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
  - 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

1 See Guideline for Vaginal Birth after One Previous Low Segment Caesarean Section
• VBAC
• Previous stillbirth or fetal anomaly
• Client requesting care outside the standards of practice
• 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.
• 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:
  o The client’s unique circumstances including relevant clinical and non-clinical factors.
  o Current information and evidence that relates to the risks and benefits of each birth setting.
  o Current information regarding RHA, hospital and community standards related to the client’s situation (eg. Emergency transportation, fetal surveillance, newborn monitoring).
  o Current information regarding local hospital’s obstetrical capacity and resources available at the time of birth.
  o 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.

2 See Guideline for Providing Care to Women with a High Body Mass Index
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.
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
College of Midwives of Manitoba

- 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\(^6\) 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 (e.g., 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

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6 Oxygen blender not required

References available upon request