) • Drug / Alcohol abuse • Age 19 or younger at EDD
Monday (PM) **Mr Lartey (JPL)**	Pre-term labour & Infectious diseases: • Anyone who needs cervical length or suture, • Late miscarriage, • Prev PPROM • HIV, Hep B/C • Current Bacterial vaginosis ≤16/40
Tuesday (AM) **Ms Gibson (ABG) & Mr Sveronis (Locum)**	General Obstetrics: • Jehovah Witness • ↑TRA • Anaemia, sickle cell thalassemia disease thrombocytopenia • Previous poor outcome (HIE)/Neonatal Death. • Recurrent 1st trimester miscarriage. • Current PET/SGA • ↑Maternal age at EDD
Tuesday (PM) **Ms Nirmal (DMN)**	Birth choices: • BAC, • Traumatic delivery, • 3rd degree tears (if has been advised) • 4th degree tears • Fistula
Wednesday (AM) **Mr Bircher (CWB) & Ms Haestier (ACH)**	Raised BMI • BMI 35 -39.9 seen in ANC with dating scan • BMI 40 + seen in ANC with dating scan
Wednesday (PM) **Ms Partridge/Mr Lartey (FHH)**	Gestational Diabetes
Wednesday (PM) **Ms Gibson (ABG)**	 Rainbow Clinic: Previous SB
Thursday (AM) **Mr Smith (RPS) & Mr Cameron (MJC)**	• Multiple Pregnancy, genetics & FMU • Rhesus isoimmunisation or significant blood group antibodies
Ms Partridge (GCP) & Ms Remadevi (Locum)	Epilepsy
Thursday (PM) **Ms Partridge & McKelvey (ACM)**	Pre-existing Diabetes – Type 1, Type 2, Pump etc.

Friday (AM) **Ms Harlow (FHH), Mr McKelvey (ACM) & Mr Lartey (JPL)**	Maternal Medicine: • Cardiac disease, • Neurology disorders (exception Epilepsy) • Renal disorders including urology problems • Pre-pregnancy hypertension, • Autoimmune disorders including Rheumatology & inflammatory bowel disease. • Endocrine disorders, • Respiratory Disease, • Malignant disease, • Other Haematological disorders, • Severe pre-eclampsia or HELLP in previous pregnancy.

Objective

To ensure that arrangements are clear as to who and how to transfer the care of women and/or neonates when outside of midwifery practice to other appropriate health professionals. It covers from pregnancy to up to 28 days post-partum.

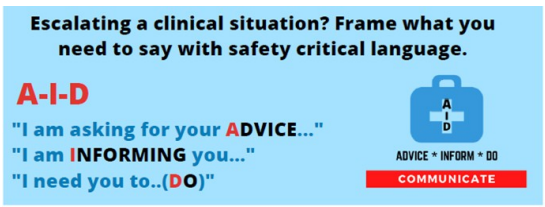
Rationale

Transfer of care between professionals is an essential part of a midwife's role. The midwife is responsible for ensuring appropriate transfer to maintain seamless safe care. There is a professional and legal duty of care requiring health professionals to record and communicate any arrangements for the continuity of care of a woman.

Effective communication and clearly identified pathways for referral and transfer of care/carer are crucial to maintain patient safety

Broad recommendations

- 'Urgent' in this instance is classified as anything that requires immediate consultation but not emergency admission.
- Continuity of consultant should be maintained wherever possible.
- Documentation of plans made and reason for transfer should be made in the maternity hand held records and on the Digital records – Euroking records.
- Any handover of care should be undertaken using Situation, Background, Assessment, Recommendation (SBAR sticker) (and in accordance with the Management of: Handover of Care Guideline Trustdocs ID: 1434.
- When escalating care clear communication is vital and using safety critical language should be used – think AID (Each baby Counts+ learn and support Programme).



Referral in Hospital Setting

Emergency
For **all** emergencies the 2222 bleep should be used stating nature of emergency location and room number. If not already under consultant care the patient will then transfer to consultant led care Obstetric emergencies.

- Major Obstetric Haemorrhage (Antenatal/Intrapartum/Postnatal).
- Shoulder Dystocia.
- Cord Prolapse.
- Imminent/visible breech birth.
- Compromised Women with suspected sepsis.
- Formulating pre-eclampsia/eclampsia/severe hypertension.
- Suspected concealed abruption.

MLBU
Following a risk assessment, and any deviation from the normal then the midwife should arrange transfer to the delivery suite. If intrapartum then the delivery suite coordinator should be informed as well as the obstetrician refer to Intrapartum Care in all Settings (Trustdocs ID: 850) and Trust Guideline for the Midwife-Led Birthing Unit (MLBU) Operational Guideline (Trustdocs ID: 7181) for more guidance.
If from MLBU then the midwife must accompany the patient to delivery Suite.

Once referred in labour, a woman will remain under consultant care until transfer home.

All other referrals
If there is any deviation from the normal on risk assessment then the usual practice, excluding emergencies, is to bleep the relevant specialist whom is needed.

Referrals in the community

Booking

All women are risk assessed at booking and the lead professional is identified using the criteria in appendix 4 (Copied from the guideline to Antenatal Booking and subsequent Antenatal Appointments and Risk Assessment, Trustdocs ID: 795).

Antenatal period

Any deviation from the normal, refer to the appropriate clinician, i.e. general practitioner (GP) or consultant obstetrician. Any issues of concern inform the appropriate expert i.e. 'safeguarding children' concerns, mental health concerns or disclosed domestic violence.

- If non urgent and <12 completed weeks of pregnancy, contact the Antenatal Clinic (ANC) or arrange an appointment at the Early Pregnancy Assessment Unit (EPAU).
- If non-urgent and over 12 completed weeks of pregnancy, contact the GP or ANC or Cley Gynae ward 01603 287242 for further review.

- If urgent and <22 completed weeks of pregnancy, arrange referral for a gynaecological opinion via, emergency department.
- For early pregnancy bleeding see flow chart appendix 3.
- If urgent and 22 or more weeks pregnant, refer directly to the MAU see Macleod Maternity Assessment Unit (MMAU) Standard Operating Procedure (SOP), Trustdocs ID: 11525.
- In an emergency and 22 or more weeks pregnant transfer by 999 paramedic ambulance. The caller must state 'this is an obstetric emergency'. Depending on the nature of the emergency and if the patient requires delivery suite, Delivery Suite should be alerted by bleep 0531 Consider if more appropriate to transfer to the Emergency Department (see MMAU SOP) e.g. severe breathlessness; chest pain ;?DVT.
- If a woman requests a home birth then she should referred to the Juniper Home birth team please see Trust guide line Clinical Guideline for Planned Home Birth Management, Trustdocs ID: 805.

Intrapartum
Home birth

In an emergency the midwife must call 999 and request a paramedic ambulance and must state "this is an obstetric emergency". Delivery Suite coordinator should be alerted by bleeping 0531 or phoning directly on 01603 287393 who will then liaise with the consultant team on call and prepare a room ready.

Calls will be documented in the delivery suite diary by the DS coordinator

See section in Trust guide line Clinical Guideline for Planned Home Birth Management, Trustdocs ID: 805, for more detail of transfer by ambulance.

The midwife will accompany the woman to delivery suite via the West Atrium. And a full handover given on arrival to the unit

Postnatal:
Maternal
Following a risk assessment, any deviation from the normal and the midwife needs to transfer in as an emergency –see process as above. Consider if the emergency department may be more appropriate:

- If urgent but not requiring emergency admission, refer to appropriate medical practitioner this may be he GP or to the obstetrician on MMAU - refer to the MAU standard operating procedure Trustdocs ID No: 11525.

Postnatal period - transfer of care to health visitor

- Transfer of care to the health visitor (HV) by a midwife may occur at any time from 11-28 days postpartum. Timing of transfer is dependent upon need for midwifery care. The situation may require the midwife to liaise directly with the HV to ensure a seamless service and avoid conflicting advice.

At whatever stage care is transferred, the midwife is required to complete the Maternal Discharge Summary Form (the blue form at the back of the post-natal notes) this is

then placed in Personal Child Health Record (the red book) ready for the health visitor. It should provide the following information:

- Birth weight.
- Last recorded weight of baby.
- Feeding progress.
- Neonatal screening test date.
- Any relevant problems/history. Specifically to include any 'safeguarding children', mental health, domestic violence or lone worker safety issues.
- Also must be noted if any birth trauma /bruising/birthmarks Good practice is to include a copy of the Neonatal and Infant Physical Examination (NIPE) form.

The maternal and baby notes are removed from the house upon discharge from midwifery care and returned to maternity unit (to a trolley in the admin corridor) for filing within the buff notes **as soon as possible** after 28 days postpartum

Neonates when the midwife detects a deviation from the normal
In an **emergency**, always ring 999, whatever the age, and the baby will be transfered to the emergency department (ED). A pre alert call by the paramedic team to the ED will be made and the appropriate team (either neonatal or paediatric) will be called to resus. If on arrival the baby is stable then transfer to the CAU will be arranged

Urgent

If within **24 hours of birth** discuss with NICU doctor/ ANNP bleep 1377 (9am-5pm) or (out of hours) bleep 1060
If they decide the neonate needs review they will arrange review on the neonatal unit.

If **greater than 24hrs but less than 14 days** refer to CAU by calling the Tier 2/consultant on refer to Trust Guideline for the Management of Admissions of infants 14 days of age and under, Trustdocs ID: 1259.

If **over 14 days**
Contact CAU via DECT phone 6580 and they will be assessed in the CAU/ Coltishall ward.

Non urgent refer to the GP

Please see also refer to Trust Protocol for the Management of Babies with Prolonged Jaundice referred from Primary Care, Trustdocs ID: 1528.

Transfer of Antenatal patients to another hospital trust

If transferring a patient for ongoing care to another hospital trust please follow the flow charts regarding E3 workflows and printing guidance. See appendix 2

Clinical Audit Standards derived from the guideline

The Maternity Services are committed to the philosophy of clinical audit, as part of its Clinical Governance programme. The standards contained in this clinical guideline will be subject to continuous audit, with multidisciplinary review of the audit results at one of

the monthly departmental Clinic Governance meetings. The results will also be summarised and a list of recommendations formed into an action plan, with a commitment to re-audit within three years, resources permitting.

Summary of Development & Consultation process undertaken before registration and dissemination

This guideline was updated by the Clinical Effectiveness Midwife in consultation with staff in NICU; EPAU; Community Team leaders and DS coordinator

Distribution List

Midwifery Director of, Community Team Leaders, Risk Manager, Clinical Managers; Practice Development Midwives; Professional Midwifery Advocates
Trust Intranet

References

1. Nursing and Midwifery Council (2018) The Code; Professional standards of practice and behaviour for nurses, midwives and nursing associates https://www.nmc.org.uk/standards/code/

2. Knight, M., Bunch, K., Tuffnell, D., Shakespeare, J., Kotnis, R., Kenyon, S., Kurinczuk, J.J. (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2019.

3. Each baby counts + learn and support