MIDWIFERY REGULATORY COUNCIL OF NOVA SCOTIA

POLICY ON OUT-OF-HOSPITAL BIRTH

As defined in the *Midwifery Act*, the scope of midwifery practice includes the provision of care during normal labour and birth in out-of-hospital as well as hospital settings. "Out-of-hospital" refers to clients' homes, birthing centres or other locations where specialized medical, obstetrical, neonatal, surgical and/or anaesthetic services are not available on site. In accordance with the standards and policies set out by the Midwifery Regulatory Council of Nova Scotia, as well as the *Regulations* pursuant to the Act, midwives must have the necessary training, qualifications and competencies to provide primary maternity care for women who choose to give birth at home. Additional MRCNS policies with specific relevance to out-of-hospital birth include:[*]

- *Indications for Multidisciplinary Review, Consultation and Transfer of Care*
- *Required Equipment and Supplies for Home Birth*
- *Policy on Second Attendants*
- *Policy on Home Birth Transport*
- *Informed Choice Policy*
- *Client Requests for Care Outside Midwifery Standards*

Safety

Safety in childbirth is of central importance for parents and maternity care providers alike. Current research evidence supports the safety of planned home birth for low risk women attended by midwives within a regulatory and organizational framework that ensures best practice and health system support.[1-7] In Canadian jurisdictions where midwives are well-integrated into the health care system and have good access to consultation, transfer of care and emergency services, midwife-attended births both at home and in hospital result in favourable outcomes with no increase in maternal or neonatal/perinatal morbidity or mortality in either setting.[5-7]

The literature suggests that the potential advantages of planned home birth include fewer interventions such as augmentation of labour, lower rates of operative vaginal delivery and cesarean section, and less need for pharmacological pain relief. Women also report higher satisfaction with their care and a greater sense of autonomy and personal empowerment compared to giving birth in hospital.

Factors that contribute to the safety of home birth include:

- Clear screening criteria to ensure that home birth candidates are low risk;
- Ongoing assessment during pregnancy of the client's health status and eligibility for home birth;
- Provision of current evidence-based information about home birth to support client decision-making and informed choice;
- Advance planning and preparation for birth in the home setting;
- Proper maintenance of supplies, medications and equipment for home birth;
- Training and continuing competency in the management of emergency situations in an out-of-hospital context;

[*] MRCNS policies and standards are available online at: http://mrcns.ca/index.php/policies-and-standards/

- Continuous one-to-one care and monitoring during active labour;
- Attendance of two midwives, or a midwife and an approved second attendant, during 2nd stage labour and the immediate postpartum;
- Clear operational policies and procedures for consultation, transfer of care, emergency transport and liaison with the hospital;
- Effective communication and collaboration among all health professionals involved in consultation, transfer or care and emergency services for out-of-hospital birth.

Eligibility for planned out-of hospital birth

Home birth is a safe and reasonable option when the client is at low risk of complications, the progress of pregnancy is normal and a normal birth is anticipated. When there are significant clinical concerns or increased risks for the mother and/or baby and the conditions for safe home birth cannot be met, a hospital birth should be planned.

As primary care providers, midwives are responsible for assessing the client's health and risk status in pregnancy and advising the client accordingly on the appropriate setting for birth. The midwife's principal reference for prenatal assessments, recommendations and decision-making with regard to home or hospital birth is MRCNS policy on *Indications for Multidisciplinary Review, Consultation and Transfer of Care.*

a) Eligibility criteria for planned out-of-hospital birth include:
   - Client preference and informed choice
   - Absence of pre-existing or pregnancy-related conditions, disorders or diseases requiring transfer of care to a physician
   - Singleton fetus
   - Cephalic presentation
   - Gestational weeks between 37+0 and 41+6 at the onset of labour
   - Availability of a second midwife or approved second birth attendant

b) Contraindications to planned out-of-hospital birth include but are not limited to:
   - Significant pre-existing or pregnancy-related conditions, disorders or diseases requiring transfer of care to a physician
   - Multiple pregnancy
   - Breech presentation or other non-vertex presentation
   - Previous cesarean section or hysterotomy
   - Preterm labour < 37 weeks
   - Documented post term pregnancy ≥ 42 weeks
   - Pre-eclampsia or eclampsia
   - History of PPH requiring transfusion or surgical intervention
   - Maternal BMI ≥ 40
   - Known fetal anomaly requiring immediate medical treatment at birth
   - Documented IUGR ≤ 3rd percentile

c) Indications requiring consultation with a physician in the prenatal period (without transfer of care) may or may not preclude out-of hospital birth, depending on the condition and prognosis. In such cases, the client's history, current health, risk status and choice of birthplace must be reviewed with the physician consultant and/or

multidisciplinary team members. Recommendations should be documented and communicated to the client.

d) Other considerations that may impact the choice of birthplace include psychosocial and cultural factors, the suitability of the home environment, family supports, distance from the hospital, time required for emergency transport, and inclement weather and road conditions.

Indications for intrapartum or postpartum transfer to hospital

Canadian studies indicate that approximately 20% of planned out-of-hospital births involve intrapartum or postpartum transfer to hospital.[6,7] The majority of these transfers however are non-urgent and initiated before a complication or emergency develops; for example, when labour is non-progressing or pharmacological pain relief is needed. Emergency transport by ambulance occurs in a relatively small percentage of planned home births.

MRCNS policy on *Indications for Multidisciplinary Review, Consultation and Transfer of Care* specifies conditions in labour or the postpartum period that require transfer of care to a physician (i.e. transfer to hospital). In an out-of-hospital context, certain maternal and newborn indications requiring consultation with a physician may also necessitate transfer to hospital. Midwives are expected to act on these indications as appropriate to the stage of labour, immanence of delivery and/or urgency of the situation.

Intrapartum or postpartum indications for transfer to hospital include but are not limited to:

<u>Maternal</u>

- Undiagnosed breech or other non-vertex presentation
- Prolonged/non-progressing active labour
- Prolonged/non-progressing second stage
- Severe hypertension, pre-eclampsia or eclampsia
- Active genital herpes at the onset of labour
- Temperature > 38^{o} on more than one occasion in labour
- Need for epidural or narcotic analgesia or sedatives
- Abnormal fetal heart pattern unresponsive to therapy
- Prolapsed cord
- Thick or particulate meconium
- Suspected placental abruption or previa
- Retained placenta
- 3^{rd} or 4^{th} degree tear
- Hemorrhage unresponsive to therapy
- Uterine rupture or inversion
- Obstetric shock

<u>Newborn</u>

- Apgar score < 7 at 10 minutes
- Significant congenital anomaly requiring immediate medical attention
- Birth injury requiring investigation
- Suspected seizure activity

- Suspected neonatal infection
- Persistent abnormal respiratory rate or pattern
- Persistent cyanosis, pallor, hypotonia or jitteriness
- Temperature instability unresponsive to thermoregulation therapy

MRCNS policy on *Home Birth Transport* outlines the responsibilities of the midwife and the procedures she must follow when transfer to hospital is indicated. These include initiating emergency measures as needed in the home setting, calling Emergency Health Services and notifying the hospital, and continuing to provide the necessary care as the primary/ most responsible provider during transport, until a physician at the hospital assumes this role. The midwife is also expected to follow any specific DHA/IWK operational policies or requirements for transfer of care/ transport to hospital.

DHA/IWK operational policies

DHA/IWK policies for midwife-attended home birth should be consistent with MRCNS regulatory standards and policies. Within its mandate to protect public safety, the MRCNS recommends that district midwifery sites establish operational policies and procedures for transfers to hospital, team liaison and effective system support around home birth. Site-specific policies, protocols or guidelines may be needed for the following:

- Hospital pre-registration
- Pre-registration of the client's name and address with EHS
- Notification of the hospital when the client is in active labour, the delivery has occurred, and/or a transfer from home is underway
- Disinfection, sterile processing and packing of instruments and equipment
- Disposal of used materials and sharps
- Disposal of the placenta
- Collection, labelling and handling of lab specimens and cord bloods
- Procurement and administration of WinRho vaccine
- Newborn screening tests
- Application for MSI number
- Registration of Live Birth
- Completion and filing of client records and report forms

Informed choice

Respect for the woman's informed choice is a fundamental tenet of midwifery practice, as set out in MRCNS *Standards of Midwifery Practice.* Midwives regard women as primary decision-makers in their own care and work in partnership with the client/family to choose the appropriate setting for birth. It is the role and responsibility of the midwife to promote and facilitate informed decision-making when the client is planning or considering a home birth. This process should include:

- Initiating discussion early in pregnancy about the client's choice of birthplace and continuing these discussions as needed throughout the course of care;
- Providing current evidence-based information about risks, benefits and outcomes related to home birth, as well as midwife-attended birth in hospital;

- Considering the client's individual circumstances and advising her on clinical and other factors that may affect the choice of birthplace;
- Informing the client about professional and regulatory standards, as well as DHA/ IWK and community standards, for midwifery practice and home birth;
- Providing information about the management of emergencies in out-of-hospital settings and the potential impact of transport time to the nearest hospital with obstetrical and neonatal services;
- Clarifying the client's responsibilities with regard to planning and preparing for home birth;
- Maintaining a relationship of open communication and addressing any barriers to mutual trust.

The midwife must make every effort to support the woman's choice of home birth, with the understanding that her health and that of her baby will be assessed on an on-going basis throughout pregnancy and labour, and that complications or increased risks at any point may necessitate a change of plan. Clients should be informed that the research on home birth safety clearly indicates that good outcomes are contingent on screening for risk, acceptance of evidence-based standards and eligibility criteria, and giving birth in hospital when home birth would be less safe for the mother and/or baby. It should also be made clear that there is no known risk screening tool or system that effectively predicts birth outcome.

The MRCNS recommends that midwives provide clients with pertinent written information or a handbook on home birth to facilitate the informed choice process. It may also be helpful to provide an informed choice document for clients to sign with respect to place of birth.

Client refusal of recommendations

MRCNS policy on *Client Requests for Care Outside Midwifery Standards* outlines clear steps for midwives to follow when a client requests care that is not in keeping with the scope or standards of midwifery practice or the midwife's clinical judgment and recommendations. In accordance with midwifery standards, the midwife has an obligation to respect the client's choice of birthplace but is not obligated to fulfill a request for home birth when prenatal assessment makes it apparent that this would not be a safe, low risk option. At the same time, the midwife is ethically bound not to abandon care of a woman in labour when a planned home birth is underway.

Exceptional situations in which a client indicates her intention to give birth at home regardless of recommendations, or refuses to transfer to hospital as indicated during a planned home birth, present particular challenges in terms of the midwife's responsibility and accountability to her regulatory body, her colleagues and employer, and the client. Professional and ethical dilemmas around out-of-hospital birth are usually avoided when there is an ongoing therapeutic alliance and relationship of trust with the client, every effort is made to explore and understand her concerns, and recommendations are conveyed in an appropriate, non-coercive manner.

When significant risk issues or conflicts arise in the course of prenatal care, the midwife must bring these to the attention of multidisciplinary team members for timely advice, perspective and support. If a client refuses to transfer to hospital during a planned home birth, the midwife must keep the hospital labour/birth unit informed and make every effort to obtain advice and support by telephone while continuing to provide care to the best of

her ability and in accordance with MRCNS standards. Balanced consideration of the bioethical principles of autonomy (the patient/client's right to decide on a care pathway), beneficence (the provider's imperative to help or benefit the client), and non-maleficence (the duty to do no harm) may be helpful in reaching a solution or course of action that is acceptable to all concerned.

References

1. Wiegers TA, Keirse MJ, Van der Zee J, Berghs GA. Outcome of planned home birth and planned hospital births in low risk pregnancies: Prospective study in midwifery practices in the Netherlands. BMJ 1996; 313:1309-1313.

2. Olsen O. Meta-analysis of the safety of the home birth. Birth 1997; 24: 2-13

3. Olsen O, Clausen JA. Planned hospital birth versus planned home birth. Cochrane Database of Systematic Reviews 2012; Issue 9. Art. No. CD000352. DOI: 10.1002/14651858.CD000352.pub2

4. Ackermann-Liebrich U, Voegeli T, Gunter-Witt K, et al. Home versus hospital deliveries: Follow up study of matched pairs for procedures and outcome. Zurich Study Team. BMJ 1996; 313: 1313-1318.

5. Janssen PA, Lee SK, Ryan EM, et al. Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia. CMAJ 2002; 166: 315-323

6. Janssen P, Saxell L, Page L, Klein M, Liston R, Lee SK. Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician. CMAJ 2009; 181: 377-383

7. Hutton E, Reitsma A. Outcomes associated with planned home and planned hospital births in low-risk women attended by midwives in Ontario, Canada, 2003-2006: A retrospective cohort study. Birth 2009; 36: 180-189

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