Protocol: Home Birth
Date of Draft:
Date approved:
Date to review:
Date of Revision:

Saskatchewan Midwifery
Home Birth Protocol

Date of Draft: 26 April 2018

Purpose:

To establish a standard of practice regarding home birth for Saskatchewan Registered Midwives in order to provide the best possible outcomes for birthing families in midwifery care who choose to birth outside of the hospital. This protocol provides a consistent approach to care and facilitates orientation for students, new members of the practice group, and members returning from leave.

Introduction:

Informed choice and choice of birthplace are fundamental principles of midwifery care in Saskatchewan. The choice of birthplace should be an informed choice discussion that includes the benefits and risks of home and hospital delivery, contraindications to home birth, community practice standards, and client preference. The client's family and social circumstances, housing situation, season (weather), availability of emergency services and distance to hospital should also be considered when discussing choice of birth place. Ongoing assessments throughout the pregnancy and labour may identify possible complications or risk factors that would influence the choice of birth place.

Available evidence confirms that a planned home birth is a safe option for low risk/well-screened women when the birth is attended by a Registered Midwife and a qualified second attendant, or two Registered Midwives, who are trained and equipped to initiate care and manage obstetrical complications and when appropriate emergency equipment and the integration of midwifery into the regional obstetrical program is in place.

Contraindications to home birth

Saskatchewan College of Midwives (SCM)
(see appendix B)

- Multiple gestation
- Breech presentation or any 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
- Any Condition indicating a Transfer of Care listed in the SCM policy *Mandatory Discussion, Consultation and Transfer of Care. (see Appendix B)*
- In some communities, a trial of labour after cesarean (TOLAC) or vaginal birth after cesarean (VBAC) are contraindications to home birth.

- Otherwise, planned home TOLAC or VBAC is contraindicated in the following circumstances:
    - History of previous lower segment cesarean section before 26 weeks
    - History of single layer closure of c-section uterine incision
    - Ballotable head in active labour in current pregnancy
    - Inter-pregnancy interval of less than 18 months
    - History of impaired scar healing
    - Prolonged active phase of labour with lack of progress
    - History of indication for a prior cesarean section was failure of descent of presenting part in second stage of labour.
    - Where midwife does not have access to operative reports of the previous cesarean section and obstetrical history.

Relative contraindications to home birth

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 the care of a specialist, that are likely to reoccur in current pregnancy
- Women with high body mass index (BMI) over 40
- VBAC
- Previous stillbirth or fetal anomaly
- Client requesting care outside the standards of practice
- Any other condition of concern to client or caregivers

Risks & Complications

As part of the discussion of risks and benefits to home birth, it is important to inform the birthing family of complications that may arise and how the outcome may be affected by place of birth. According to the SCM this discussion should include:

- placental abruption/antepartum hemorrhage
- postpartum hemorrhage
- retained placenta
- shoulder dystocia
- cord prolapse
- undiagnosed twins
- undiagnosed breech/malpresentation
- meconium stained amniotic fluid
- neonatal resuscitation and intubation
- abnormal fetal heart tones
- uterine rupture
- anaphylaxis.

Transfer to Hospital

With a home delivery, most obstetrical interventions are unavailable unless there is a transfer to hospital. Some of the interventions would include: c-section, vacuum, forceps, episiotomy, oxytocin augment, blood transfusions, and epidural anesthesia.

Transport by hospital by ambulance is indicated when the well-being of the mother or baby is in jeopardy. For example:

- retained placenta
- postpartum hemorrhage
- complicated neonatal resuscitation or respiratory distress
- abnormal fetal heart rate in labour.

Some cases of transport to hospital are non-urgent and do not require emergency services or paramedics. For example:

- prolonged labour
- pain relief
- meconium stained amniotic fluid
- 3rd or 4th degree perineal laceration

At times, an ambulance may be used for transport to hospital because it is the fastest or most appropriate means of transportation even in the absence of a health emergency. At other times, transport to hospital may not necessarily occur despite emergency services being called to the intended birth setting. For example:

- resolved shoulder dystocia
- after a resuscitation that was not as involved as initially anticipated

Management

WHAT ARE THE THINGS THAT WE WANT TO BE STANDARD CARE FOR A HOME BIRTH?

Planned home birth:

- A list of items required for a home birth should be given to the client by 36 weeks gestation.
- A home visit should be done by 37 weeks to assess suitability and access of planned place of birth.
- Assess labouring woman as appropriate.
- Once active labour is established, primary midwife must remain in attendance.
- Fetal heart rate to be auscultated every 15-30 minutes and documented.
- Maternal vitals signs (blood pressure, pulse, temperature) to be assessed every four hours.
- Assess frequency, intensity duration and uterine resting tone every 30 minutes and document on partogram.
- Encourage woman to empty her bladder and document voids on partogram.
- Set up birth equipment and supplies prior to second stage of labour. Test equipment to ensure it is all in working order.
- Ensure reasonable access for emergency services in the event of a transfer.
- Call second midwife or second attendant to attend delivery at appropriate time.
- Second midwife or second attendant should test equipment and be aware of where necessary supplies are located.
- Assess newborn and maternal vital signs (# of times??? Q15-30?) in the first two hours postpartum.
- Primary midwife should remain at the birth place for a minimum of two hours postpartum, and depart after that time only when both mother and baby are stable.

Unplanned/Precipitous home birth:

- As above.
- Consider calling EMS for support and possible transfer if family preference or clinical situation indicates a transfer to hospital.

Required equipment and medications (see Appendix A)

The equipment and supplies that midwives bring to home births is similar to the equipment in a level I community hospital, including oxygen, neonatal resuscitation equipment, medications to treat postpartum hemorrhage and sterile instruments. Midwives who attend home births are responsible for having well-maintained equipment, supplies and medications that may be required during labour, birth and/or the postpartum period.

Appendix A

REQUIRED EQUIPMENT AND SUPPLIES FOR HOME BIRTH SETTING

The following list is the minimum required equipment and supplies for safety at a home birth. Midwives may choose to carry further equipment and supplies depending on their location and clients served. All equipment and supplies must be appropriately cleaned, disinfected or sterilized and functional to ensure safety.

EQUIPMENT

- Non-electronic instrument for assessing fetal heart rate
- Doppler fetoscope and Doppler gel
- Adult and infant (or neonatal) Stethoscopes
- Sphygmomanometer with appropriately sized cuffs
- Thermometer and measuring tape
- Newborn scale
- Electric heating pad
- Portable suction equipment compatible with intubation
- Newborn intubation equipment including newborn laryngeal mask airway
- Newborn resuscitation bag and mask including: pressure gauge, PEEP valve
- Pulse oximeter and CO2 detector
- Equipment for administration of epinephrine and/or fluids for volume expansion via the umbilical vein (UV)
- Sterile suturing pack (scissors, needle driver, tissue forceps) and suture material
- Sterile birth pack (4 hemostats, episiotomy scissors, cord scissors)

MEDICATIONS

- Oxytocin (10 units/mL, 1 ml vials) and Misoprostol (200 mcg tablets)
- Benadryl (50 mg/mL, 1 mL vials) & Gravol (IM) (50 mg/mL, 1 mL vials)
- Local anesthetic 1% and 2% Lidocaine
- Epinephrine (1:1000 adult, 1:10,000 newborn)
- Oxygen tanks, masks and tubing (sufficient for transport)
- Erythromycin for eye prophylaxis, 5 mg/g, 1 mg tubes
- Vitamin K (10 mg/mL, 1 mL ampules)
- Pencillin G 2.5 and 5 million units, (5 million IU vials)

SUPPLIES

- Cord clamps
- Sterile and non-sterile gloves
- Sterile lubricant
- Syringes and needles (appropriate sizes)
- Urinary catheter supplies
- Venipuncture supplies and sharps container
- IV supplies and fluids (normal saline, IV tubing, lock etc)

Appendix B

SCM Indications for Mandatory (Discussion, Consultation and) Transfer of Care

Indications for Mandatory Consultation (Labour & Birth)

- Preterm labour (35+0 to 36+6 weeks to a doctor for the baby)
- Vaginal bleeding, continued or repeated
- Twins
- Stillbirth
- Breech presentation
- Gestational hypertension
- Failure to progress, after appropriate use of oxytocin
- Meconium during labour
- Sudden or severe abdominal pain
- Maternal indication for or request for epidural anaesthesia/narcotic analgesia
- Lacerations involving the anus, anal sphincter, rectum, urethra
- Persistent fever greater than 380 C after treatment
- Malpresentation/Abnormal presentation other than breech (transfer of care if feasible)
- HIV positive (transfer of care if unsuppressed or unknown viral load)

Indications for Transfer of Care (Labour & Birth)

- preterm labour less than 35 weeks
- Breech presentation (if feasible)
- Active genital herpes
- Uterine rupture
- Abnormal fetal heart rate pattern unresponsive to therapy
- Cord prolapse
- Malpresentation/Abnormal presentation other than breech (transfer of care if feasible)
- Eclampsia
- Gestational hypertension which is considered severe by the most current guidelines
- HIV positive (if viral load unsuppressed or unknown)

Indications for Mandatory Consultation (Postpartum, Maternal)

- Retained placenta with or without bleeding (transfer of care if feasible)
- Persistent uterine atony
- Severe uterine prolapse
- Vulvar hematoma not stabilizing
- Persistent bladder dysfunction
- Persistent temp greater than 38 degrees C
- Secondary postpartum hemorrhage
- UTI not responsive to therapy
- Subinvolution of the uterus with signs and symptoms of uterine infection
- Suspected deep vein thrombosis
- Gestational hypertension

- Breast infection unresponsive to treatment
- Serious psychological problems
- Request for immediate postpartum tubal occlusion

Indications for Transfer of Care (Postpartum, Maternal)

- Hemorrhage unresponsive to treatment
- Gestational hypertension which is considered severe by the most current guidelines
- Unexplained persistent chest pain or dyspnea
- Inversion of the uterus (if feasible)
- Postpartum eclampsia
- Thromboembolic disease

References

Saskatchewan College of Midwives
Professional Practice Policies
Planned Out of Hospital Birth

Saskatchewan College of Midwives
Professional Practice Policies
Mandatory Discussion, Consultation and Transfer of Care

College of Midwives of BC
Registrant's Handbook
Home Birth Standards

College of Midwives of BC
Registrant's Handbook
Required Equipment and Supplies for Home Birth Setting

Association of Ontario Midwives (AOM)
Choice of Birthplace

College of Midwives of Ontario (CMO)
Standards of Practice
Home & Out of Hospital Births (2014)

College of Midwives of Ontario (CMO)
Standards of Practice
Essential Equipment, Supplies and Medications (June 2015)