Smooth Transitions Template Protocol

Hospital Transfer from Planned Community Birth

Please customize this protocol according to your hospital. The protocol is a place to clarify the process of transfer and meet everyone's needs: receiving provider and transferring midwife, while keeping the patient/client at the center. As the protocol is being used, make modifications as needed to maximize efficiency, safety, and satisfaction.

1. Community midwives will encourage their clients to:
   - pre-register with the local hospital several months prior to their due date
   - take a tour of the local hospital
   - draft a birth plan in the event of hospital transfer

2. The community midwife will contact the hospital through the designated route and notify the receiving provider of an incoming transfer from a planned community setting. *Each hospital will have their unique way to access appropriate care. List those details, including phone numbers, here.* The community midwife's communication will include the name, age, G/P and DOB of the patient, reason for transfer, relevant clinical background information, the condition of mother and/or baby, the planned mode of transfer, and the expected time of arrival. *Any other patient information can be specified in the protocol. An SBAR script is helpful here.*

3. The receiving provider will then convey this information to the NTL (nurse team lead/charge nurse) who will facilitate a direct admission so that the patient can be brought to a labor room upon arrival.

4. The community midwife will provide relevant medical records at the time of transfer which will be placed in the patient's chart. *Transfer forms may be used as well*. Records may be faxed, sent electronically, or brought in and photocopied. *Please list fax numbers or other details around records here.*

5. If possible, the licensed midwife will accompany her client to the hospital to facilitate a smooth transfer of care. At the hospital, **prior to initiating care**, the receiving provider will meet with the community midwife along with the NTL and the bedside nurse assigned to the patient, to discuss the patient's care, plan of action, and answer questions. The community midwife will then introduce the hospital care team to her client.

6. The hospital care team recognizes the community midwife as the patient's primary care provider who has an established relationship with the patient. We encourage the community midwife to join with the hospital care team to provide ongoing support and care of the patient.

7. The hospital care providers (OB hospitalist, CNM, pediatric hospitalist) will coordinate with the community midwife a schedule of follow-up care for the patient and/or her baby.

8. The discharging provider will request that relevant hospital records are sent to the community midwife, so they are available for review prior to follow-up with the patient. *Outline the discharge records process here.*

9. The community midwife, receiving hospital provider, nursing staff (ideally the NTL and bedside nurse), and the client will fill out their appropriate Smooth Transitions™ surveys and data collection tools. If EMS was involved, they have a survey to fill out as well.