PLANNED OUT-OF-HOSPITAL BIRTH TRANSPORT GUIDELINE

Updated February 2011

PREPARED BY THE MAWS TRANSPORT GUIDELINE COMMITTEE WITH THE AD HOC PHYSICIAN – LICENSED MIDWIFE WORKGROUP OF THE STATE PERINATAL ADVISORY COMMITTEE

Midwives' Association of Washington State

Midwives Association of Washington State
PMB 2246
10002 Aurora Ave N #36
Seattle, WA 98133-9348
1-888-422-4784
www.washingtonmidwives.org

1. INTRODUCTION

This document speaks to an underlying and mutual interest in the health and safety of mother and baby in the event of a transfer from an out-of-hospital birth setting to a hospital birth setting. When complications develop during labor or in the immediate postpartum period, access to a higher level facility with appropriate medical technology is an essential component in the achievement of good outcomes for mother and baby. Although the mother and her family are prepared in advance for the possibility of the need to transfer to a hospital setting during labor, it is often an emotionally difficult transition. The Society of Obstetricians and Gynaecologists of Canada summarizes this well in their Maternal Transport Policy:

> "All care providers involved in maternal transport must be attentive to the emotional needs of the woman and her family during what is frequently a frightening and sometimes grief-filled experience. The establishment of a support system is important to the woman's well-being. Even in emergency situations, it is important not to neglect the principles of family-centred care."
> (SOGC 2005, p. 1)

It is clearly in the mutual interest of both the transferring midwife and the receiving physician to avoid poor outcomes which could potentially lead to malpractice suits. This is likely a concern for the receiving hospital staff and physician, who typically have never met the family and may have little or no knowledge of the midwife or her practice guidelines. Unobstructed admittance, good communication, continuity of care, as well as appropriate and timely medical attention, all have the potential to improve maternal and neonatal outcomes and client satisfaction. The clinical situation and the attitudes of the mother and her family, the physician, and the midwife all play a part in how the home to hospital transfer proceeds. This document will provide background regarding licensed midwives, define expectations, and enhance the flow of information, ultimately allowing transfers to proceed more smoothly, efficiently, and safely.

2. BACKGROUND ON LICENSED MIDWIVES

Washington State Department of Health defines two types of legal midwifery practice: Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs). Another credential sometimes used is Certified Professional Midwife (CPM). CPMs have met the standards for certification set by the

North American Registry of Midwives (NARM) but may or may not have passed the licensure exam in Washington State. Many LMs are also CPMs, but the credential of CPM is not equivalent to licensure in Washington State.

Although some out-of-hospital deliveries are attended by CNMs, the vast majority in Washington State are attended by LMs. Most LMs in this state have completed 2 years of prerequisites followed by a 3-year program which includes relevant curriculum, nursing skills, and attendance at 100 births, prior to passing an examination provided by the North American Registry of Midwives (NARM) as well as an additional test specific to Washington State practice issues. LMs are regulated under RCW 18.50 and usually have independent practices, attending deliveries in homes and/or free-standing birth centers. LMs are authorized to obtain and administer the following:

MATERNAL	NEWBORN
antibiotics for intrapartum GBS prophylaxis per current CDC guidelines	newborn ophthalmic ointment
anti-hemorrhagic drugs to control postpartum hemorrhage (oxytocin, misoprostol, methylergonovine maleate, and Hemabate)	newborn Vitamin K injection
local anesthetic for perineal repair	HBIG
terbutaline (pending transport)	HBV
epinephrine (pending transport)	
magnesium sulfate (pending transport)	
MMR vaccine	
RhoGAM	

LMs may purchase and use the following devices: dopplers, syringes, needles, phlebotomy equipment, suture, urinary catheters, IV equipment, airway suction, electronic fetal monitoring devices, oxygen, neonatal and adult resuscitation equipment, glucometers, centrifuges, and may

prescribe breast pumps, compression stockings/belts, diaphragms, and cervical caps (WAC 246-834-250).

The state professional association for LMs is the Midwives' Association of Washington State (MAWS). A requirement of membership is participation in the MAWS QA/QI program of formal incident and peer review. LMs are able to contract with a variety of health insurance plans, including Medicaid. Professional liability insurance is available through a joint underwriting association.

3. INDICATIONS FOR TRANSPORT

An essential component of safe out-of-hospital maternity care is access to a higher level facility when indicated. It is important to remember that the vast majority of LM transports are still "normal" OB cases, resulting in vaginal delivery, the most likely reasons for transport being a combination of prolonged labor, request for pain relief, and maternal exhaustion.

LMs are trained to care for women having normal pregnancies and labors. The Washington State law that governs the practice of midwifery states that "It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the infant" (RCW 18.50). When complications are detected before the onset of labor, early consultation or referral is ideal. It is always preferable to avoid intrapartum emergency transport, and most transports occur long before the situation becomes emergent. A recent study by Kenneth C. Johnson and Betty-Anne Daviss, "Outcomes of planned home births with certified professional midwives: large prospective study in North America" published in the British Medical Journal in June of 2005, informs this discussion, providing useful statistics gathered from 5418 planned out-of-hospital births in North America in the year 2000. The study confirms that "Planned home birth for low risk women in North America using certified professional midwives was associated with lower rates of medical intervention but similar intrapartum and neonatal mortality to that of low risk hospital births in the United States" (Johnson and Daviss 2005, p. 1416). The study reported a 3.7% cesarean section rate, while the national average for singleton, vertex term women in the year 2000 was 19.0% (Johnson and

Daviss 2005, p. 1419). The authors summarize the incidence of the various indications for transfer in the following paragraph:

> *Of the 5418 women, 655 (12.1%) were transferred to hospital intrapartum or postpartum … Five out of every six women transferred were transferred before delivery, half (51.2%) for failure to progress, pain relief or exhaustion. After delivery, 1.3% of mothers and 0.7% of newborns were transferred to hospital, most commonly for maternal haemorrhage (0.6% of total births), retained placenta (0.5%), or respiratory problems in the newborn (0.6%). The midwife considered the transfer urgent in 3.4% of intended home births. Transfers were four times as common among primiparous women (25.1%) as among multiparous women (6.3%) but urgent transfers were only twice as common among primiparous women (5.1%) as among multiparous women (2.6%).* (Johnson and Daviss 2005, p. 1417)

Table 1 – INDICATIONS FOR INTRAPARTUM TRANSFERS:

INDICATION	% OF ALL BIRTHS[1]	% OF ALL TRANSFERS[2]
INTRAPARTUM		
Failure to progress in 1st stage	4.2%	34.7%
Failure to progress in 2nd stage	1.5%	12.2%
Pain relief	2.2%	18.2%
Maternal exhaustion	2.1%	17.1%
Malpresentation	1.7%	14.4%
Thick meconium	0.9%	7.5%
Sustained fetal distress	0.9%	7.5%
Baby's condition	0.4%	3.2%
Prolonged or premature ROM	0.4%	2.9%
Placenta abruption or placenta previa	0.2%	1.5%
Hemorrhage	0.1%	1.1%
Pre-eclampsia or hypertension	0.2%	2.0%
Cord prolapse	0.1%	0.9%
Breech	0.1%	0.5%
Other	0.3%	2.6%
POSTPARTUM		
Newborn:		
Respiratory problems	0.6%	5.0%
Evaluation of anomalies	0.1%	1.2%
Other reasons	0.3%	2.6%
Maternal:		
Hemorrhage	0.6%	5.2%
Retained placenta	0.5%	4.3%
Suturing or repair of tears	0.2%	2.1%
Maternal exhaustion	0.1%	0.6%
Other reasons	0.1%	1.2%

1. Source: Johnson and Daviss 2005, p. 1419 (Table 2 "Transfers to hospital among 5418 women intending home births with a certified professional midwife in the United States, 2000, according to timing, urgency, and reasons")
2. These percentages were derived by simply dividing the number transferred for a particular reason by the total number transferred (n=655). This column adds up to more than 100% as both primary and secondary reasons (if reported) for transfer to hospital are presented, It is intended to give an overview of the likelihood of specific clinical situations being present during a transfer.

4. COMMUNICATION and EXPECTATIONS

The circumstances surrounding an intrapartum or postpartum transport of a planned out-of-hospital birth heighten the need for clear and respectful communication among the transferring midwife, receiving physician, hospital personnel, and the client. The midwife should do everything possible to promote understanding of any relevant clinical information. The "Transport Summary Form" provided by the MAWS Transport Policy Committee can be utilized to provide a quick reference for hospital personnel, but verbal communication is the primary means of communication.

4.1. IN GENERAL, THE HOSPITAL CAN EXPECT THE FOLLOWING:

The midwife will discuss the need for transport with the client and her family, allowing adequate opportunity for questions and concerns, time permitting. The midwife will also prepare her client for any anticipated hospital procedures. The midwife will strive for respectful and collegial interactions with hospital providers. During such a transfer of care, the midwife will generally interface with the receiving hospital in the following ways:

1. A telephone call to the nursing supervisor or labor and delivery charge nurse notifying him/her of incoming transfer, providing clear, concise clinical information about the mother and/or baby.
2. A telephone call to the accepting practitioner will include the reasons for transport, background clinical information, the condition of the mother and/or baby, the planned mode of transport, and the expected time/location of arrival.
3. If the transfer is emergent, a telephone call will be made to notify EMS of urgent need for transport, including the above information, and any anticipated interventions necessary for stabilization during transfer.
4. The midwife will either provide photocopies of the relevant medical records or will provide originals which can be copied by the hospital and returned to the midwife.
5. If possible, the midwife will accompany the client to the hospital to facilitate a smooth transfer of care and provide ongoing support for the client. This continuity of care has the potential to enhance the professional relationship between midwives and hospital practitioners and greatly improve client satisfaction with care.

6. After the delivery, follow-up communication with the hospital practitioner(s) will ideally occur. This allows for feedback and further strengthens relationships.

4.2. IN GENERAL THE MIDWIFE CAN EXPECT THE FOLLOWING:

1. Recognition of the midwife as a primary care practitioner who has transferred to a higher level facility due to a need for advanced resources and skilled personnel. The goal is respectful, collegial interaction between hospital personnel and the midwife.
2. Hospital staff will provide safe, respectful care to the client and attempt to integrate the family's preferences with any necessary interventions.
3. The hospital practitioner(s) and the midwife will coordinate a schedule of follow-up care for mother and/or baby.
4. After the delivery, relevant medical records are sent to the midwife.

5. ONGOING PERFORMANCE EVALUATIONS and FOLLOW UP

Ongoing communication benefits of all parties. Case review may at times be appropriate, and all parties would, hopefully, be open to this. It is a primary goal to have an environment of collegial dialogue and mutual feedback which would contribute to seamless coordination of care across settings.

6. SOURCES

Chapter 18.50 RCW (Revised Code of Washington) – Midwifery

Chapter 246-834-250 WAC (Washington Administrative Code) – Midwives: Legend Drugs and Devices

Johnson, Kenneth, C. and Daviss, Betty-Anne. "Outcomes of planned home births with certified professional midwives: large prospective study in North America" British Medical Journal. 2005; 330:1416.

Society of Obstetricians and Gynaecologists of Canada (SOGC). Maternal Transport Policy. No 165, October 2005.