STANDARD FOR PLANNED OUT OF HOSPITAL BIRTH

INTRODUCTION

The College of Midwives of Manitoba (CMM) defines an out of hospital (OOH) birth as a birth conducted by a midwife, and occurring in a location where other specialized medical care (obstetrical, paediatric, surgical and/or anaesthetic skills) is not provided on site. Such sites may include homes, birth centres, nursing stations and some hospitals.

Available evidence confirms that for low risk/well-screened women a planned OOH birth with trained attendants and appropriate emergency equipment is a safe option.

Client evaluation for the appropriateness of OOH birth is a complex process involving:

- informed choice
- skilled interviewing
- prenatal, intrapartum and postpartum observations and measurements
- opportunities for the client to alter identified risk factors
- the midwife's judgment
- ongoing midwife-client communication

CONTRAINDICATIONS

Certain contraindications exist to planned out of hospital birth. These include:

- Multiple gestation
- Breech presentation or other types of non-vertex presentation
- Preterm labour prior to 37 weeks of pregnancy
- Documented evidence of change in fetal status in a post term pregnancy of more than 42 weeks
- Planned OOH VBAC is contraindicated in the following circumstances[1]
- One previous lower segment caesarean section before 26 weeks
- Interpregnancy interval of less than 18 months
- History of impaired scar healing
- Prolonged active phase of labour with lack of progress
- Any Condition on the Transfer list of the *Standard for Discussion, Consultation and Transfer of Care.*

Clients with the following conditions are carefully reviewed and may or may not be advised to give birth in a hospital with specialist services depending on the specific and overall clinical and/or psychosocial profile:

- Previous obstetric history of complications requiring specialist care likely to reoccur in this pregnancy (eg. Severe postpartum haemorrhage, retained placenta)
- Alcohol or drug use and/or exposure to teratogens
- Women with high BMI[2]

[1] See *Guideline for Vaginal Birth after One Previous Low Segment Caesarean Section*
[2] See *Guideline for Providing Care to Women with a High Body Mass Index*

- VBAC[3]
- Previous stillbirth or fetal anomaly
- Client requesting care outside the standards of practice[4]
- Any other condition of concern to client or caregivers

OTHER CONSIDERATIONS

- Distance and time required to access specialized care
- Access to telephone
- Weather conditions
- Availability of emergency support systems
- Family supports
- Condition of the woman's birth environment
- Other psycho-social factors

PREPERATION

In preparation for an OOH birth, the midwife will ensure that the following are completed:

- Arrange for a second birth attendant, in accordance with the *Standard for the Use of a Second Attendant*. This second attendant must be skilled in handling both maternal and neonatal emergencies.
- Establish links with the nearest hospital or health facility capable of dealing with an obstetrical emergency.[5]
- Initiate discussion with the client early in pregnancy regarding choice of birth place and continue throughout the course of her care. This discussion must include:
- The woman's unique circumstances including relevant clinical and non-clinical factors.
- Current information and evidence that relates to the risks and benefits of each birth setting.
- Current information regarding RHA, hospital and community standards related to the woman's situation (eg. Emergency transportation, fetal surveillance, newborn monitoring).
- Current information regarding local hospital's obstetrical capacity and resources available at the time of birth.
- Perinatal complications that may arise and how the outcome may be affected by place of birth. *This discussion must include: placental abruption/antepartum haemorrhage, postpartum haemorrhage, shoulder dystocia, cord prolapse, undiagnosed twins, undiagnosed breech/malpresentation, meconium stained fluid, neonatal resuscitation and intubation, abnormal fetal heart tones, uterine rupture and anaphylaxis.*
- The effect that transport time to the nearest hospital with obstetric services may have on her birth outcome. A delay in receiving specialist care could contribute to a poor outcome for mother and baby including severe disease, disability or death.
- How the skill, experience and number of attendants might affect the outcomes of the complications.

---

[3] See *Guideline for Vaginal Birth after One Previous Low Segment Caesarean Section*
[4] See *Policy: When the Client Requests Care Outside the Midwifery Standards of Practice*
[5] Common practice is to fax a client's prenatal record at 36 weeks to the potential receiving hospital.

Consideration of how the woman and her support system may react in the event of a bad outcome.

- The woman may change her decision about place of birth at any time.
- Document discussions regarding choice of birth place.

Equipment

Midwives who attend out of hospital births are responsible for having well-maintained equipment, supplies and medications that may be required during labour, birth and the post-partum period.

Emergency Birth Kit

Any time a midwife is in attendance with a pregnant woman carrying a fetus of viable age, she will have access to an emergency birth kit regardless of planned place of birth. The birth kit will include:

- 2 forceps
- 1 pair of scissors (capable of cutting an episiotomy)
- 1 cord clamp
- gauze
- oxytocin
- syringe and needle
- alcohol swabs
- bulb suction
- sterile gloves
- reflective heat blanket

Essential equipment and supplies for a planned out of hospital birth

Midwives who attend out of hospital births are responsible for having well-maintained equipment, supplies and medications that may be required during labour, birth and/or the post-partum period.

- Fetal surveillance equipment
  - Fetoscope
  - Waterproof Doppler and gel

- Maternal surveillance equipment
  - Sphygmomanometer with appropriate sized cuff
  - Stethoscope
  - Watch with a second hand
  - Thermometer
  - Urinalysis supplies
  - Sterile and non-sterile examination gloves
  - Sterile lubricant

- Method of assessing status of membranes
- Instrument for artificial rupture of membranes

- Supplies for bladder catheterization
- One pair of scissors for cutting episiotomy
- Equipment, supplies and instruments for repairing perineal and/or labial lacerations, and repairing an episiotomy, including mosquito forceps and ring forceps
- Equipment and supplies for IV and IM injections
- Supplies for collecting blood samples
- Container for disposing of sharp supplies
- Oxygen masks and tubing for mother and newborn
- Equipment for cutting cord (2 haemostats, cord clamp/bander, scissors)
- Equipment and supplies for newborn resuscitation as per current NRP guidelines
  - Source for keeping infant warm (eg. heating pad)
  - Portable suction equipment compatible with intubation
  - Intubation equipment
  - Newborn resuscitation bag and mask
  - Umbilical vein catheterization supplies
- Equipment and supplies for newborn assessment and treatment
  - Measuring tape
  - Thermometer
  - Pediatric stethoscope
  - Infant scale
  - Glucometer
- Forms for documentation/health record

Essential medications:

- Oxytocics
- Neonatal ophthalmic prophylaxis
- Antibiotics for GBS treatment
- Vitamin K
- Epinephrine for woman and newborn
- Antihistamine for anaphylactic reactions
- Oxygen: a minimum of two tanks with enough oxygen to allow for transport to the nearest hospital
- Drugs for neonatal resuscitation as per NRP guidelines appropriate for OOH births
- Intravenous solutions
- Local anaesthetics

AMBULANCE REGISTRATION

Planned OOH births should be pre-registered with the Emergency Medical Services (EMS) if:

- the birth is to occur in a rural location

- the client lives in a location with difficult or obscure access

Midwives will have a process in place with local EMS to inform them of clients needing to be pre-registered. This process should describe by which gestation EMS should be notified, by which method, as well as a process for informing them the birth has taken place. Documentation of notification should be kept in the client's health record.

REFERENCES

British Columbia Reproductive Care Program. (2000). Maternity care services in rural communities: Consensus symposium update. BCRCP Perspectives, Spring, 2000.

Chamberlain, M., Moyer, A., Nair, R., Nimrod, C., England, J., & Smith, M. (1996). Evaluation of the Birthing Project in Rankin Inlet, N.W.T. (Unpublished).

College of Midwives of British Columbia. (2005). Statement on Home Birth. *Registrant's Handbook.*

College of Midwives of British Columbia. (2005). Indications for Planned Place of Birth. *Registrant's Handbook.*

College of Midwives of British Columbia. (2005). *Required* Equipment and Supplies for Home Birth Setting. *Registrant's Handbook.*

College of Midwives of Ontario. (1994). Essential equipment, supplies and medications. *Registrant's Booklet.*

College of Midwives of Ontario. (1994). Indications for planned place of birth. *Registrant's Booklet.*

College of Midwives of Ontario. (1994). Policy on ambulance registration of planned home births. *Registrant's Booklet.*

Dimond, B. (2000). Is there a legal right to a home confinement? *British Journal of Midwifery,* 8(5):316 -319.

Government of Alberta. (1992). *Report of the midwifery services review committee.*

Government of British Columbia. (1998). Saxell, L.: Research studies on out-of-hospital birth. *Handbook for midwives and health care professionals.* Ministry of Health and Ministry Responsible for Seniors.

Government du Québec. (1998). *Midwifery pilot projects: Final report and recommendations.* Pilot project assessment board.

Mehl-Madrona, L., Madrona, M. M. (1997). Physician- and midwife-attended births. Effects of breech, twin, and post-dates outcome data on mortality rates. *Journal of Nurse-Midwifery*, 42(2):91-98.

Murphy, P. A., Fullerton, J. (1998). Outcomes of intended home births in nurse-midwifery practice: a prospective descriptive study. *Obstetrics and Gynecology,* 92(3): 461-470.

Olson, O. (1997). Meta-analysis of the safety of home birth. *Birth,* 24(1):4-13.

Society of Obstetricians and Gynecologists of Canada, Society of Rural Physicians of Canada, College of Family Physicians of Canada. (1992). Guidelines for physicians and nurses in maternal/fetal transport (No.16).

Society of Obstetricians and Gynecologists of Canada, Society of Rural Physicians of Canada, College of Family Physicians of Canada. (April,1998). Joint position paper on rural maternity care. No. 72. http://www.sogc.org/SOGCnet/sogc_docs/common/guide/library_e.shtml.

Suarez, S. 1999. Guidelines for informed consent. Candidate Information Bulletin. The North American Registry of Midwives.

The House of Commons. (1992). Health committee Second report: Maternity Services, Vol 1. London: The House of Commons.

Walsh D. (2000). Evidence-based care series 1: Birth environment. *British Journal of Midwifery,* 8(5): 276-278.