

## 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 the needs of the community midwife and receiving provider(s) and nurses, while keeping the patient/client at the center. As the protocol is being used, make modifications as needed to maximize efficiency, safety, and satisfaction.***

***Hospital Name*** welcomes patients who are transferred from a planned community birth. We work with the local community midwives needing our services to provide a smooth transfer of care in order to optimize outcomes and experiences for our shared patients. The hospital team recognizes that the hospital is not the patient's preferred site for delivery, postpartum, or neonatal care. Our staff will strive to acknowledge this and convey our understanding directly to the patient, while providing them with high quality and compassionate care.

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. Often the NTL (nurse team lead/charge nurse) is part of this communication to assess the receiving facility's staffing and capacity. ***Each hospital will have their unique way to access appropriate care. List those details, including phone numbers, here.*** The community midwife's report to the receiving provider will include the client's name, age, G/P and DOB, reason for transfer, relevant clinical background information, their current condition, 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 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 either before arrival or 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 related to records here.**

5. If possible, the licensed midwife will accompany their client to the hospital to facilitate a warm, provider-to-provider handoff of care. At the hospital, **prior to initiating care**, the hospital care team (receiving provider, NTL, bedside nurse) will gather at the bedside of the client with the community midwife and the client's doula and/or support team for introductions. The group will then discuss the patient's care, plan of action, and answer questions (**reference TeamBirth here**).

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. If the community midwife leaves the hospital and the hospital care team has questions or clarification, they will reach out to the community midwife (**consider making a directory of the local community midwives for the hospital**)

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 the newborn.

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 sending the discharge records process here and consider giving the community midwife read-only access to the hospital EMR.**

9. Everyone's feedback is encouraged through the Smooth Transitions™ surveys and data collection tools. There are surveys for the **receiving provider, nursing, community midwife, client, doula, and EMS providers**. The data from these surveys are de-identified, aggregated

into a report and reviewed quarterly. See posters for QR codes (program coordinator can send them to the hospital) or go to links here: [www.qualityhealth.org/smoothtransitions/resources](http://www.qualityhealth.org/smoothtransitions/resources)

If the transfer of care to *hospital name here* fell below expectations, we ask that follow-up be provided to the nursing and provider leadership so that we can provide direct, immediate feedback to our care team.

**Please direct feedback to:**

*List appropriate contact details here (i.e., Nurse Manager, OB Medical Director, Medical Director, etc.)*

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