

# Enhancing the Safety of Referrals to Intermountain Medical Center of Women with a Planned Out-of-Hospital Birth

## A. Referral arrangements

### 1. Patient with non- urgent problem, not in labor (e.g. suspected IUGR, suspected anomaly, malpresentation, post-dates)

- a. During regular work days, the referring midwife will call the MFM office (801-507-7400) and ask to speak to the MFM physician who is on call for the inpatient service. The physician will either direct the midwife to send the patient to labor and delivery for immediate assessment or schedule the patient in the MFM diagnostic center. If the latter, the physician should decide how soon this outpatient consult needs to occur.
- b. If the patient is to go to labor and delivery, see the next section.
- c. If the patient is to be scheduled in the MFM diagnostic center, the referring midwife will call the clinic front desk (801-507-7400) to make the appointment at the proper time, as indicated by the MFM physician. The referring midwife will fax an order and a copy of the prenatal record to 801-507-7493.

### 2. Patient in labor or who requires urgent or emergent referral to Labor and Delivery at Intermountain Medical Center.

- a. The referring midwife will decide the best method of transport of the patient to the hospital. This might be by ambulance or private car.
- b. The referring midwife will call the charge nurse in Labor and Delivery at 801-507-7735.
- c. The charge nurse will determine who will be the accepting provider, according to the algorithm for unregistered patients posted at the charge nurse's work station
- d. The charge nurse will obtain identifying data on the patient, the name and contact information for the referring midwife, and a description of the reason for referral.
- e. The charge nurse will request that the referring provider complete and fax to labor and delivery (801-507-7798) a copy of the prenatal record and the form "Maternal Transfer to Hospital: Provider- to- Provider Report" obtainable on line at <http://health.utah.gov/uwnqc/> "Current Projects", "Out-of-Hospital Birth", "Out-of-Hospital Birth Resources", "Printable UWNQC Maternal Transfer Form". This form contains key medical information about the patient and the referring midwife's contact information. As an alternative to fax, the prenatal record and the Provider-to-Provider report may be brought to labor and delivery by the patient.
- f. The charge nurse will notify the accepting provider of the referral, and convey the patient information she received as well as the referring midwife's contact information.
- g. If possible, the accepting provider will call the referring midwife to obtain a report. This telephone report will supplement the written Maternal Transfer to Hospital: Provider- to- Provider Report.
- h. The accepting provider assumes responsibility for the patient once she arrives at the hospital.
- i. The process is the same for postpartum referral to Labor and Delivery for non-emergent conditions that are best handled in this setting ( e.g. laceration repair, suspected preeclampsia)

**3. Delivered patient who requires urgent transport to the Emergency Department for conditions such as hemorrhage, eclampsia, infection, or preeclampsia with severe features:**

- a. The referring midwife will decide the best method of transport of the patient to the hospital. This might be by ambulance or private car.
- b. The personnel in the ED will notify the Ob/Gyn on emergency call to assist in the care of the patient, as needed.
- c. If admission to the hospital is needed (other than to an ICU) the patient will be admitted to the Ob/Gyn on emergency call

**4. Communication with the referring provider:**

- a. The “Maternal Transfer to Hospital: Provider- to- Provider Report” should include the telephone number and address of the referring midwife
- b. The hospital provider ultimately caring for the patient will notify the referring midwife of the patient’s hospital course by telephone
- c. A discharge summary will be mailed

**B. Topics a referring midwife may want to address with a patient prior to an intrapartum referral:**

**a. Reason for the referral**

**b. Method of transport and unit to which they should go.** If the patient is going by private car, she should be given directions to the receiving unit.

**c. Discussion of interventions that may be recommended at the hospital** (may vary according to the reason for the referral and the patient’s status after arrival at the hospital).

i. For laboring patients, usual care includes:

1. Complete review of the patient’s history and performance of physical exam
2. Placement of an IV and administration of intravenous fluids
3. Continuous fetal heart rate monitoring
4. Birth in a labor and delivery room
5. Immediate skin to skin contact between mother and baby
6. Immediate opportunity to breast feed
7. Vitamin K administration, antibiotic eye prophylaxis
8. Discussion between IMC provider and patient regarding all proposed interventions

ii. Procedures that are not commonly used:

1. Enema
2. Episiotomy
3. Immediate separation of the mother from the baby

iii. Options that are usually available, depending on the patient/ baby status, patients’ desires, and discussions with provider

1. Epidural
2. Choice of delivery position
3. Delayed cord clamping

**d. Involvement of others who wish to accompany the patient to the hospital**

- i. The patient may decide who is present for her labor and delivery at IMC. These may include:
  - 1. Non-sick siblings of the baby. Because of concerns over viral transmission, in some seasons there may be visiting restrictions of well-children under the age of 12. Children must be supervised by an adult in the patient room or the waiting room.
  - 2. Up to 4 adults may be in the room with the patient. Adults will be given a visitor pass upon entry to the Labor and Delivery unit.
- ii. There are waiting rooms near each labor room
- iii. There are no additional restrictions during placement of an epidural
- iv. The patient may choose one person to accompany her if delivery in the operating room becomes necessary. In the rare event that the patient has a general anesthetic for a cesarean, the visitor will be asked to leave
- v. While the referring midwife is welcome to accompany the patient in the hospital, she will not perform the delivery or provide nursing or medical care.

**C. Postpartum care**

- a. If postpartum care is required in the first few weeks after delivery (for conditions such as staple removal, wound or BP check), this will usually be performed by a hospital- based provider. By mutual agreement, this can be provided by the referring midwife.

**D. Neonatal issues**

- a. If the baby is born outside the hospital and requires hospital evaluation and treatment, but the mother does not require hospital admission or treatment:
  - i. The baby should be brought to the Emergency Department
  - ii. The baby's care will be established with involvement of NICU personnel
- b. If the baby is born outside the hospital, and is well, but the mother requires hospital admission:
  - i. It is generally assumed that the baby will be with the mother in the hospital
  - ii. Policies regarding the involvement of hospital staff in the observation and care of the baby are not yet in place (there are unresolved logistical and legal issues).
- c. If the baby is born in the hospital:
  - i. Routine admission and care- the same as with planned in-hospital births

**E. Other miscellaneous**

- a. If there has been a stillbirth, fetal growth restriction, or hemorrhage, a patient transferred after delivery should bring the placenta in a plastic bag.
- b. If a referring midwife has questions or concerns about the operation of this process, she may contact Angela Anderson CNM at [angela.anderson@imail.org](mailto:angela.anderson@imail.org) or Dr. Doug Richards at [douglas.richards@imail.org](mailto:douglas.richards@imail.org)