PRACTICE STANDARD

B-00-16-10007 – Nurse/ Midwife Roles

Roles of Nurses and Midwives working together in the SPH Maternity Centre.

Related Standards & Resources:

1. **Maternity Centre Guidelines**
   - Antepartum Care
   - Induction/Augmentation of Labour
   - Intrapartum Care
   - Maternity Centre Guidelines
   - Medication Therapy - Maternity
   - Newborn Care
   - Perinatal Loss
   - Post Partum

Skill Level:

Perinatal Registered Nurses, Maternity Licensed Practical Nurses and Registered Midwife

Need to Know

This document will clarify the interactions and professional roles for the RN and Midwife working together to provide optimum patient care at SPH.

Supportive Role:

Care Definition:

Supportive care can involve education, counseling and advocacy in a collaborative relationship with the primary caregiver. It may also include labour support and assistance with infant feeding. A midwife in a supportive care role is not responsible for the provision of clinical care, but may work co-operatively within her scope of practice with the physician/nurse team.

PRACTICE GUIDELINE

The RN introduces herself to the patient and family she is caring for and reviews plan of care. The RN and the midwife discuss care issues. The RN provides the same level of nursing support to midwifery patients as she would to physician patients.

ANTEPARTUM PERIOD

- All antepartum admissions require an obstetrical consult, transfer of care and standard nursing care. The midwife collaborates with the obstetrical team and nursing staff in a *supportive care* role for her patient.

- For Antepartum out patients, i.e. those patients who come to hospital for post dates monitoring Non stress test (NST) and Ultra Sound (US), Electronic Fetal Monitoring (EFM) for reduced fetal movement, the midwife remains the primary care provider and nurses provide standard nursing care and communicate any concerns to the midwife. Please refer to Appendix A: Indications for Consultation from Midwifery/Family Practice to an Obstetrician.

CERVIDIL INDUCTION

- All midwifery clients requiring cervidil induction must have obstetrical consult. Please see Appendix B, Protocol for low risk, post dates Midwifery or Family Practice (without induction-prescribing privileges) patients electing induction between 41^{+3} and 42 weeks gestation.

- Every midwifery patient who has cervidil inserted must have a consult form completed.

- The obstetrician is the most responsible provider of care for the period of continuous monitoring following cervidil insertion.

- The obstetrician is the most responsible care provider until active labour is established at which point care may be transferred back to the midwife at the discretion of the obstetrician and midwife in collaboration. The patient must be made aware of this and it should be documented.

INTRAPARTUM PERIOD

When a client is admitted to SPH Maternity centre, use the following guidelines:

- **On admission and at shift change the primary RN and midwife discuss who is responsible for assessment, care and documentation.** ***Document this discussion***.

- The midwife notifies the Clinical Nurse Leader (CNL) or Charge Nurse (CN), of pending arrival of patient and level of urgency.

- On admission to SPH, the relevant SPH documentation is commenced. The Triage form and Partogram are to be completed by the midwife and RN.

- A new Partogram is initiated regardless of any previous care or documentation at home.

- The CNL/CN facilitates the triaging to SPH Maternity Centre.

- The CNL/CN assigns a primary nurse to the midwifery patient. The goal with all patients is that continuity of nursing care will be provided whenever possible.

- The RN introduces herself to the patient and family

- The midwife gives report to the nurse regarding the client's history progress and plan of care, as soon as possible following admission.

- The RN is responsible for getting minimum hourly updates on patient status.

- The midwife and RN are both responsible in updating each other on changes in patient's status.

- All bedside care is documented on the partogram.
- In the absence of the midwife the RN provides care and documentation as for any other patient.
- At SPH Maternity Centre, the RN provides bedside care in the following situations:
  - High risk
  - Oxytocin
  - Epidural
  - FHS: atypical or abnormal
  - Second stage of labour
- The midwife and RN are both responsible for setting up and checking all equipment in preparation for delivery.
- Break Relief:
  RN must cover RN
  RN may cover RM

BIRTH AND IMMEDIATE POSTPARTUM-PATIENT CARE

	MIDWIFE	RN
Administrative	**1.** Completes Interdisciplinary Progress Notes, Registration of Livebirth/Stillbirth, Labour & Delivery Summary and Newborn Summary PPO's and Discharge Orders **2.** Ensures that all instruments and sharps appropriately accounted for **3.** Requests OB consultation as indicated, and provides report/handover upon their arrival **4.** Requests Pediatric consultation as indicated, and provides report/handover upon their arrival **5.** Leaves delivery room in reasonable state of cleanliness	**1.** Ensures that Partogram, Labour & Delivery Summary and Newborn Summary are complete **2.** Calls for additional nursing presence as needed **3.** Calls for Obstetrical presence as needed **4.** Calls for Pediatric presence as needed **5.** Assists midwife with report to Obstetrical and Pediatric consultants if necessary **6.** Arranges cleaners to come as needed **7.** Monitors and documents the maternal and newborn status on the appropriate care paths
Maternal Surveillance	**1.** Manages birth **2.** Manages 3rd stage **3.** Anticipates the need for	**1.** Supports midwife during the birth **2.** Administers 3rd stage medications as ordered

	emergency care, such as hemorrhage, and communicates this to nurse **4.** Supports skin-to-skin with baby **5.** Initiates and completes perineal repair if required	**3.** Anticipates the need for emergency care and supports midwife in management of maternal emergency, such as hemorrhage **4.** Supports skin-to-skin with baby **5.** Supports midwife during perineal repair if required
Newborn resuscitation and care	**1.** Prepares for and initiates newborn resuscitation as needed **2.** Arranges with RN who will be responsible for administration of Erythromycin ointment and Vitamin K	**1.** Supports midwife with newborn resuscitation **2.** Administers Erythromycin ointment and Vitamin K if not done by RM

- If care is transferred to OB for delivery, the midwife assumes a supportive care role.
- In the event of an emergency situation (e.g. Emergency C/S), the primary RN takes responsibility to complete the OR checklist and accompany the patient to the OR. The midwife is present in the OR in a supportive role for the patient

POSTPARTUM PERIOD

Early hospital discharge is common for midwifery clients with a non-operative delivery. Women who meet hospital discharge criteria may go home under midwifery care as early as three hours postpartum.

	MIDWIFE	**RN**
Administrative	1. Documents all postpartum visits and care plans on Interdisciplinary Progress notes and Newborn Record 2. Writes orders as required and within scope 3. Communicates directly with primary RN regarding patient care 4. Completes Newborn Screening Deferral form as indicated	**1.** Completes postpartum and newborn pathways **2.** Provides patient with postpartum teaching materials as per hospital protocol **3.** Communicates directly with midwife regarding patient concerns **4.** The Community Liaison Nurse contacts the client or sends information 24 to 48 hours following discharge from hospital.
Maternal Surveillance	1. Performs daily physical assessment 2. Provides postpartum	1. Provides daily physical assessment and monitors vital signs as per hospital protocol

	instructions and education 3. Assists with breastfeeding and refers to lactation consultant as indicated 4. Consults directly with OB as indicated for postpartum concerns	2. Assists with breastfeeding 3. Provides postpartum instructions and education as per hospital protocol 4. Carries out orders as per RM and OB if consulted
Newborn Surveillance	1. Performs daily physical assessment 2. Recommends and orders nutritional supplementation as indicated 3. Obtains pediatric consult as per SPH guidelines.	1. Provides daily physical assessment and monitors vital signs as per hospital protocol

- When a pediatrician is consulted at delivery the pediatrician remains the most responsible care provider until care is transferred back to the midwife.

- The Newborn Screening Deferral form must be completed if it is to be done in the community. The midwife assumes responsibility for ensuring that the Newborn Screening is done.

Documentation:

- PSBC Perinatal Triage and Assessment Record
- BC Labour Partogram
- B.C. Labour and Birth Summary Record – complete all appropriate parts
- B.C. Newborn Record Part I – complete all appropriate parts
- B.C. Newborn Normal Term Care Path - assessments

References:

1. Perinatal Services BC (May 2008) Fetal Health Surveillance: Antepartum and Intrapartum Consensus Guideline. Vancouver:
2. Perinatal Services BC (May 2011 2nd ED) Guidelines for Registered Nurses: Core Competencies and Decision Support Tools: Management of Labour in an Intuitional Setting if the Primary Care Provider is Absent. Vancouver:
3. Perinatal Services B.C. (2011). Decision Support Tool No. 4: Evaluation of progress of labour dystocia. Vancouver.

Persons/Groups Consulted:
Midwifery Department SPH

Approved By:
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Appendices:
Appendix A: - Indications for Consultation from Midwifery/Family Practice to an Obstetrician
Appendix B: - Protocol for low risk, post dates Midwifery or Family Practice (without induction prescribing privileges) patients electing induction between 41+3 and 42 weeks gestation

Appendix A Indications For Consultation From Midwifery/Family Practice to an Obstetrician:

ANTEPARTUM

- Multiple gestation
- Severe oligohydramnios (Amniotic fluid index (AFI) less than or equal to 60/2.5%) or severe polyhydramnios (AFI greater than or equal to250/97.5%)
- Mild or Moderate oligohydramnios/polyhydramnios may merit consultation if other complicating factors are present
- Intrauterine Growth Restriction (abdominal circumference less than10%)
- Gestational hypertension +/- adverse features
- Preterm premature rupture of the membranes (PPROM) less than 37 weeks
- Placenta previa, marginal previa, vasa previa
- Antepartum hemorrhage (APH) not including vaginal spotting
- Underlying maternal medical conditions including, but not limited to: Systemic lupus erythmatosis, Insulin dependant diabetes mellitus, cardiovascular disease/cardiac lesion (other than Mitral valve prolapse), neurologic disease, epilepsy, renal disease, chronic hypertension, Grave's disease, pulmonary disease, inflammatory bowel disease, thromboembolic disease, drug addiction
- Gestational diabetes mellitus requiring insulin
- Incompetent cervix
- Induction of labour (except uncomplicated post dates and term premature rupture of the membranes)
  *See "Guideline for Family Physician Oxytocin Induction of Labour"
  *Cervadil may be used by Family Physicians who have completed the OB teaching session
- Any need for surgical interventions during pregnancy
- Any condition requiring antepartum admission
- Large fibroids (with complications e.g. degeneration, causing malpresentation)
- Mullerian anomalies
- Previous cesarean section (C/S) with contraindications to labour, greater than 1 previous C/S, need for induction, or other concerns
- Previous myomectomy or hysterotomy
- Request for elective C/S
- Breech or other abnormal presentation greater than 36 weeks

INTRAPARTUM:

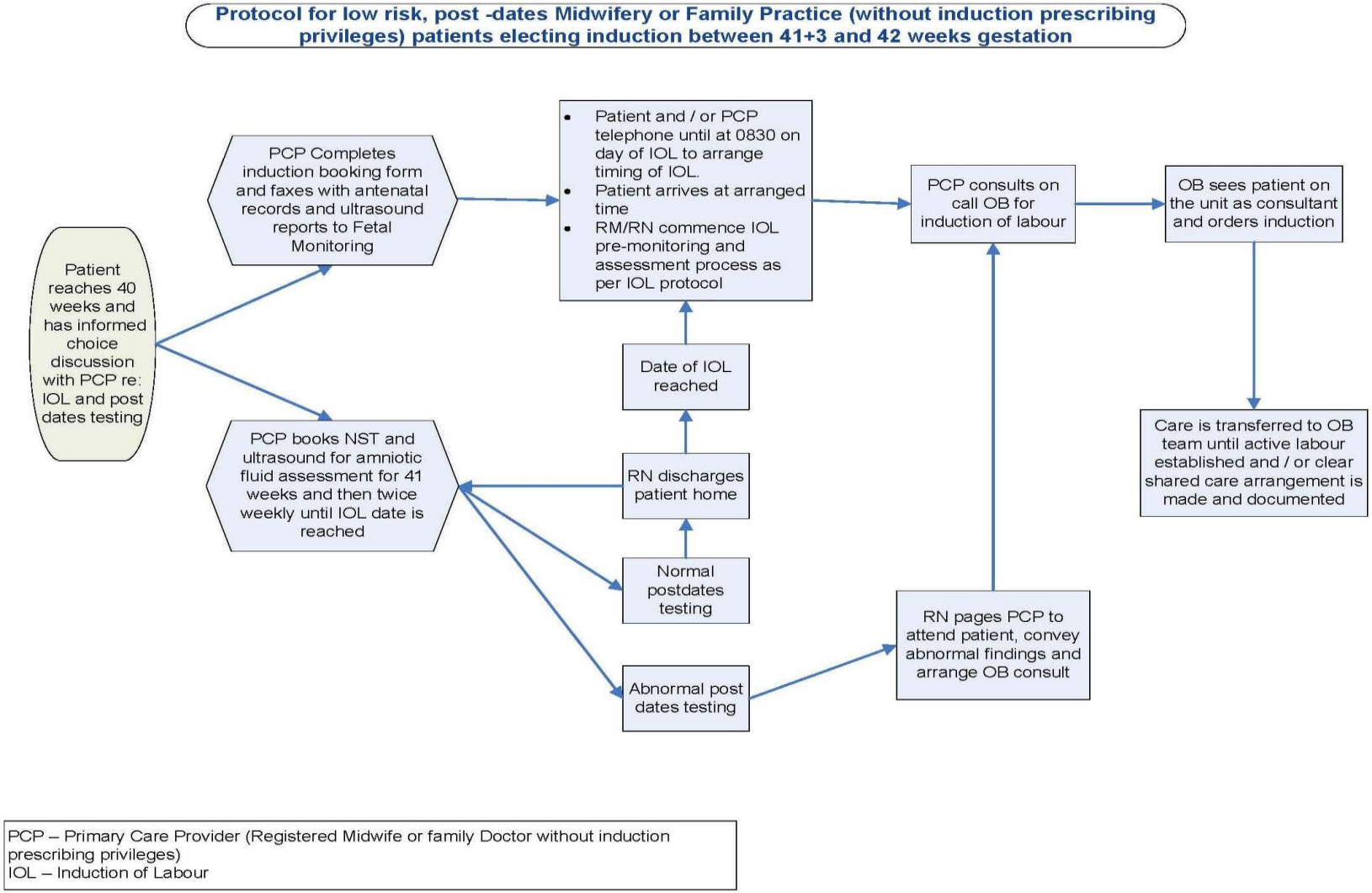
- Delivery of multiple gestation
- Preterm Labour less than 37 weeks
- Breech or other abnormal presentation
- Evidence of chorioamnionitis
- Abnormal fetal heart rate pattern
- Gestational hypertension +/- adverse features, pre-eclampsia, eclampsia
- Assisted vaginal delivery (except Family Physician skilled in use of vacuum or outlet/low

forceps)
- Active genital herpes
- Oxytocin augmentation - *See "Guideline for Family Physician Oxytocin Augmentation of Labour"
- Arrest of progress in active labour
- Prolonged second stage of labour (greater than 2 hours without evidence of significant fetal descent or imminent delivery)
- Uterine rupture
- Shoulder dystocia
- Placental abruption
- Vaginal birth after cesarean (VBAC)

*See SOGC clinical Practice Guideline No. 155, February2005 "Guideline for Vaginal Birth after Previous Caesarean Birth" and PHC VBAC Guideline

POSTPARTUM:
- Moderate to severe postpartum hemorrhage (PPH)
- 3rd and 4th degree tears, Complex vaginal or cervical lacerations
- Postpartum hypertensive disorder (Hypertension, elevated liver enzymes, low platelets (HELLP), Pre-eclampsia)
- Shock
- Uterine inversion
- Retained placenta

Appendix B:


Protocol for low risk, post -dates Midwifery or Family Practice (without induction prescribing privileges) patients electing induction between 41+3 and 42 weeks gestation
Patient reaches 40 weeks and has informed choice discussion with PCP re: IOL and post dates testing
PCP Completes induction booking form and faxes with antenatal records and ultrasound reports to Fetal Monitoring
PCP books NST and ultrasound for amniotic fluid assessment for 41 weeks and then twice weekly until IOL date is reached
Patient and / or PCP telephone until at 0830 on day of IOL to arrange timing of IOL.
Patient arrives at arranged time
RM/RN commence IOL pre-monitoring and assessment process as per IOL protocol
Date of IOL reached
RN discharges patient home
Normal postdates testing
Abnormal post dates testing
RN pages PCP to attend patient, convey abnormal findings and arrange OB consult
PCP consults on call OB for induction of labour
OB sees patient on the unit as consultant and orders induction
Care is transferred to OB team until active labour established and / or clear shared care arrangement is made and documented
PCP – Primary Care Provider (Registered Midwife or family Doctor without induction prescribing privileges)
IOL – Induction of Labour