

# College of Midwives of Manitoba

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## STANDARD FOR PLANNED OUT OF HOSPITAL BIRTH

### INTRODUCTION

The College of Midwives of Manitoba 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 OOH 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 Vaginal Birth After Caesarean (VBAC) is contraindicated in the following circumstances<sup>1</sup>
  - One previous lower segment caesarean section before 26 weeks
  - Inter-birth 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
- Clients with high BMI<sup>2</sup>

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<sup>1</sup> See *Guideline for Vaginal Birth after One Previous Low Segment Caesarean Section*

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- VBAC<sup>3</sup>
- Previous stillbirth or fetal anomaly
- Client requesting care outside the standards of practice<sup>4</sup>
- 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 client's birth environment
- Other psycho-social factors

## PREPARATION

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 shall 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.<sup>5</sup>
- Ensure access to Emergency Medical Services (EMS) is available and establish process for pre-notification if required by local EMS.
- Initiate discussion with the client early in pregnancy regarding choice of birth place and continue throughout the course of care. This discussion shall include:
  - The client'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 client'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 shall 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, abnormal maternal or newborn vitals, uterine rupture and anaphylaxis.*

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<sup>2</sup> See *Guideline for Providing Care to Women with a High Body Mass Index*

<sup>3</sup> See *Guideline for Vaginal Birth after One Previous Low Segment Caesarean Section*

<sup>4</sup> See *Policy: When the Client Requests Care Outside the Midwifery Standards of Practice*

<sup>5</sup> Common practice is to fax a client's prenatal record at 36 weeks to the potential receiving hospital.

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- The effect that transport time to the nearest hospital with obstetric services may have on the 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.
- Consideration of how the client and their support system may react in the event of a bad outcome.
- The client may change their 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 client carrying a fetus of viable age, they shall 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**

- Fetal surveillance equipment
  - Fetoscope
  - Waterproof Doppler and gel
- Maternal surveillance equipment
  - Sphygmomanometer with appropriate sized cuff
  - Stethoscope
  - Suitable time-keeping device
  - 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

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- One pair of scissors for cutting episiotomy
- Equipment, supplies and instruments for suturing, including mosquito forceps
- 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<sup>6</sup> including:
  - Resuscitation bag and mask
  - Oxygen saturation monitor
  - Portable suction equipment compatible with intubation
  - Intubation equipment
  - Umbilical vein catheterization supplies
- Source for keeping infant warm (eg. heating pad)
- 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 adult 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

*References available upon request*

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<sup>6</sup> Oxygen blender not required