



Transfer Guidelines

These Transfer Guidelines were ratified at NZCOM Annual General Meeting on 11 September 2008

Transfer of a woman under the care of an LMC midwife to a secondary / tertiary obstetric service or facility within the New Zealand maternity services context.

1. Purpose of this document

The purpose of this document is to set out the process and considerations when:

- undertaking a **transfer** of a woman from a primary or community based setting to a base hospital and / or,
- there is a **transfer of care** for a women under the care of an LMC midwife to an obstetric service and,
- there is a **transfer of midwifery care** from an LMC midwife to a core midwife following a **transfer of care**.

2. Background

The Section 88 Primary Maternity Services Notice 2007 (Part A4) states that the objectives of primary maternity services are to:

- give each woman, her partner, and her whanau or family, every opportunity to have a fulfilling outcome to the woman's pregnancy and childbirth by facilitating the provision of primary maternity services that are safe, informed by evidence and that are based on partnership, information, and choice; and*
- recognise that pregnancy and childbirth are a normal life-stage for most women; and*
- provide the woman with continuity of care through her LMC who is responsible for assessment of her needs, planning of her care with her and the care of her baby; and*
- facilitate the provision of appropriate additional care for those women and babies who need it.*

Part DA8 of the Section 88 Notice states:

- (1) *If there is a transfer of care to secondary maternity services, tertiary maternity services, or specialist neonatal service, clinical responsibility for the woman and baby transfers, until there is a transfer of care back to the LMC.*
- (2) *Every transfer of care must be documented in the clinical notes, including the date and time of transfer.*
- (3) *If responsibility for a woman's care transfers to a secondary maternity service or tertiary maternity service after established labour, the woman's LMC may continue to support the woman.*

3. Context

LMC care provided under the Section 88 Notice is a primary care service. At times women and / or their babies may require 'additional care', from obstetric or other specialist services. The need for additional care and how it is provided is guided by the Referral Guidelines¹. The Referral Guidelines describe 3 levels of referral.

- **Level 1** – The LMC may recommend that a consultation with a specialist is warranted – clinical responsibility for the woman's care remains with the LMC unless it is agreed that there is a ***transfer of care***.
- **Level 2** – The LMC must recommend that a consultation with a specialist is warranted - clinical responsibility for the woman's care remains with the LMC unless it is agreed that there is a ***transfer of care***.
- **Level 3** – The LMC must recommend that responsibility for care be transferred to a specialist - clinical responsibility for care transfers to the appropriate specialist service – a ***transfer of care*** takes place.

4. Definitions

For the purposes of this document the following definitions apply.

- ***Transfer*** means the physical transfer of a woman from primary maternity unit or home to a base hospital either; before, during or after labour. This may or may not be accompanied by a ***transfer of care***.
- ***Transfer of care*** means transfer of clinical responsibility for decision making regarding the woman's care from a primary based LMC to the secondary or tertiary based specialist. It may occur during pregnancy, labour or in the post

¹ **Referral Guidelines** means the *Guidelines for Consultation with Obstetric and Related Specialist Medical Services* that identify clinical reasons for consultation with a specialist and that are published by the Ministry of Health from time to time.

natal period. Clinical responsibility will be transferred back to the LMC at some stage as negotiated and agreed by all parties.

- Women still require midwifery care, even when there has been a **transfer of care** to the obstetric team. Following a **transfer of care**, a decision is made about who the most appropriate midwife to care for the woman is. It may be the LMC or it may be the core midwife, or a combination of both. The decision is made following a negotiation between the woman, the LMC, the specialist service and the core midwifery team. If appropriate, there may be a **transfer of midwifery care**, which means that the LMC is no longer responsible for providing midwifery care to the woman and hands that responsibility to the core midwifery staff.

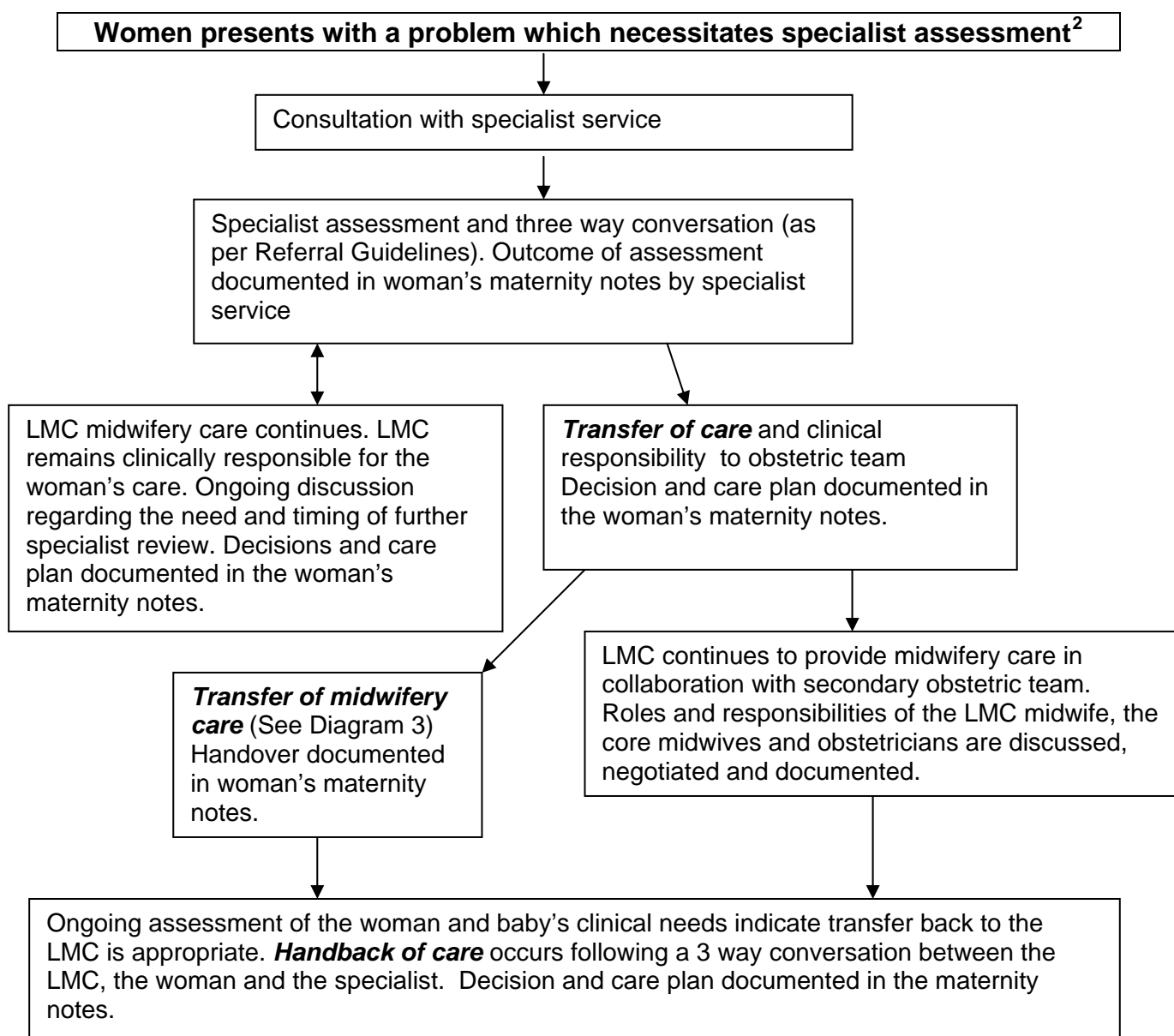
5. What determines the need for a **transfer of midwifery care**.

A **transfer of midwifery care** is a negotiated process. If a **transfer of care** has taken place it is because it has been identified that the woman has additional care needs, beyond the primary LMC responsibilities. Therefore a documented discussion is required between the woman and her support people, the LMC, the core midwifery service and the obstetric service to determine who is best to provide the woman's midwifery care – the LMC or the core midwifery staff, or a combination of both.

Under the provisions of the Access Agreement, LMCs are required to inform the secondary services which areas of care they are planning to provide in relation to epidural, induction of labour, CTG monitoring and operative deliveries. This can be used, amongst other considerations, as a discussion point for deciding ongoing midwifery care arrangements.

If the LMC is remaining to provide midwifery care for the woman, following a **transfer of care**, there still needs to be a discussion and negotiation, with documentation between the core midwifery staff and the LMC regarding midwifery roles and responsibilities, as the LMC may need support and assistance from the core staff in order to continue providing care.

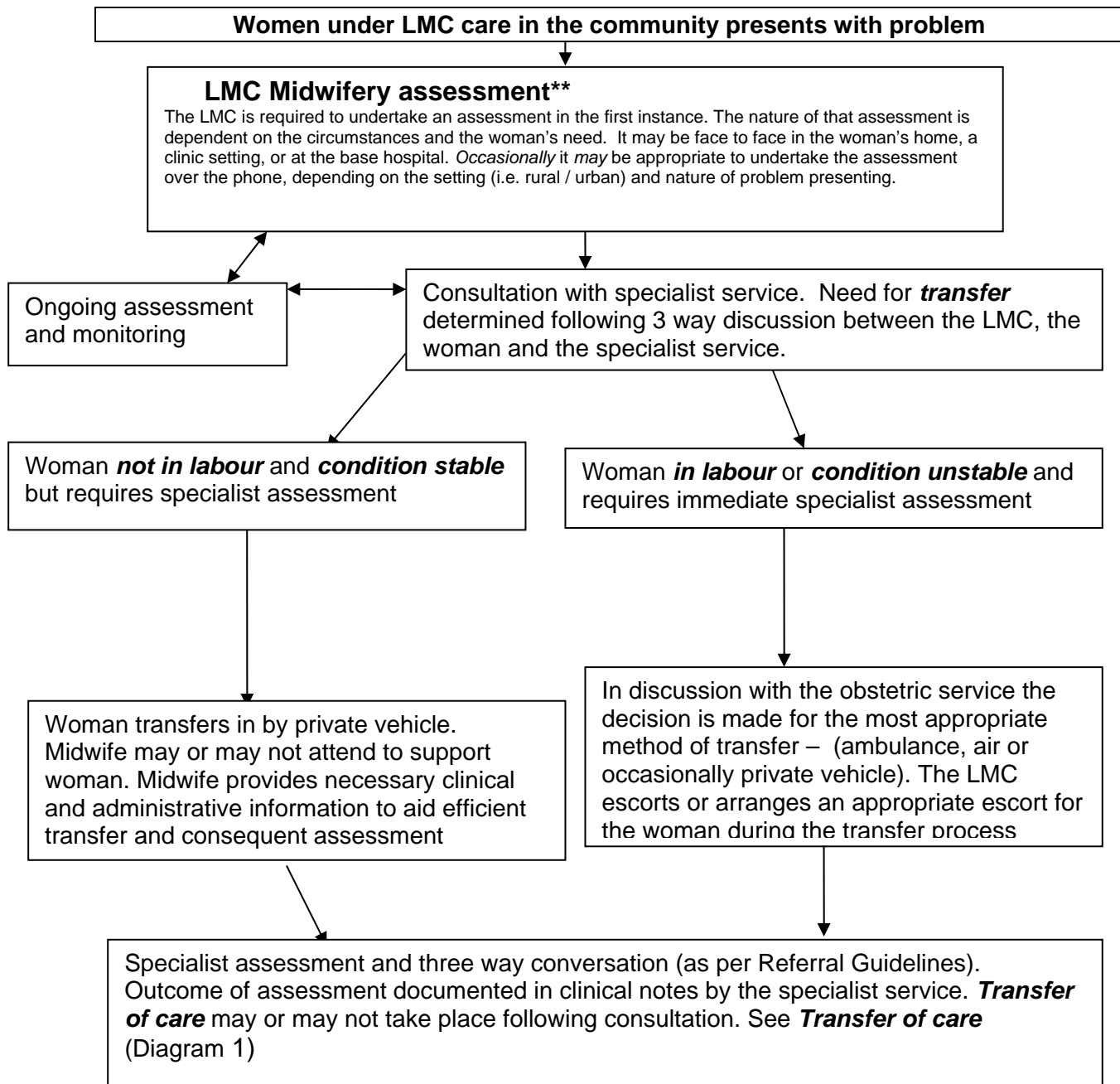
Diagram 1 - Transfer of care



² The woman may be either pregnant, in labour or in the post partum period. She may be in a primary maternity unit, base hospital or in the community.

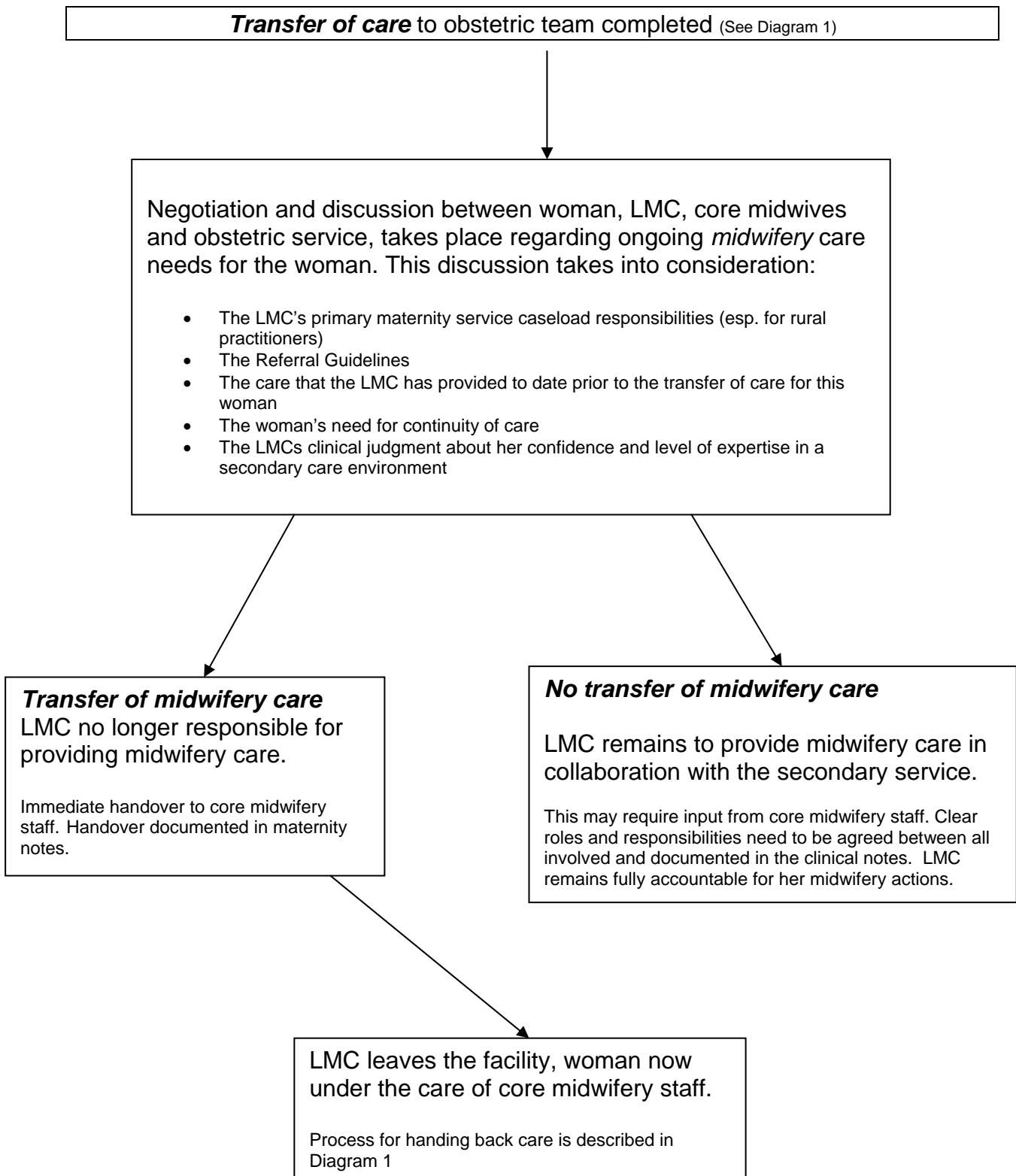
* Midwifery assessments are ongoing and contextual based on; the setting, the Competencies for Entry to the Register of Midwives, the Standards for Midwifery Practice and the Midwifery Scope of Practice, the Referral Guidelines, NZCOM Consensus statements, relevant evidence based and agreed practice guidelines. The need to transfer takes into account the proximity to other services. Transfers from rural settings will require case by case consideration of the transport method, level and availability of midwifery support.

Diagram 2 – Transfer from community to base hospital



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Diagram 3 – Transfer of midwifery care



Appendix One

LMC responsibilities prior to and during *transfer* process

1. Familiarity with usual processes when needing to arrange a *transfer*

It is useful for the LMC to be familiar with usual response / transfer times for ambulance transfer from the setting to the base hospital. This will assist with timeliness of decision making regarding *transfer*.

It is also useful to know the usual staffing arrangements for ambulances (i.e. are there double crewed or single crewed volunteer ambulance staff available?). In each case where a woman needs to be transferred in an ambulance, the midwife should be prepared to accompany her, or ensure that another appropriate person does.

2. Be prepared if there is a delay

The LMC should ensure that she has the necessary equipment available to cover emergency care if she needs to *transfer* a woman and / or baby in any situation, particularly if she is some distance from a base hospital.

3. Gain informed consent of the woman

Using the Referral Guidelines as a frame of reference, the LMC has the responsibility of discussing with the woman the reasons for recommending *transfer* and gaining informed consent for the *transfer* to take place.

4. Liaise with obstetric services to arrange for *transfer*

This is usually done verbally (over the phone or in person) or in writing (depending on the setting and urgency of need) and is initiated by the LMC.

The LMC provides relevant written and verbal information (including woman's details, history, reason for referral etc) in order to facilitate specialist assessment and decision making about the most appropriate transport method.

5. Provide up to date clinical records and the necessary administrative data to facilitate *transfer*

Using women held maternity notes (such as the Midwifery and Maternity Provider Organisation (MMPO) notes) which keep a contemporaneous record of the woman's care and all relevant test results will ensure that relevant clinical information is readily available. These notes should accompany the woman throughout the maternity episode (including *transfer* if that is necessary). The midwife LMC should update and make these notes available to other clinical staff during any *transfer* process.

Complete any administrative requirements to facilitate *transfer*. This requirement is noted in the Access Agreement (Sections 19).

The practitioner will meet any reasonable administrative requirements of the facility to the extent necessary to enable the facility to run an efficient and co-ordinated service.

This can be interpreted to mean that the LMC completes a booking form with client information that is necessary for administrative purposes. As the LMC is making available the relevant clinical notes and information it is not mandatory or even reasonable that the LMC enter clinical data (or any other data) into the computer. Section 24 of the Access agreement stipulates that:

The facility shall facilitate the practitioners compliance with any administrative requirements.

DHBs can interpret this to mean that they will make available referral forms for LMCs to complete and that if they require anything other than administrative data from LMCs they will facilitate its collection – i.e. provide data entry service.

6. Provide timely notice of transfer of midwifery care in order for the facility to arrange midwifery staff to continue providing the woman's care.

DHBs may need to arrange for additional midwifery staff to be available in order to accommodate the needs of the woman who is being transferred to the secondary service. LMCs can provide timely notice of the plan for a transfer of midwifery care and be available for an agreed time period to continue care until additional core staff are available.

Appendix Two

Obstetric service responsibilities during *transfer* process

1. Timely assessment once the woman is on site

When a ***transfer*** takes place either during labour or when a possible or actual obstetric emergency has been identified, the obstetric service will respond in a supportive and timely manner. If a ***transfer*** has occurred it is because a deviation from the normal has been identified. These cases should be assessed as soon as possible. A community based service relies upon rapid responses from the acute obstetric / back up services.

2. Work with the LMC to ensure that the woman's needs for continuity of care is considered

Section 88 and the Referral Guidelines provide a framework for assessing the woman's ongoing care needs once ***transfer*** has taken place.

In some instances it is appropriate for the LMC to continue to provide the midwifery care of a woman following either a ***transfer*** or a ***transfer of care***. In some it is not. Section 88 states (DA8) that if '*responsibility for a women's care transfers to a secondary or tertiary maternity service after established labour, the woman's LMC may continue to support the woman*'.

Each situation should be assessed individually and the decision regarding respective roles and responsibilities decided following a ***three way conversation***.³ The relative roles and responsibilities of each team member providing care to the woman should be discussed, agreed and documented in the clinical notes.

The secondary service is funded to provide secondary care. It is responsible for providing staff to continue midwifery care if there is an agreed ***transfer of midwifery care*** and the LMC is not able to continue to provide the midwifery care.

3. Recognise the role the LMC has played prior to transfer and the LMCs other community caseload obligations.

It is ultimately the LMCs decision on her ability and willingness to continue or not to continue to provide care once clinical responsibility has been transferred to obstetric services. It is acceptable for an LMC to withdraw from care provision if it is her judgement that she has reached the level of her expertise, is tired or has other community midwifery obligations which take priority e.g. returning to rural practice.

³ The requirement for a three way conversation between the woman, the LMC and the specialist service is noted within the Referral Guidelines.

4. Work with the relevant services to ensure that there is effective liaison between primary, secondary and ambulance services

There should be no barriers to rapid *transfer* in an emergency. Clear pathways and guidelines on the process of *transfer* to an obstetric unit should be established. This requires regular liaison and communication between the ambulance service, the obstetric service, NZCOM regional representatives and any other relevant organisations.

Communicate the usual *transfer* processes to the relevant groups. For example, does the neo-natal service usually retrieve babies who require assessment and admission or are they transferred in an ambulance? Is the obstetric service willing to travel to primary maternity facilities to assess and provide intra-partum care?

Effective communication about transfer processes and the support offered to community based services will assist the LMCs and women in the region to have confidence in using the primary facilities in the region.

5. Liaise with the LMC to determine when care will be transferred back.

It should be agreed with the LMC that it is appropriate for care to be transferred back once the woman's condition is stable and can be managed by the LMC. The timing of handing back care to the LMC will vary from woman to woman and midwife to midwife. It will be driven by what is in the woman's best interests and the midwife's ability to provide the level of care necessary. It will be a negotiated process and fully documented in the clinical notes.

Women who have had surgical intervention and require pain relief or have a condition which requires ongoing medication (e.g. anti-hypertensive's) will ideally have a prescription or medication provided by the secondary service before discharge.