Midwives and Nurses Working Together in Intrapartum Care

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A. INTRODUCTION

A collaborative relationship between nurses, midwives, physicians and other health professionals in intrapartum care is essential to ensure safe and quality care for labouring individuals and newborns. This is best achieved through a team approach with effective communication. This document is a guide for collaborative intrapartum and postpartum care to support the individual's best birth experience with optimal clinical outcomes. For teamwork and collaboration, we outline roles of the health care team members at different stages of an individual's admission to the hospital including pre-admission, triage, labour, birth, recovery and postpartum care. Collaborative care results in a positive working environment with clear and efficient communication between healthcare providers. We provide feedback to each other and keep each other accountable to person-centred care and evidence-informed practice.

The "Midwives and Nurses Working Together in Intrapartum Care" was developed collaboratively with the WRHA Women's Health Program and Midwifery Services.

B. DEFINITIONS

Individual: The person who is in intrapartum phase (also known as a patient or client)

Primary Health Care Provider (HCP): A physician, midwife or nurse practitioner registered with their respective regulatory body, authorized to provide health services within their scope of practice as autonomous practitioners. The HCP may change during the course of care due to transfer of care.

- The most responsible provider for the individual's care
- Signs orders
- Completes the discharge summary notes

Charge Nurse: Responsible for assigning nurses, managing workflow and patient flow.

Nurse: A nurse is assigned by the charge nurse to care for the individual for their hospital stay. The nurse may change over the course of the admission; there is always a nurse assigned to the individual.

Midwifery care includes comprehensive antenatal care, intrapartum care and care of the birthing parent and infant to 6 weeks postpartum.

C. TEAMWORK

All team members are empowered to ensure patient safety. In this environment, teamwork is prioritized, communication is open and all healthcare providers are respected and valued.

D. UNIQUE PLAN OF CARE

There are times when a patient makes choices or declines routine practice or guidelines. In our community, when it is known in advance that an individual is planning to decline routine care the care team works with the client to create a unique plan of care. The client, midwife, clinical specialist, manager and consultant collaborate to accommodate the requests and manage the risks. This unique plan of care is documented on the individual's chart outlining their informed choice including the risks, alternatives and plan of care. The healthcare team works together using ethical principles of beneficence, maleficence and patient autonomy. Communication within the healthcare team and with the individual is essential.

E. ROLES

1. Prenatal care

Prior to 36+6 weeks gestational age, the midwife:

- Ensures Manitoba Prenatal Record is faxed to triage
- Lists consultant's name on the Prenatal record if a prenatal consult was done
- Lists themselves as the newborn care provider
- Discuss early discharge options with clients

2. Admission and Triage

Midwives may assess individuals in the community prior to admission to the hospital. When a midwife assesses the individual in the community and a plan is made for moving into the hospital, the midwife contacts the appropriate hospital staff:

- If the individual needs a triage assessment, the midwife calls the triage nurse
- If the midwife would like to request a direct admission, the midwife calls the LDR charge nurse

The phone conversation between the midwife and the charge nurse includes:

- Estimated time(s) of arrival for the individual and the midwife
- Discuss availability of rooms and staffing
- Discuss a plan for a triage assessment or direct admission

Triage Assessment:

- The midwife calls triage to advise them a client is coming in
- The individual is admitted under the midwife
- The midwife directs the triage staff as to whether the client is to be assessed by nursing or midwifery
- If the client has presented without alerting the midwife, then the nurse does an assessment and calls the midwife with same

Direct Admission for actively labouring individuals:

- All labouring individuals present to the admission desk in triage (unless in active 2nd stage)
- If the individual was assessed in the community recently by the midwife and the findings are normal, the individual is eligible for direct admission
- The midwife and the charge nurse discuss the direct admission and determine room allocation
- Admission assessments (STBBI screening, fetal health surveillance (FHS) and maternal vitals) are done in the room in accordance with routine care for admission

3. During Labour

The midwife is the primary care provider. A nurse is assigned to support the midwife. The midwife and nurse work collaboratively to provide care within their respective scope of practice. All healthcare providers participate in the Transfer of Accountability process when indicated (i.e. break relief, midwife to nurse/ nurse to midwife and midwife to midwife handover).

The midwife:

- Provides routine care to the individual and makes routine labour progress assessments
- Checks the equipment and supplies for the birth
- Introduces student midwives to the charge nurse and nurse and clearly identifies the student's role
- Documents labour progress and assessments in the electronic patient record (EPR)
- At St. B the midwife asks the nurse to update the Napadex
- Communicates with the charge nurse when a new midwife takes over care
- Submits labour and birth orders and completes medication reconciliation

The midwife and charge nurse:

- Discuss labour progress and other relevant information including the plan of care and variations from normal
- Discuss break relief scheduling

The charge nurse:

- Coordinates nursing assignment for break relief for midwives
- Coordinates nursing assignment when a transfer of care occurs from the midwife to the physician

- Coordinates nursing assignment for second stage nursing support

The nurse:

- Checks the equipment and supplies for the birth
- Provides routine care to the individual when the midwife is on break
- Is available to dispense medications from PYXIS

4. Pharmacological Pain Management in Labour

All labouring individuals have access to both supportive care in labour (SCIL) and pharmacological pain management. Pharmacological pain medication is available to all labouring individuals when indicated or requested.

1. **Nitrous Oxide:** Midwives order nitrous oxide

2. **Opiates:** Midwives consult with a physician to order opiates. The midwife can administer the opiates as per hospital guidelines and the physician's orders. The nurse retrieves the medication from PYXIS. **PYXIS:** The nurse retrieves medications from the PYXIS machine. The prescriber (midwife) is not able to pull drugs from the machines.

3. **Epidurals:** Midwives maintain primary care for individuals with an epidural analogous to family physician care. When the birthing person requests an epidural, the midwife talks with the charge nurse to begin the process and follows the MWPG-12 Midwifery Epidural Guideline

5. Second Stage

- During passive 2nd stage, the midwife provides routine care. The nurse may be requested to assist the midwife, depending on the clinical picture and on the needs of the individual.
- During the active 2nd stage, the midwife and nurse work together.
- A nurse is present at the bedside throughout the active second stage, third stage, during perineal assessment and repair until the nurse and midwife agree that the individual is stable.

During the birth, the midwife:

- Conducts the birth
- Conducts the third stage; communicates with the nurse regarding active or physiological management of the third stage depending on the individual's informed choice and clinical circumstances

During the birth, the nurse:

- Auscultates fetal heart rate in second stage or electronic fetal monitoring (EFM) as per hospital guideline and document

- Assists the midwife in managing emergencies such as shoulder dystocia and postpartum hemorrhage (PPH)
- Documents on the birth summary
- Admits the newborn under the midwife as per site process (communicates with unit clerk)
- Collects cord blood from the placenta and sends cord blood (gases and newborn Rh testing) per site's practice
- Provides care of the newborn including APGAR and initial steps of neonatal resuscitation (NRP)
- Provides immediate postpartum care of the individual, including fundal checks and vitals
- Assists the midwife in preparation for perineal repair, as indicated

6. Initial Recovery

After the placenta has been delivered, the perineum has been sutured and the individual is stable. The midwife and nurse:

- Discuss the clinical care needs of the birthing parent and newborn and ongoing roles
- In some circumstances, the midwife may need to leave and the nurse continues caring for the individual for the initial recovery

The midwife:

- Provides routine care for new parent and infant
- Communicates with the nursing team any concerns and approximate time of the recovery
- Conducts the Transfer of Accountability when the midwife leaves the hospital
- Performs the primary care provider's newborn examination within 24 hours
- Submits the Birth Summary
- Usually stays on the unit for about 2 hours for a normal recovery (there are times when the midwife may be called to care for another issue and the nurse provides care for the recovery)
- Gives report the postpartum nurse if the midwife is present at the time of admission to woman-child unit
- Discusses with the LD charge nurse about ongoing clinical care for recovery i.e. if the individual is ready to move to the postpartum unit at shift change in which case, the midwife may give report to the LD nurse who completes the recovery and transfer to the postpartum unit
- Works with the nurse to ensure infant security

The nurse:

- Documents on the Birth Summary and flowsheets for birther and infant
- Provides routine care for new the parent and newborn (i.e. vitals of birther and infant
- Supports the midwife with any urgent concerns or routine care (i.e. glucose screening)
- Works with the midwife to ensure infant security (i.e. bands, HUGs, etc)
- Completes the newborn exam if at St Boniface hospital

The normal newborn is admitted under the midwife. If there are indications for a direct admission to the NICU, the midwife consults neonatology and the newborn is admitted under the neonatologist.

7. Operative Birth

When a midwifery client requires an operative birth, assisted delivery or caesarean section, a transfer of care to a physician is required. The physician is the primary care provider until the individual's care is transferred back to the midwife. The midwife is the primary care provider for the newborn unless there is an indication for NICU admission.

8. Postpartum Care

The midwife

- Offers early discharge to individual if indicated
- If the individual requests early discharge, and the midwife agrees that early discharge is appropriate, the midwife and nurse discuss the plan for early discharge.
- Assesses patients admitted under midwifery (maternal and newborn) each calendar day during their hospital stay and documents the visit.

The nurse

- Provides routine care
- Completes the Postpartum Referral form prior to discharge from hospital, if accepted by the individual and notes that the individual is a midwifery client
- Ensures metabolic screening is done in hospital if the stay is greater than 24 hours or communicates with the midwife directly if the metabolic screen is not done prior to discharge
- Organizes newborn hearing screening to be done in hospital or in the community
- Completes postpartum teaching
- Discharges the individual and the newborn as ordered
- Calls the midwife if discharge plans are changed from the orders

9. Postpartum Care when the Length of Stay is ≤ 6 Hours in Hospital Following Childbirth

This guideline outlines the expected management and standard of care for the new parent and newborn whose length of stay in hospital following childbirth is ≤ 6 hours. If the stay is 3 hours or less, the family may be discharged directly from Labour Delivery Recovery Unit (LDR). If the stay is anticipated to be greater than 3 hours, then the family would be moved to the mother-child units for completion of care and early discharge by the assigned nurse.

The midwife:

- Informs the LD charge nurse as soon as early discharge is confirmed
- Writes discharge orders for newborn and birthing parent
- Documents plan for follow up care i.e. primary care provider will see this person at home within 24-36 hours for routine care which includes postpartum teaching topics, infant feeding, pulse oximetry, jaundice screening, newborn metabolic screening, etc.
- Ensures clear communication with the nurse regarding expectations and plan of care for early discharge
- Documents teaching topics that are addressed
- Completes the Postpartum Referral Form and ensures it is faxed to the Public Health Central Intake office on the day of discharge.
    - The following should be written on the Postpartum Referral: "Follow up will occur at home by midwife. 24 hour screening will be done by midwife."

Note: the midwife does metabolic screening, jaundice screening and pulse oximetry in the community between 24-36 hours of age.

The nurse:

- To facilitate an early discharge directly from the LDR room
    - the HSC LDR charge nurse may assign nurse who works in the float pool at HSC (trained in LDR and PP)
    - the St. Boniface Hospital Mother Child Unit (MCU) charge nurse may be able arrange for a postpartum nurse to come to the labour floor to complete the early discharge after the initial recovery is completed
- Performs routine maternal and newborn assessments
- Completes teaching topics for the period of time that the new parent is in hospital
- Ensures the Manitoba *Registration of Birth* form is complete and accurate and is delivered to the correct location on the unit
    - at St Boniface Hospital this is the front desk of MCU- give directly to the nurse assistant

  - at HSC there is birth registration folder WN4 reception – give directly to the nurse assistant

- Clarifies any questions with the primary care provider
- Ensures that the Manitoba Newborn Hearing Screening referral form is completed and informs parent they will be contacted to book an appointment for a hearing test for the newborn
  - The midwife or nurse completes the referral form and returns to the reception of WN4 at HSC or MCU at St Boniface Hospital

APPENDIX 1

Intrapartum transfer from planned out-of-hospital births

1. **Non-urgent intrapartum transfer**

A non-urgent transport takes place in personal vehicles. Indications for a non-urgent transport from an out of hospital setting include:

- Individual request or change of plans; non-clinical indications
- Meconium-stained fluid or other non-emergent indications for EFM
- Request for pharmacological pain management
- Prolonged labour in the first stage

During a non-urgent transport from the community, the midwife speaks with the CRN to discuss the case and plan for admission. The midwife and nurse determine the best admission process. Upon arrival at the hospital, the midwife continues to provide care, consults or transfers care.

2. **Urgent intrapartum transfer to hospital**

Urgent intrapartum transfer from community to hospital occur with Emergency Medical Services (EMS) in an ambulance.

Urgent transfer from the community may include but are not limited to the following indications:

- Abnormal fetal heart rate (FHR)
- Prolonged 2nd stage of labour
- Cord prolapse
- Postpartum Hemorrhage requiring ongoing assessment or treatment

The midwife:

- Speaks directly with the attending Obstetrician to form a plan
- Speaks directly with the charge nurse to communicate the plan
- The individual bypasses the triage area and is transported directly to LDR or the NICU

3. **Emergency intrapartum transfer: When treatment must immediately commence upon arrival**

The midwife

- Speaks directly with the charge nurse of LDR or NICU during the transport process

- Speaks directly with the Consultant Obstetrician to provide a report on the case and request that the consultant be ready to receive transfer of care and initiate immediate treatment upon the arrival of the individual at the hospital
- Reports the plan to the charge nurse and requests that the acute care team be ready to receive transfer of care and initiate immediate treatment
- A timeframe is determined by the midwife and the EMS team

The charge nurse

- Receives report of the situation from the midwife
- Notifies the triage area of expected time of arrival and the need to expedite the individuals' transfer immediately to the case room, by-passing the triage area
- Initiates appropriate actions to provide immediate care
- Calls for medical help to stand by and await arrival and transfer of care (Obstetrics, Anaesthesia, Neonatology)
- Prepares the operating room for immediate caesarean section, if indicated

Appendix 2: Record of Updates

1. **June 2018-** First edition
2. **December 2022 -** Added midwifery epidural guideline at St Boniface Hospital]
3. **May 2023**

- Switched CRN to charge nurse because the charge nurse is responsible for patient flow and workload assignment.
- Added midwifery epidural guideline to both hospitals
- Updated the early discharge section with timelines and roles