

Home Birth

Handbook for Midwifery Clients

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INTRODUCTION

Hello

This handbook contains important information for you to read through as you consider and prepare for a home birth.

The introduction to the handbook gives you a brief overview of some of the steps that have gone into making midwifery-attended home birth an integrated part of maternity care in BC.

Section A contains a discussion of who can have a home birth in BC, introduces you to the importance of informed choice in midwifery care, and outlines the steps in preparing for a planned safe, informed home birth. There is also a description of the arrangements that your midwife will have in place should you need to be transported to a hospital during a home birth.

Section B is a list of pre-existing or emerging medical conditions which mean that home birth is not an option for you or, if they arise during labour and delivery, that you will be transferred to hospital.

Section C contains the College of Midwives of BC (CMBC) Policy on Informed Choice. Reading this policy can help you to understand informed choice and how it will shape your midwifery care. Importantly, this section describes types of information that your midwife will provide to you and lists topics that you will need to think about in order to make informed decisions during your pregnancy.

Section D provides the results of some research projects examining the safety of homebirth, including results from the Home Birth Demonstration Project completed in BC. There are also a number of CMBC policies for you to look over which relate directly to home birth.

Please take some time to read through this Handbook. You may wish to return to various sections of the Handbook as your pregnancy progresses. As you are reading the handbook, you may have questions. Don't hesitate to ask these questions of your midwife.

We hope this handbook helps you to prepare for a safe and informed home birth.

HOME BIRTH IN BRITISH COLUMBIA

In 1993, the Government of British Columbia announced the decision to integrate midwifery into the health care system in order to regulate midwifery and give women more choice about birth setting and care. The Home Birth Demonstration Project (HBDP) was incorporated into the Midwives Regulation of the *Health Professions Act*, which established midwifery as a self-regulating profession in the province. The CMBC remains responsible for setting standards of practice and monitoring the clinical practice of individual midwives.

The goal of the HBDP was to evaluate the provision of home birth care by midwives in the first two years of regulated midwifery in British Columbia to ensure the integration of midwife-attended home births into the health care system, as a safe choice for pregnant women in British Columbia.

Home birth involves careful screening of clients by their midwives for suitability and coordination between midwives and other health care providers. Home birth is not simply an interaction between a midwife and client, but is provided within a broader support system that includes hospitals, physicians and emergency services.

The HBDP facilitated coordination among maternity care providers to ensure that the necessary support systems for planned home birth were in place. The project also collected and analyzed data from all of the planned home births, including those where transfer to hospital was required, attended by registered midwives from January 1, 1998 through December 31, 1999. The project's independent evaluation team conducted an analysis and evaluation of these two years of data, and recommended that home birth services continue to be delivered to a well-screened low-risk population of BC women by registered midwives with training in emergency management, the necessary equipment and supplies, and access to ambulance and hospital back-up services.

The HBDP adopted the policies pertaining to home birth established by the College of Midwives of British Columbia (CMBC), and developed further policies and protocols that clarified the responsibilities of midwives, clients, and other health care providers in planning for and managing a home birth. Many of these policies and protocols were found to be useful to midwives and their clients, as well as to hospital and ambulance personnel. Since the project has come to an end, the Board of the College of Midwives decided that it would be valuable to continue to offer this *Home Birth Handbook for Midwifery Clients* to families considering home birth. The *Home Birth Demonstration Project* outcomes were also published in the *Canadian Medical Association Journal* in 2002.¹

1. Janssen PA, Lee SK, Ryan EM, Etches DJ, Farquharson DF, Peacock D, et al. "Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia." *CMAJ* 2002;166(3):315-23.

SECTION A: PREPARATION FOR HOME BIRTH

Are You Eligible for a Home Birth?

Your midwife will help you determine if you are eligible for a home birth by: (1) screening for clinical risk factors and (2) determining whether other conditions for safe home birth can be met.

The goal of risk assessment for home birth is to select low-risk women with a good prognosis for a normal, healthy pregnancy, birth, and postpartum course. However, it is important to recognize that pregnancy and birth is a dynamic process and no risk screening system can identify every woman who will experience an adverse outcome.

Although the first opportunity for screening is during the initial interview between you and your midwife, choosing the appropriate birth setting is an ongoing process. Situations can occur during pregnancy or labour that require the birth to take place in the hospital. Also, you may, at any time during pregnancy or labour, change your planned place of birth. You and your midwife have a joint responsibility for determining the suitability of a home birth and communicating about anything that arises that may affect your plans. Together you may alter the plan, if necessary, at any point.

The CMBC has set out the criteria for midwifery care and home birth in the documents: *Indications for Discussion, Consultation and Transfer of Care* (Appendix 2) and *Indications for Planned Place of Birth* (Appendix 3). You may wish to look at the first document to be aware of circumstances and complications which require consultation or transfer of care to a physician; and the second document which lists those situations which would make you unable to have a home birth. You may also want to look at Section B of this Handbook for a list of conditions which preclude home birth. Section B is based on the College's *Indications*.

Additional Considerations for Safe Home Birth

For health care professionals concerned with childbirth, the central issue is safety². While childbirth for healthy women is usually low-risk, birth in any setting is not risk-free. Current research addressing the safety of home birth has consistently concluded that planned home birth attended by qualified caregivers can be a safe option for low-risk pregnancies (Appendices 1 and 4). You and your midwife must consider some additional factors to decide whether a home birth is appropriate in your situation.

2. There are different opinions among health care professionals about the safety of home birth.

The conditions that should be present include:

- the birth is planned and prepared for in the home (or another suitable out-of-hospital setting);
- the birth is attended by two registered midwives, or a registered midwife and a CMBC approved second birth attendant;
- supplies, equipment and the training required to treat emergency conditions in the home³ are maintained and updated by each registered midwife;
- continuous one-to-one care and monitoring during active labour is provided;
- your midwife has a well-developed system of consultation with and referral to physicians;
- cooperation exists among health care professionals in your community;
- emergency transportation with trained personnel and access to medical services are available;
- a plan for *Hospital Procedures for Emergency Transport from Planned Home Birth* is in place at the closest hospital providing obstetric and newborn care;
- where a midwife works with a second birth attendant, consideration is given to the training and qualifications of that second attendant; and
- consideration is given to the length of time required to travel to hospital under the current local road and weather conditions in your community.

There may be circumstances where the added risk of time, distance or adverse weather conditions precludes a planned home birth. In this case, you may consider a hospital birth or giving birth at an alternate site closer to hospital (e.g., a friend's home).

Informed Choice

Choosing the appropriate setting in which to give birth involves an informed choice process. Your midwife should provide you with information on her scope of practice, CMBC policies and guidelines, referral mechanisms, and eligibility criteria for home birth.

Detailed information on the benefits, risks and safety of home birth, as well as information about how emergency procedures may be carried out at home must also be covered. Planning a home birth will not ensure a home birth for every woman. You will need to agree to inform your midwife of changes in your circumstances which could affect the safety of a home birth and agree to be transported to hospital during labour or postpartum in the event problems arise that cannot be safely managed outside a hospital.

Further discussion of *Informed Choice* can be found in Section C.

³ While midwives are trained to manage maternal and newborn emergencies in the home setting, situations can arise where the availability of additional trained personnel, more commonly found in the hospital setting, can enhance the midwife's ability to respond to certain emergency situations. For example, performing umbilical vein cannulation to administer emergency medication during newborn resuscitation requires the assistance of an additional trained care provider. While this emergency measure is only required in about 1 in 1,000 births, women considering home birth should be aware of such limitations.

Client / Midwife Arrangements for Home Birth

During regular prenatal visits, your midwife will continue to evaluate you and your baby's health status, and will discuss with you any changes to your risk status.

Together, you and your midwife are responsible for ensuring that the following preparations for home birth are in place:

- your midwife ensures that the *CMBC Required Equipment and Supplies for Home Birth Setting* (Appendix 6) are available;
- you ensure that the supplies in the *Sample List of Client Supplies for Home Birth* (Appendix 7) or as requested by your midwife are available;
- your midwife ensures that a second midwife or second attendant is available as per the *CMBC Policy for Second Birth Attendants*⁴ (Appendix 9); and
- you prepare directions to the home where you plan to give birth, especially if the location is difficult or rural.

Hospital Arrangements for Planned Home Birth

Before providing home birth services in a community, midwives contact the local hospital(s) to determine the procedure to use in the event of an emergency. The midwife will have forwarded a copy of these *Hospital Procedures for Emergency Transport from Planned Home Birth* to the CMBC, identifying the personnel responsible for receiving emergency transport calls and initiating emergency measures whenever transport to hospital is needed.

You and your midwife are responsible for ensuring that the following hospital arrangements for home birth are in place:

- you will need to pre-register with the hospital before 36 weeks of pregnancy, according to hospital procedure, and let the hospital know that you are planning a home birth with a registered midwife;
- at 36 weeks of pregnancy, your midwife will forward a copy of your prenatal record to the hospital where you are pre-registered;
- the midwife will notify hospital staff when labour is established and your planned home birth is underway; and
- your midwife will notify hospital staff when your baby is delivered at home as planned.

4. Ideally, the second care provider at the birth should be another registered midwife. In communities where this option is restricted or non-existent, second attendants may come from other health professions like nursing or the paramedical field. However, the minimum qualifications for a second birth attendant are certification in emergency resuscitation techniques. Whether a second birth attendant can do such things as administer drugs or initiate intravenous access depends on their professional scope of practice and individual qualifications. Women who are served by midwives using second birth attendants rather than second midwives should be aware of the skill set and experience of the second attendants available to better inform their decision around place of birth.

Transport from Planned Home Birth to Hospital

A safe and smooth transport from home to hospital is the goal whenever transport is required.

In an emergency situation, the receptivity of personnel and level of preparation at the hospital are key factors in ensuring that you or your baby have timely and appropriate access to medical skills and technology when it is needed. Registered midwives work together with ambulance and hospital personnel toward the common goal of providing the safest care possible to women choosing home birth by ensuring that the necessary support systems are in place.

In general, transport to hospital should take place when resources available in the home birth setting are not adequate to manage existing or anticipated complications. The majority of transports from home to hospital are not emergencies and generally take place by private car. In emergency situations, transport most often takes place by ambulance. Urgency, weather/road conditions, imminence of the birth and type of back-up hospital (with or without caesarian section capability) are taken into consideration when deciding when and how to transport.

An organized and effective response in an emergency situation involves the coordinated efforts of all health care professionals including midwives, physicians, nurses, other hospital staff, and the British Columbia Ambulance Service (BCAS). When accessing emergency transport to hospital, midwives will be working within the BCAS dispatch system protocols currently in place throughout the province.

According to BC Ambulance Service policy, midwives requesting ambulance services have the authority and responsibility to continue providing care to the maternity client and/or newborn as the primary caregiver and medical escort during transport to hospital. All registered midwives carry photo identification from the CMBC in order to identify themselves to ambulance personnel.

Summary of Activities for Planned Home Birth

- Together, you and your midwife determine your eligibility for a planned home birth.
- You and your midwife determine whether additional conditions for safe home birth can be met.
- Your midwife provides you with detailed information summarizing the research on the risks, benefits and safety of planned home birth.
- If you choose a home birth, you sign the *Home Birth Informed Consent*. Your midwife will keep this form in your chart. The ideal time to go through this process is at or before 36 weeks.
- You attend regular prenatal visits with your midwife who provides ongoing evaluation of your continued eligibility for a home birth.
- Your midwife has a plan on file with the local hospital(s) which sets out who is responsible for receiving emergency transport calls and initiating emergency measures. A copy of this plan is kept on file at the CMBC.
- You pre-register with the hospital before 36 weeks of pregnancy.
- Your midwife forwards a copy of your prenatal records by 36 weeks of pregnancy to the hospital where you are pre-registered.
- Your midwife ensures that the *CMBC Required Equipment and Supplies for Home Birth Setting* are available.
- You ensure the *Sample List of Client Supplies for Home Birth* are available.
- Your midwife ensures that a CMBC approved second birth attendant is available for the birth.
- Your midwife notifies the hospital where you have pre-registered when you are in labour and again when your baby is born at home as planned.

SECTION B: CLINICAL CONDITIONS PRECLUDING HOME BIRTH OR REQUIRING TRANSPORT TO HOSPITAL

The CMBC has addressed home birth in a number of its documents including: *Indications for Discussion, Consultation and Transfer of Care* (Appendix 2), *Indications for Planned Place of Birth* (Appendix 3) and *Statement on Home Birth* (Appendix 4). The CMBC expects midwives to use their professional judgment in making decisions to consult or transfer care where a combination of circumstances may exist or where circumstances arise that are not addressed in CMBC standards.

The following list, which is not exhaustive, contains clinical conditions which preclude a planned home birth and/or require transport to hospital during labour or the postpartum. Please note that indications for consultation in the CMBC *Indications for Discussion, Consultation and Transfer of Care* (Appendix 2) may in some situations lead to a transfer of care which would also preclude a home birth.

Antenatally:

- any serious medical condition;
- cardiac or renal disease with failure;
- insulin-dependent diabetes mellitus;
- multiple pregnancy;
- proteinuric pre-eclampsia or eclampsia;
- symptomatic placental abruption; and
- documented post-term pregnancy (more than 43 completed weeks).

At the onset of labour:

- active genital herpes;
- pre-term labour prior to 37 weeks of pregnancy;
- breech or other abnormal presentation; and
- severe hypertension.

After the onset of labour:

- temperature over 38 degrees Celsius on more than one occasion;
- abnormal foetal heart rate patterns unresponsive to therapy;
- thick or particulate meconium⁵;
- prolapsed cord;
- placental abruption and/or previa;
- uterine rupture; and
- haemorrhage unresponsive to therapy.

5. Where thick or particulate meconium is identified, delivery in hospital is indicated unless the membranes rupture so close to the birth that transport to hospital would be unsafe. A midwife should be prepared to intubate a non-vigorous newborn. NRP standards recommend intubation of any non-vigorous infant born in the presence of meconium. A midwife should discuss her skill and experience with intubation, as well as what expertise is available in hospital, with any client planning a home birth where meconium is noted in labour to assist informed decision-making.

Postpartum - maternal:

thrombophlebitis or thromboembolism;
postpartum eclampsia;
uterine prolapse or inversion;
haemorrhage unresponsive to therapy; and
obstetric shock.

Postpartum - newborn:

Apgar score lower than 7 at 10 minutes;
suspected seizure activity;
significant congenital anomaly requiring immediate medical intervention, (e.g.,
omophalocele, myelomeningocele); and
respiratory distress or temperature instability unresponsive to therapy.

SECTION C: INFORMED CHOICE

Informed choice is a fundamental principle of midwifery care in British Columbia, as noted in the CMBC *Informed Choice Policy* (Appendix 8). Your midwife is responsible for providing complete, relevant and objective information regarding what is known and unknown about screening and diagnostic tests, procedures, and medications. She must provide you with information about procedures or treatments including: the expected benefits, the risks and side effects, alternative courses of action, and the likely consequences of not having a treatment or procedure considered standard in the community.

The choice of having a home birth is yours, so long as you remain low-risk. You can change your mind and decide to give birth in hospital at any time. The informed choice process should support you in developing the understanding, skills and motivation necessary to make decisions about your care.

Informed choice regarding home birth includes:

- informing yourself about the midwife's scope of practice, as well as her individual experience with out-of-hospital birth, and reviewing the CMBC's documents, *Indications for Discussion, Consultation and Transfer of Care* (Appendix 2), *Indications for Planned Place of Birth* (Appendix 3) and *Statement on Home Birth* (Appendix 4);
- informing yourself about your eligibility for home birth through review of your medical and obstetrical history, physical examination findings, and screening and diagnostic tests with your midwife;
- informing yourself about the current research pertaining to the risks, benefits, and safety of home birth including procedures and emergency measures provided in the local hospital that would not be available at home;
- informing yourself about the approximate rate of transport to hospital from a planned home birth, including the risks associated with potential delays in accessing medical services;
- taking the time to discuss issues and concerns with your midwife and to ask her questions;
- talking with your midwife about your ongoing risk assessment throughout pregnancy, labour, birth and the postpartum period and discussing any deviations from normal that would necessitate transport to hospital;
- possibly being referred for a consultation with a physician, if indicated, using the CMBC's *Indications for Discussion, Consultation and Transfer of Care*, (Appendix 2) and your midwife's professional judgment;
- informing yourself of the risks and benefits of any treatments and procedures the midwife uses in the home setting;

- taking responsibility to be forthright about any changes or circumstances that could potentially affect your health and safety in giving birth in the home;
- agreeing to transport to hospital during labour or the immediate postpartum should problems arise that cannot be safely managed out-of-hospital, as indicated by the list of clinical conditions precluding home births (Section B); and
- agreeing to allow your midwife to proceed with emergency measures if required.

Your midwife will provide you with the information you need to make informed choices about your care, and with time and opportunities for discussion and for answering your questions throughout your care.

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Appendix 1

THE HOME BIRTH DEMONSTRATION PROJECT – A SUMMARY OF THE RESULTS

The Home Birth Demonstration Project (HBDP) was designed to integrate midwife-attended home births into the British Columbia health care system, as a safe choice for pregnant women. Prior to the regulation of midwifery in January 1998, midwives managed home births outside the health care system, and relationships and interaction with physicians, hospitals and emergency services varied greatly across the province. With the regulation of midwifery, the project monitored the integration of midwives into the health care system and facilitated the development of systems to support a smooth transition from home to hospital when necessary.

Midwives and their clients were required to participate in the project from the beginning of registration on January 1, 1998, until October 31, 2000. The project encompassed all geographical areas in the province where midwives practiced. This enabled the project to assess integration in non-urban as well as urban areas, across communities with different hospital capabilities, access to specialists, and ambulance transport conditions. It also enabled midwives to continue caring for clients they had before the onset of regulation. In January 1998, 29 midwives were practicing in BC based in nine communities, the majority (69%) in Victoria and Vancouver. By September 2000, the number of practicing midwives had increased to 61, based in 24 communities. Now the majority (59%) of midwives practice outside Victoria and Vancouver.

The BC Ministry of Health established the HBDP Advisory Committee, composed of health care professionals, representatives from the College of Midwives of BC (CMBC), and ministry staff, to design and oversee the project, as well as advise on emerging issues. The Committee set policies and protocols to guide midwives' interactions with clients, hospitals, physicians, and emergency services during the integration process. A data collection and monitoring system was established to identify systemic issues as well as provide a basis for evaluation.

The Ministry contracted with the Centre for Health Evaluation Research at the BC Research Institute for Children's and Women's Health⁶ to provide ongoing monitoring of incoming data and to conduct an outcome evaluation. Cases involving emergency transports to hospital, adverse outcomes and unattended births were identified and subsequently forwarded to a panel of clinical experts, who reviewed them to identify practice and integration issues. Reviews were based on anonymous documents that did not identify clients, midwives, hospital staff, physicians, and paramedics, to maintain the

6. The BC Research Institute for Children's and Women's Health (BCRICWH) is a partnership of Children's and Women's Health Centre of British Columbia (CWHCBC) and the University of British Columbia. The evaluation team consisted of Patricia Janssen, MPH, PhC Epidemiology, Research Associate, CWHCBC (Project Leader); Shoo Lee, PhD, Director, Centre for Health Evaluation Research; Martin Mroz, Data base administrator, BCRICWH; and Laurie MacWilliams, statistician, BCRICWH.

focus on systemic issues rather than individual practices.

The evaluation team conducted an analysis and evaluation of the first two years of data, which consisted of 864 planned home births occurring in 1998 and 1999. Fifty-eight midwives were involved in the management of these births. The objectives of the evaluation were to assess whether safe and appropriate care was provided to clients, whether midwives complied with the communication requirements set out by the project, and to examine client experience during the project.

The HBDP was initially designed as a two-year project, but was later extended to October 31, 2000, to complete the evaluation process. The duration of the project was based on the need to assess the outcomes of a large number of home births in order to identify systemic issues and to establish statistical rates for comparison with births in the hospital setting. As the evaluation of the project shows, even a two-year period of data collection was insufficient to evaluate infrequent outcomes.

Outcome Evaluation

To assess the provision of safe and appropriate care the evaluation team reviewed records to confirm that midwives were providing care within the standards set by the College. The team compared the incidence of adverse maternal and newborn birth outcomes in the 864 planned home births in the project with low risk births that occurred in a hospital setting during the same period. Two hospital comparison groups were formed; one consisting of births attended by physicians (743 births) and the other of births attended by midwives (571 births).

The evaluation objectives were to assess:

- whether safe and appropriate care had been provided to clients;
- whether midwives had complied with the communication requirements set out in the project policies and protocols;
- client experience during the project.

The comparison groups allowed the evaluation to distinguish between differences due to setting and differences more likely due to style of practice.

Overview of Evaluation Findings

Safe and Appropriate Care

Appropriateness of Client Screening

- Midwives were able to appropriately screen women for planned home birth. 94% of enrolled clients were eligible to deliver at home according to College policy.

Consultations and Transfers of Care to Physicians

- Midwives practiced home birth cautiously, consulting physicians in 33% of cases, at some point during the course of care. Midwives were able to obtain a consultation when needed in 98% of cases.
- In 18% of births, care of the mother and/or newborn was transferred to physician care. Midwives were able to transfer care when needed in 97% of cases. In over 90% of transfers, the midwife later reassumed care.
- Early in the project, difficulties in obtaining consultations or transfers were sometimes due to a lack of receptiveness by physicians. Later on, difficulties were more related to physicians not being present or available in the hospital. In general, the consultation and transfer process worked efficiently for midwives and their clients.

Birth Setting and Second Attendant

- 76% of births planned for the home took place in the home or a home-like setting (friend's home, hotel); 24% took place in hospital.
- A second attendant was present at 91% of home births. Precipitate birth was the major reason for the absence of a second attendant.

Transports to hospital

- 22% of births attempted at home resulted in a transport to hospital either during labour or the postpartum period. 4% of births attempted at home resulted in an emergency transport.
- HBDP clients were likely to be approximately 10 minutes away from ambulance assistance and 37 minutes away from hospital admission.
- Hospital staff did not report any problems with transport and admission to hospital other than that hospital staff was not always immediately available.
- In 87.5% of emergency transports, a physician assessed the client within 10 minutes of the client's arrival at hospital.

Clinical Outcomes

- Rates of maternal adverse outcomes were low for all study groups. Home births were associated with significantly fewer infections than hospital births and resulted in fewer 3rd or 4th degree lacerations than for midwife-attended hospital births.
- There was no difference in the rate of maternal postpartum hemorrhage between home and hospital birth. The two cases of obstetrical shock and three of the four cases requiring blood transfusion occurred in the home birth group. Larger numbers would be needed to know if this has significance, but the College of Midwives has subsequently made regular updating of emergency management skills mandatory for all midwives.
- The study did not identify any increased risk of adverse outcomes for the newborn associated with home birth. Three of the four perinatal deaths in the study groups occurred in the home birth group (two stillbirths, one neonatal death⁷), but these numbers are consistent with the expected perinatal mortality rate for a low-risk population, and the overall numbers are too low for statistical comparison. At the current annual rate of midwife-attended planned home births in BC, a study large enough to compare perinatal death rates would require 7-8 years of data collection.
- Incidence of low Apgar scores, birth asphyxia, meconium aspiration, low birth weight, and seizures did not differ between the home birth and hospital birth groups.
- Although newborn exposure to thick meconium and meconium aspiration did not differ between home and hospital births, fewer babies in the home birth group received tracheal suction, including babies who required resuscitative efforts at birth.

Clinical Interventions

Rates of interventions during the intrapartum period were predictably lower for the planned home birth group than for the planned hospital births of similarly low-risk women cared for by both midwives and physicians. Significantly lower rates of intervention were found for analgesia/anesthesia, electronic fetal monitoring, augmentation of labour, induction of labour, episiotomy, and cesarean section.

7. Among the three cases of perinatal death, one stillbirth had no obvious explanation and an autopsy was refused. Based on a clinical assessment, death appeared to have occurred before the onset of labour. In the second stillbirth, the final cause of death on autopsy was reported as undetermined and death was thought to have occurred within a few hours of delivery. Transport was initiated in early labour. The cause of death for an infant who died at two days of age was severe hypoxic-ischemic encephalopathy. This case was the subject of a coroner's inquest that ruled the final cause of death undetermined.

Compliance with Communication Requirements

- In 96% of cases, midwives pre-registered the client with the hospital at 36 weeks gestation.
- Midwives notified hospitals when labour was established in 76% of births where the intended place of birth was at home. The major reasons stated for non-notification was that the client was transferred to hospital or the birth happened soon after the midwife arrived.
- In 94% of births at home, midwives notified the hospital when labour was complete.

Client Satisfaction

- 80% of home birth clients received satisfaction questionnaires to fill out from their midwives⁸. The response rate for these clients was 82%. Those who submitted questionnaires to the project expressed their overwhelming support for planned home birth.

The evaluation team recommended the continuation of planned home births in BC within the guidelines established by the College of Midwives of BC.

Actions Taken During and Following the Project

Throughout the project, the HBDP Advisory Committee and the CMBC have responded to issues and events as they arose, as well as to the recommendations that came from the evaluation team.

The CMBC has communicated with midwives regularly on a variety of clinical issues related to home birth and has taken the following actions:

- added the use of a partogram to the requirements for record-keeping during labour;
- developed a continuing education module for midwives on documentation;
- developed a midwifery-specific guideline for assessment of the fetal heart in labour;
- developed a guideline for home birth after a previous cesarean section;
- added re-certification in emergency management skills to existing requirements for neonatal and cardiopulmonary resuscitation re-certification;
- provided midwives with additional support and encouragement for upgrading and maintaining endotracheal intubation skills;

8. Clients returned questionnaires directly to the Ministry of Health.

- met with representatives from BC Ambulance Service to clarify the role of the midwife as the most responsible caregiver during the transport of midwifery clients from home to hospital.

While the project has now ended, the College remains committed to supporting continuous improvement in midwifery care for clients choosing home birth. Standards, policies and clinical practice guidelines are reviewed regularly to ensure that they are based on the most recent evidence and support a high quality of care.

Appendix 2

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

INDICATIONS FOR DISCUSSION, CONSULTATION AND TRANSFER OF CARE

As a primary caregiver, the midwife is fully responsible for decision-making, together with the client. The midwife is responsible for writing orders and carrying them out or delegating them in accordance with the standards of the College of Midwives.

The midwife discusses care of a client, consults, and/or transfers primary care responsibility according to the *Indications for Discussion, Consultation and Transfer of Care*. The responsibility to consult with a family physician/general practitioner, obstetrician and/or specialist physician lies with the midwife. It is also the midwife's responsibility to initiate a consultation within an appropriate time period after detecting an indication for consultation. The severity of the condition and the availability of a physician will influence these decisions.

The College of Midwives expects members to use their professional judgement in making decisions to consult or transfer care. The following list is not exhaustive. Other circumstances may arise where the midwife believes consultation or transfer of care is necessary.

The informed choice agreement between the midwife and client should outline the extent of midwifery care, so that the client is aware of the scope and limitations of midwifery care. The midwife should review the *Indications for Discussion, Consultation and Transfer of Care* with the client.

DEFINITIONS

Discussion with Another Midwife or a Physician⁹

It is the midwife's responsibility to initiate a discussion with, or provide information to, another midwife or a physician in order to plan care appropriately. It is also expected that the midwife will conduct regularly scheduled reviews of client charts to assist in planning care. Discussion should be documented by the midwife in her records.

Consultation with a Physician¹⁰

It is the midwife's responsibility to initiate a consultation and to communicate clearly to the consultant that she is seeking a consultation. A consultation refers to the situation where a midwife, using her professional knowledge of the client and in accordance with the standards of the College of Midwives, requests the opinion of a physician competent to give advice in the relevant field. A midwife may also seek a consultation when another opinion is requested by the client. Consultation must be documented by the midwife in her records in accordance with the standards of the College of Midwives.

⁹ Discussion should occur with a physician, or with another primary care provider such as a nurse practitioner, where another midwife is not available.

¹⁰ In this document, consultation with a physician means consultation with a physician licensed by the College of Physicians and Surgeons of BC unless otherwise specifically indicated.

The midwife should expect that the consultant will address the problem that led to the referral, conduct an in-person assessment(s) of the client, and promptly communicate findings and recommendations to the client and to the referring midwife. Discussion may then occur between the midwife and the consultant regarding the future care of the client.

Where urgency, distance or climatic conditions do not allow an in-person consultation with a physician, the midwife should seek advice from the physician by phone or other similar means. The midwife should document this request for advice in her records, in accordance with the standards of the College of Midwives, and discuss the advice received with the client.

A consultation can involve the physician providing advice and information, and/or providing therapy to the woman/newborn, or prescribing therapy to the midwife for the woman/newborn.

After consultation with a physician, primary care of the client and responsibility for decision-making, with the informed consent of the client, either:

- a) continues with the midwife, or
- b) is transferred to physician.

If care is transferred to a physician, the midwife may continue to provide supportive care and whatever care is within her scope of practice and is agreed to by the physician who is in the role of most responsible care provider.

Once a consultation has taken place and the consultant's findings, opinions and recommendations have been communicated to the client and the midwife, the midwife must discuss the consultant's recommendations with the client and ensure that the client understands which health professional will have responsibility for primary care.

The consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within her scope of practice. Areas of involvement in client care must be clearly agreed upon and documented by the midwife and the consultant.

Only one health professional has overall responsibility for a client at any one time, and the client's care should be co-ordinated by that person. The identity of the primary caregiver should be clearly known to all of those involved and documented in the records of the referring health professional and the consultant. Responsibility could be transferred temporarily to another health professional, or be shared between health professionals, according to the client's best interests and optimal care; however, transfer or sharing of care should occur only after discussion and agreement among the client, the referring health professional, and the consultant(s).

Transfer to a physician for primary care

When primary care is transferred permanently or temporarily from the midwife to a physician, the physician assumes full responsibility for subsequent decision-making, together with the client. When primary care is transferred to a physician, the midwife may provide supportive care within her scope of practice, in collaboration with the physician and the client.

INDICATIONS: Initial History and Physical Examination

Discussion:

- adverse socio-economic conditions
- age less than 17 years or over 40 years
- cigarette smoking
- grand multipara (5 or more previous births)
- history of infant over 4,500 g
- history of one late miscarriage (after 14 weeks) or pre-term birth
- history of one low-birth-weight infant
- history of serious psychological problems
- less than 12 months from last delivery to present due date
- obesity
- poor nutrition
- previous antepartum haemorrhage
- previous postpartum haemorrhage
- one documented previous low-segment caesarean section
- history of essential or pregnancy-induced hypertension
- known uterine malformations or fibroids

Consultation

- current medical conditions, for example: cardiovascular disease, pulmonary disease, endocrine disorders, hepatic disease, neurologic disorders, severe gastrointestinal disease
- family history of genetic disorders, hereditary disease or significant congenital anomalies
- history of cervical cerclage or incompetent cervix
- history of repeated spontaneous abortions
- history of more than one late miscarriage or pre-term birth
- history of more than one low-birth-weight infant
- history of eclampsia
- history of significant medical illness
- previous myomectomy, hysterotomy or caesarean section other than one documented previous low-segment caesarean section
- previous neonatal mortality or stillbirth
- rubella during first trimester of pregnancy
- significant use of drugs, alcohol or other toxic substances
- age less than 14 years
- history of postpartum haemorrhage requiring transfusion

Transfer:

- any serious medical condition, for example: cardiac or renal disease with failure, or insulin-dependent diabetes mellitus

INDICATIONS: Prenatal Care

Discussion:

- presentation other than cephalic at 4 weeks prior to due date
- no prenatal care before 28 weeks gestation
- uncertain expected date of delivery

Consultation:

- anaemia (unresponsive to therapy)¹¹
- documented post-term pregnancy (42 completed weeks)
- suspected or diagnosed foetal anomaly that may require physician management during or immediately after delivery
- inappropriate uterine growth
- medical conditions arising during prenatal care, for example: endocrine disorders, hypertension, renal disease, suspected significant infection, hyperemesis
- placenta previa without bleeding
- polyhydramnios or oligohydramnios
- pregnancy-induced hypertension
- isoimmunization, haemoglobinopathies, blood dyscrasia
- serious psychological problems¹²
- sexually transmitted disease¹³
- twins¹⁴
- repeated vaginal bleeding other than transient spotting
- presentation other than cephalic at 37 weeks

Transfer:

- cardiac or renal disease with failure
- insulin-dependent diabetes
- multiple pregnancy (other than twins)
- proteinuric pre-eclampsia or eclampsia
- symptomatic placental abruption

INDICATIONS: During Labour and Delivery

Discussion:

- no prenatal care
- thin, non-particulate meconium¹⁵

11 Consultation may be with a physician or a nurse-practitioner

12 Consultation may be with a physician, clinical psychologist, mental health worker, or nurse practitioner.

13 Consultation may be with a physician, or a nurse-practitioner.

14 In many settings the management of a twin pregnancy will involve transfer of care to an obstetrician. The midwife may continue to provide supportive care and whatever care is within her scope of practice and is agreed to by the physician who is in the role of most responsible care provider.

15 Whenever meconium is present the midwife in attendance must be prepared to intubate any non-vigorous newborn.

Consultation:

- breech presentation¹⁶
- pre-term labour (34-37 completed weeks)
- prolonged active phase
- prolonged rupture of membranes
- prolonged second stage
- suspected placenta abruption and/or previa
- retained placenta
- third or fourth degree tear
- twins¹⁷
- unengaged head in active labour in primipara
- thick or particulate meconium¹⁸

Transfer:

- temperature over 38°C on more than one occasion
- active genital herpes at time of labour
- pre-term labour (less than 34 weeks)
- abnormal presentation (other than breech)
- multiple pregnancy (other than twins)
- proteinuric pre-eclampsia or eclampsia
- prolapsed cord
- placenta abruption and/or previa
- severe hypertension
- abnormal foetal heart rate patterns unresponsive to therapy
- uterine rupture
- uterine inversion
- haemorrhage unresponsive to therapy
- obstetric shock

16 While many of these deliveries may become transfers of care, breech presentation and twins are listed as indications for consultation to allow an obstetrical consultant discretion in deciding if a midwife may manage such a delivery, where a spontaneous birth is reasonably anticipated. Usually a midwife would conduct the delivery under the direct supervision of an obstetrician. In a remote area, the availability of an experienced midwife who has the confidence of her obstetrical colleagues can prevent a woman from having to leave her family and community. Midwives may also gain important hands-on experience under obstetrical supervision.

17 See footnote #16 above

18 Where thick or particulate meconium is identified, delivery in hospital is indicated unless the membranes rupture so close to the time of birth that transport to hospital would be unsafe. The midwife should initiate appropriate surveillance of fetal well-being (see *Guideline for Fetal Health Surveillance in Labour*) and consult with a physician in hospital. Indicators such as a reassuring or non-reassuring fetal heart rate pattern will affect whether or not transfer of care during labour is indicated. With thick or particulate meconium, it is important to have a midwife or physician in attendance who is both skilled and prepared to intubate any non-vigorous newborn. In hospitals where pediatricians are available on-call, it is recommended that a pediatrician be consulted and in attendance at the birth.

INDICATIONS: Postpartum (Maternal)

Consultation:

- breast infection unresponsive to therapy¹⁹
- wound infection²⁰
- uterine infection²¹
- signs of urinary tract infection²²
- temperature over 38°C on more than one occasion²³
- persistent hypertension
- serious psychological problems²⁴

Transfer:

- haemorrhage unresponsive to therapy
- postpartum eclampsia
- thrombophlebitis or thromboembolism
- uterine prolapse

INDICATIONS: Postpartum (Infant)

Discussion:

- feeding problems²⁵

Consultation:

- suspicion of or significant risk of neonatal infection
- 34 to 37 weeks gestational age²⁶
- infant less than 2,500 g
- less than 3 vessels in umbilical cord
- excessive moulding and cephalohaematoma
- abnormal findings on physical exam
- excessive bruising, abrasions, unusual pigmentation and/or lesions
- birth injury requiring investigation
- congenital abnormalities, for example: cleft lip or palate, congenital dislocation of hip, ambiguous genitalia
- abnormal heart rate or pattern
- persistent poor suck, hypotonia or abnormal cry
- persistent abnormal respiratory rate and/or pattern
- persistent cyanosis, pallor or jitteriness
- jaundice in first 24 hours
- failure to pass urine or meconium within 24 hours of birth
- suspected pathological jaundice after 24 hours
- temperature less than 36°C unresponsive to therapy

19 Consultation may be with a physician or a nurse-practitioner

20 Consultation may be with a physician or a nurse-practitioner

21 Consultation may be with a physician or a nurse-practitioner

22 Consultation may be with a physician or a nurse-practitioner

23 Consultation may be with a physician or a nurse-practitioner

24 See footnote #12 on page 28

25 Discussion may be with another midwife, a physician, a nurse-practitioner or a lactation consultant.

26 Consultation may be with a physician or a nurse-practitioner

- temperature more than 37.9°C unresponsive to therapy
- vomiting or diarrhoea²⁷
- infection of umbilical stump site²⁸
- significant weight loss (more than 10% of body weight)
- failure to regain birth weight in 3 weeks
- failure to thrive

Transfer:

- Apgar score lower than 7 at 10 minutes
- suspected seizure activity
- significant congenital anomaly requiring immediate medical intervention, for example: omphalocele, myelomeningocele
- temperature instability

²⁷ Consultation may be with a physician or a nurse-practitioner

²⁸ Consultation may be with a physician or a nurse-practitioner

Appendix 3

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

INDICATIONS FOR PLANNED PLACE OF BIRTH

There is an important distinction to be made between a client's choice of the caregiver she wishes to attend her during pregnancy and childbirth, and her choice of the setting in which she plans to give birth. A client may choose a midwife to provide care. Similarly, a client may choose to give birth at home, in an out-of-hospital birth centre, or in hospital.

A midwife providing primary care will provide or make accessible to her client all the information the client wishes or requires to make an informed decision about the appropriate setting for her to plan to give birth. Where consultation has taken place, this information will include the recommendation of the consultant.

When care has been transferred to a physician, either because it has been required as an indication for a transfer of care or because of some other complicating condition, it is unlikely that out-of-hospital birth will be considered appropriate.

When the midwife is providing primary care, she will support the client's choice, after the client has carefully considered the information and recommendations. In the event that a client requests a home birth despite having been advised that such a course of action might be outside midwifery standards of practice, the midwife will follow CMBC policy.²⁹ There are a number of situations in which a hospital birth should be planned. Multiple birth, breech presentation, pre-term labour prior to 37 weeks of pregnancy, and documented post-term pregnancy of more than 43 weeks are examples of such situations. Other situations in which hospital birth should be planned will be assessed on an ongoing basis during pregnancy and the intrapartum period, with appropriate consultation as detailed in *Indications for Discussion, Consultation and Transfer of Care*.

²⁹ Refer to *Policy for Client Requests Outside Midwifery Standards of Practice*.

Appendix 4

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

STATEMENT ON HOME BIRTH

In British Columbia most births occur in hospital and midwives must be available to attend birth in this setting. However, some expectant parents will continue to choose to give birth in their own homes and midwives must be fully trained and equipped to attend them.

A 1986 World Health Organisation report concluded that *“home is the most appropriate birth setting for most childbearing women. Women (and their attendants) choosing this option must be provided with necessary diagnostic, consultative, emergency and other services as required, regardless of place of birth.”*⁽¹⁾

In the Netherlands, where the perinatal mortality rate is one of the lowest in the world, approximately 35% of all births take place at home. An integrated system of home birth services includes well-trained midwives who carry emergency equipment, and a well-established system for emergency transport and the reception of home birth transfers in hospital.⁽²⁾

The College of Midwives of British Columbia (CMBC) endeavors to unite practitioners (midwives, physicians, nurses, hospital staff and ambulance personnel) with the common goal: ***that home birth be made as safe as possible for mothers and babies in B.C.***

Informed choice

Midwifery promotes decision-making as a shared responsibility between the woman, her family (as defined by the woman) and her caregivers. Midwives recognise women as primary decision makers.*

The CMBC supports a woman’s right to choose to give birth in her own home with her family. The World Health Organisation describes health as multi-dimensional.⁽³⁾ Decisions about health are based on many factors including physical, emotional, social, spiritual and cultural considerations. Women must be free to make decisions regarding birth based on all of these factors. Birth is more than a physical or medical event.

In 1993, the American College of Obstetricians and Gynaecologists issued the following statement:

Informed consent is an expression of respect for the patient as a person; it particularly respects a patient’s right to bodily integrity, to self-determination, and supports the patient’s freedom within caring relationships. It also makes possible the active involvement of the patient in planning and care through a process that includes ongoing shared information and developing choices. This freedom is maximised in relationships marked by mutuality and equality.⁽⁴⁾

* Supporting the woman as an active decision maker is what makes the process of informed choice different from the process of obtaining informed consent.

The International Confederation of Midwives' Code of Ethics states that: "*Midwives respect a woman's informed right of choice and promote the woman's acceptance of responsibility for the outcomes of her choices. Midwives work with women, supporting their right to participate actively in decisions about their care, and empowering women to speak for themselves on issues affecting the health of women and their families in their culture/society.*"⁽⁵⁾

Throughout pregnancy and childbirth, midwives have the duty to fully inform the women in their care about the safety, efficacy, risks and benefits of care options and to support women in making decisions about their care, including their choice of birth place.

Safety

For parents and care providers concerned with childbirth, the issue of safety is central. In supporting normal birth at home, the CMBC is not advocating that all births take place at home. There are mothers and babies who will be safer in hospital and many mothers will choose hospital birth.

Available evidence confirms that for low-risk women, a planned home birth with trained attendants is a safe and viable option.^(6, 7, 8, 9, 10, 11, 12, 13, 14) In Alberta, a review of the literature on the safety of home birth was undertaken for the government and concluded that "*with proper risk assessment, selection and care, low risk women may safely give birth at home.*"⁽¹⁵⁾ A ten-year retrospective evaluation of 49,371 births (10,998 out of hospital) in Washington state found no significant difference in neonatal mortality between licensed midwives, physicians and nurse-midwives, regardless of place of birth.⁽¹⁶⁾

The literature has demonstrated that when home births are planned with a well-screened population of women, and attended by professionally trained midwives carrying emergency equipment, optimum safety conditions are met and the best outcomes are achieved.^(17, 18, 19, 20, 21) The CMBC has developed a list of *Indications for Discussion, Consultation and Transfer of Care*⁽²²⁾, as well as *Indications for Planned Place of Birth*⁽²³⁾ to guide midwives in risk assessment.

It is often assumed that a hospital, by virtue of immediate access to technological support, provides maximum safety. In fact the available literature does not provide conclusive evidence that hospital birth is safer for properly screened clients. Many hospitals in rural and northern communities do not provide on-site operative delivery, and have emergency equipment comparable to the equipment a midwife carries to a home birth. With careful antenatal screening, these hospitals have been able to deliver safe and effective care to women and their babies.^(24, 25, 26)

Even where home birth numbers are small, it has been observed that it is at home that birth is most likely to remain normal.^(27, 28) Home birth provides midwives with an opportunity to observe normal birth without intervention, which can in turn lead to a reduction in interventions in hospital. Providing home birth services offers the opportunity to examine and promote normal birth, as well as to support one of midwifery's fundamental principles - choice.⁽²⁹⁾

Internationally, maternity care is moving toward clinical practice that is evidence or research-based⁽³⁰⁾ and current research does not support the routine use of many obstetrical procedures.^(31, 32) In several countries, including the U.K.,⁽³³⁾ Australia⁽³⁴⁾ and the U.S.,⁽³⁵⁾ initiatives are underway to encourage health care professionals to offer home birth as a safe and viable option for low-risk women.

The CMBC encourages further research into the conditions which support safe home birth. When

midwifery was first regulated in BC, the College joined the Ministry of Health in requiring all BC midwives to participate in the Home Birth Demonstration Project to determine how to best organize and administer home birth services in BC to ensure the safest possible care. The project's independent evaluation team conducted an analysis and evaluation of data from both midwife-attended home births and a comparison group of low-risk hospital births for 1998 and 1999. As a result of their evaluation they recommended that home birth services continue to be delivered by registered midwives to a well-screened low-risk population of BC women.⁽³⁶⁾

The *Home Birth Demonstration Project* outcomes were also published the in the *Canadian Medical Association Journal* in 2002⁽³⁷⁾.

This statement has been adapted from the Midwives Association of B.C. *Statement on Home Birth (August 1992)*, and the Ontario College of Midwives *Statement on Home Birth (January 1994)*. It was first issued by the CMBC in 1997 and was updated and re-issued in October 2005.

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Appendix 5

Home Birth Informed Consent

I, _____ (the client), am aware that only a midwife registered with the College of Midwives of British Columbia may provide midwifery services, including conducting home birth, and I am satisfied that my midwife is so registered.

1. My midwife has discussed with me the following information:
 - a. the benefits of home birth,
 - b. the risks associated with home birth,
 - c. the alternatives to home birth, including the option of giving birth in hospital with a registered midwife in attendance,
 - d. the standard procedures and emergency measures that may be used by a midwife assisting with home birth,
 - e. the standard procedures and emergency measures available in the hospital that will not be available at a home birth, without transport to hospital,
 - f. the criteria when transport from home to hospital is indicated,
 - g. the situations when transfer of care from a midwife to a physician would be appropriate and the procedures for carrying out a transfer with the midwife remaining in a supportive role, and
 - h. the inability to predict birth outcome in any setting.
2. I have received and had the opportunity to read and discuss with my midwife the Home Birth Handbook for Midwifery Clients.
3. My midwife has answered all of my questions concerning home birth to my satisfaction.
4. I understand the information given to me and wish to plan a home birth.
5. As a client planning a home birth:
 - a) I agree to transport to hospital during labour or the immediate postpartum should problems arise that cannot be safely managed outside of a hospital.
 - b) I understand that planning a home birth will not ensure me a home birth,
 - c) I understand that I can change my plan at any time, and choose to give birth in hospital with the support of my midwife.
 - d) I will provide my midwife with all relevant information about my health status or other circumstances that could potentially affect the health or safety of giving birth at home,
 - e) I understand that all information about myself and my baby will be kept confidential, except as required by law, and will be afforded the privacy protections of the BC Personal Information Protection Act,
 - f) I understand that some of the information I provide will be submitted to the BC Perinatal Health Program (BCPHP), a program of the Provincial Health Services Authority, for inclusion in a provincial perinatal registry.
 - i. The data submitted will be kept confidential, except as required by law, and will be afforded the privacy protections of the BC Freedom of Information and Protection of Privacy Act.
 - ii. The data submitted will be used to evaluate perinatal outcomes, care processes and resources, ultimately improving maternal, fetal, and newborn care in British Columbia.
 - iii. I understand that if I have any questions regarding the collection, use and disclosure of my personal information, I can contact the Registrar at the BC College of Midwives at registr@cmbc.bc.ca or (604) 742-2234.

Signed at _____, British Columbia,
_____, on _____
(City/Town) (Date)

(Signature of Client) (Signature of Witness)

Midwife: _____

(Print name of Witness)

Reg. #: _____

Appendix 6

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

REQUIRED EQUIPMENT AND SUPPLIES FOR HOME BIRTH SETTING

The following list is the minimum required equipment and supplies necessary for safety in the home birth setting. There may be further equipment and supplies that individual midwives will choose to carry depending on their particular practice location and clientele served. It is expected that all equipment and supplies will be appropriately cleaned, disinfected or sterilised and functional to ensure safety. It is expected that all midwives will have access to appropriate communications and transportation equipment. It is understood that midwives will use their best clinical judgement in prioritizing their actions in the management of emergency situations. Some emergency procedures, such as umbilical vein cannulation, will not be able to be carried out without an adequate number of qualified attendants available to assist.

EQUIPMENT

- Foetoscope
- Doppler foetoscope
- Stethoscope
- Paediatric stethoscope
- Sphygmomanometer with appropriate sized cuff
- Thermometer
- Two haemostats
- Portable suction equipment compatible with intubation
- Newborn intubation equipment
- One pair of blunt-ended scissors
- One pair of scissors for episiotomy
- Newborn resuscitation bag and mask
- Newborn laryngeal mask airway
- Equipment for administration of epinephrine and/or fluids for volume expansion via the umbilical vein³⁰(effective May 1, 2009)
- Suturing instruments
- Baby scale

MEDICATIONS

- Oxytocic drugs
- Local anaesthetic
- Epinephrine
- Oxygen (sufficient for transport)

30 Minimally syringes (for epinephrine 1/10,000 .1ml/K followed by normal saline flush), 3-way stop cock and UV cannula or #5 sterile feeding tube. Midwives may also carry other supplies and equipment that support umbilical vein cannulation.

- Eye prophylaxis
- Vitamin K
- IV fluids

SUPPLIES

- Cord clamps or ties
- Antiseptic solution
- Sterile gloves
- Non-sterile gloves
- Sterile lubricant
- Syringes
- Needles (appropriate sizes)
- Suture material
- Urinary catheter
- Urinalysis supplies
- Cord blood tubes
- Sharps container
- IV supplies
- Maternal oxygen masks
- Oral airways

A midwife must carry an emergency birth kit whenever she is in attendance with a woman in labour, regardless of stage of labour or planned place of birth. The kit must include:

- 2 hemostats
- 1 pair of scissors
- 1 cord clamp
- gauze
- oxytocin
- syringe with needle
- suction

Appendix 7

SAMPLE LIST OF CLIENT SUPPLIES FOR HOME BIRTH

(Your midwife may have her own list of suggested supplies)

- 1 small bottle of Hibitane or other anti-bacterial Skin Cleanser
- 24 4 X 4" sterile gauze squares
- 24 disposable underpads (approximately 18" X 24")
- 2 rolls of paper towels
- 1 oral thermometer (preferably Celsius)
- 1 hot water bottle or heating pad
- 1 flashlight and extra batteries
- 2 gel-type cold packs (place in freezer)
- 1 plastic sheet (shower curtain, vinyl tablecloth or plastic mattress cover) to cover mattress
- 1 large box of sanitary pads (overnight, extra long or maternity)
Ibuprofen or Tylenol (acetaminophen, not aspirin) for after pains
- 2 large garbage bags
- 1 ziplock bag or yogurt container (for placenta)

LINEN

- 2 flat sheets
- 2 fitted sheets
- 2 hand towels
- 4-6 large towels
- 8 wash cloths
- 8 receiving blankets
- diapers
- newborn nightgowns or sleepers

OPTIONAL

- 1 small, unopened bottle of unscented oil (olive, vitamin E, etc.)
- 1 large pot with lid or electric crock pot
- 1 hand mirror
- 1 or 2 pairs of disposable, net underwear
- 1 box of newborn paper diapers for the first few days
- homeopathic arnica

Appendix 8

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

INFORMED CHOICE POLICY

Informed choice is a fundamental principle of midwifery care in British Columbia. Women have the right to receive information and be involved in the decision-making process throughout their midwifery care. In the College of Midwives of British Columbia's *Philosophy of Care* document, the childbearing woman is recognised as the primary decision-maker. The interactive process of informed choice involves the promotion of shared responsibility between the midwife and her client. Midwives encourage and give guidance to clients wishing to seek out resources to assist them in the decision-making process. It is the responsibility of the midwife to facilitate the ongoing exchange of current knowledge in a non-authoritarian and co-operative manner, including sharing what is known and unknown about procedures, tests and medications.

The College of Midwives of British Columbia requires that registered midwives provide each client with the following information at the onset of their care, ideally given in writing and followed up in discussion:

- education and experience in midwifery of the midwives in the practice;
- services provided, including:
 - scope of practice
 - philosophy of care
 - choice of birth setting
- contact information, including how the client can reach a midwife known to her 24 hours a day³¹, change of appointment procedure, off-call coverage arrangements, back-up arrangements;
- second attendant arrangements, if applicable;
- standards of practice and protocols, including:
 - continuity of care
 - consultation and transfer of care
 - supportive care
- role and responsibilities of the client;
- confidentiality and access to client records;
- any student and/or supervised practice arrangements.

The College of Midwives of British Columbia requires registered midwives to provide each client with the following information throughout the course of care:

- potential benefits and risks of, and alternatives to, procedures, tests and medications;
- relevant research evidence;
- community standards and practices.

31 Where a midwife is in solo practice and cannot make arrangements for on-call coverage by another midwife, she must inform her client of how to access an alternate primary caregiver when she is off-call. Ideally that alternate care provider would also be known to the woman.

Appendix 9

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

POLICY FOR SECOND BIRTH ATTENDANTS

It is required that two people trained and currently certified in CPR and neonatal resuscitation attend each birth according to the *Standards of Practice Policy* of the College of Midwives of BC (the College).

The ideal assistant to the principal midwife at a birth would be another midwife. However, the second attendant the midwife will choose to assist at a birth will depend on many factors. Some of these will be dictated by the geographic area in which she works, the availability of appropriate professionals in that area, and the midwife's and the woman's preferences. Ideally, the second birth attendant will be known to the woman.

Use of a second birth attendant who is not a registered midwife must be approved by the College. Please see "Approval Process" below. Only general registrants without conditions or limitations on their registration may use second birth attendants who are not registered midwives at out-of-hospital births.

Where a midwife works with a second attendant, the midwife is responsible for primary care throughout the full course of care. The midwife must ensure that the care provided is in accordance with the *Philosophy of Midwifery Care* and the *Code of Ethics* of the College of Midwives. The midwife may not delegate reserved acts to a second birth attendant who is not otherwise legally authorized to perform them, and may not ask a second birth attendant to provide client care beyond the roles and duties outlined below which must be carried out under the direct supervision of the midwife. **Sole attendance with a woman in labour is not considered an appropriate responsibility for the second birth attendant who is not a registered midwife or licensed physician.**

The second birth attendant is expected to be present with the principal midwife for the second and third stage of labour. At the discretion of the principal midwife in attendance, a second attendant may be asked to be present prior to the second stage of labour.

It is the responsibility of the principal midwife attending a birth to ensure that:

1. The second birth attendant is competent and currently certified in the following:
 - a) Neonatal resuscitation; and
 - b) Cardiopulmonary resuscitation.
2. The second birth attendant is knowledgeable and competent in the following:
 - a) Assessment of vital signs (blood pressure, pulse, temperature, respirations);
 - b) Postpartum assessment of uterine tone and position, and blood loss;
 - c) Body substance precautions;
 - d) Basic knowledge of labour and birth;
 - e) Basic knowledge of instruments, supplies and drugs used by midwives;
 - f) Appropriate record keeping; and
 - g) Basic knowledge and understanding of midwifery in B.C. and the midwife's practice protocols.

The midwife and her practice may use multiple evaluation processes including

interviews, oral assessments, and review of documentation such as references, registration certificates and certificates for CPR and neonatal resuscitation, to evaluate the knowledge base and competence of a second birth attendant. Documentation of this process should be maintained by the midwifery practice.

Potential Second Birth Attendants if a Second Midwife is Unavailable:

- Senior midwifery student (clerkship³² or equivalent) in a program recognized by the CMBC
- Non-practicing midwife member of the College
- Physician
- Nurse
- Ambulance attendant or paramedic
- Respiratory therapist
- or another appropriately trained person where none of the above attendants are available³³.

RECOMMENDED ROLES AND DUTIES OF A SECOND BIRTH ATTENDANT

Under the direction of the principal midwife, the second attendant may be requested to:

Late First stage or Second stage of labour

- Provide assistance to the midwife
- Provide support to the woman
- Check layout of supplies to ensure accessibility of drugs and instruments
- Auscultate and chart foetal heart rate
- Check maternal blood pressure and pulse
- Document in the health care record

Birth

- Provide assistance to the midwife
- Ensure warmth and safety of the newborn
- Check, report and record the condition of the newborn
- Assess Apgar scores

Postpartum

- Provide assistance to the midwife
- Provide support and assistance to the woman
- Check maternal blood pressure, pulse, fundus and lochia

Emergency Situation

- Phone Emergency Medical Services
- Assist with neonatal resuscitation
- Assist midwife in setting up intravenous/drug therapy for postpartum haemorrhage
- Check maternal blood pressure and pulse
- Assist with CPR
- Assist in preparation for transport

32 A student in the clerkship portion of her program of midwifery education is in the final year of her midwifery education. She has successfully completed certification in Emergency Skills and her program has assessed her to be competent to provide primary care under direct supervision.

33 The midwife must submit to the College and keep on file documentation of her attempts to obtain second attendant support from an appropriate regulated health professional. Minimally this must include a posting at her local hospital.

The second birth attendant's role in emergency situations such as precipitate delivery, haemorrhage, infant resuscitation, meconium-stained amniotic fluid and shoulder dystocia, should be clearly agreed upon ahead of time and routinely reviewed.

A written agreement between the midwife and the second birth attendant outlining roles and responsibilities should be maintained. Where nurses are used as second birth attendants in hospital, the College recommends that midwifery practices work with their hospitals to develop clear guidelines that support the midwifery model of practice.

Midwives should be aware that use of second birth attendants outside the roles and responsibilities outlined in this policy may affect their professional liability coverage.

APPROVAL PROCESS

The midwife must enclose with this form a photocopy of the proposed second attendant's:

- membership in a health regulatory body (e.g. RNABC)
- current NRP certificate (annual)
- current CPR certificate (within the last two years), and
- a Criminal Record Review Authorization form if the proposed second attendant has not had a criminal record review in the past 12 months, or have a copy of a current criminal record clearance forwarded to the College

Where the proposed second attendant is not a regulated health professional listed under "Potential Second Birth Attendants", the following must also be submitted:

- a C.V. or summary of the potential second attendant's relevant education and experience;
- copies of letters, posters and other documentation verifying an attempt to obtain second attendant support from an appropriate regulated health professional with the dates and locations of the postings noted. A notice seeking a regulated health professional for the role must be posted in the local hospital for a minimum of four weeks.

Second birth attendants who are regulated health professionals from the list above may be approved by the Registrar based on fulfilling the above policy for a period of up to a year, expiring no later than March 31 of the current registration year. Any concerns about the approval of these second birth attendant applications will be referred to a panel of the Quality Assurance Committee for review. Requests for approval of "other appropriately trained persons" who are not regulated health professionals will be reviewed and approved by a panel of the QA Committee.

All approved second birth attendant arrangements that are not set for a shorter term shall expire on March 31st at the end of the registration year. Reapplication for second attendant support can be made to the College with the member's application for renewal of registration.

Appendix 10

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

SUPPORTIVE CARE POLICY

A midwife may provide supportive care when another health care professional is the primary caregiver. This usually takes place after a transfer of care during the pregnancy or labour, or in the postpartum period. Because a midwife must continue to meet her annual active practice requirements for births attended as a principal midwife, supportive care can only make up a small portion of a midwife's annual caseload.

Supportive care can involve education, counselling and advocacy in a collaborative relationship with the primary caregiver. It may also include labour support and assistance with infant feeding. A midwife in a supportive care role is not responsible for the provision of clinical care, but may work co-operatively within her scope of practice with the physician/nurse team. After the birth has occurred the midwife may provide primary care to the healthy newborn. Primary care responsibility for the mother may also be transferred back to the midwife after the birth, or the midwife may continue to provide supportive care to either the mother or newborn, should specialist care continue to be required.

It needs to be clear to all those involved in the woman's/newborn's care who the primary caregiver is at any given point in time. Whenever a transfer of care between a midwife and another primary caregiver takes place, it should be clearly documented in the client's records. The midwife is no longer responsible for record keeping after care has been transferred. However, she may include a summary of the supportive care she provides in the midwifery records.

These provisions for supportive care are consistent with the principle of continuity of care and enable the midwife to resume primary care if and when it becomes appropriate.

Appendix 11

SAMPLE – CALLING 911

Call taker will ask: Fire? Police? Or Ambulance?: **Ambulance** City: _____

Dispatcher will ask for the address: _____

Dispatcher will ask for the phone number the call is coming from: _____

Dispatcher will ask what the problem is: _____

Dispatcher will stay on the line, asking:

Age of Client: _____

How many months pregnant?: _____

First pregnancy?: _____

Timing of labour pains: _____

Bleeding?: _____

Alert?: _____

Hand the phone to an EMA when they arrive

Client's name: _____

Date of birth: _____

Address: _____

PHN: _____

Medications?: _____

Allergies?: _____

Appendix 12

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

POLICY FOR HOME BIRTH TRANSPORT PLAN

Hospital Procedure for Receiving an Emergency Transport from a Planned Home Birth

The College of Midwives of British Columbia requires each Registered Midwife to have hospital arrangements in place for planned home births before providing home birth services in a community to ensure a safe and smooth transport from planned home birth to hospital when required. Clear organization of responsibilities, teamwork, and an effective response when an emergency occurs is achieved through the coordinated efforts of all health care professionals involved. In an emergency transport, the receptivity of personnel and level of participation at the hospital are key factors in ensuring that women and their babies have timely and appropriate access to medical skills and technology when they are needed.

If a transport plan is not already in place, it is the responsibility of the midwife to organize a meeting with the appropriate hospital personnel, as designated by the hospital (e.g. hospital administration, midwifery integration committee, nursing, medicine), to establish transport procedures which identify the personnel responsible for receiving emergency transport calls for midwives and for initiating emergency measures in an appropriate and timely manner.

The form below is provided as a sample. A transport plan may be set out in any way that clearly delineates communication channels and the roles and responsibilities of all of the professionals involved in all stages of transporting the woman and/or her newborn from home to hospital in an urgent or emergent situation.

BC midwives are required to file a copy of their transport plan with the College of Midwives. When a midwife is joining a midwifery practice where a transport plan is already in place, she should review the existing plan, initial it and submit a copy to the College.

Sample - Transport Plan

Name of Hospital: _____

Address: _____

Phone: _____ Fax: _____
(to be called in initiating a transport)

Name of Midwife (midwives): _____ CMBC Registration Number(s): _____

Date of Meeting: _____

Hospital and Midwifery Staff Present at Meeting (name and title):

Midwife agrees to:

- forward a copy of the antenatal record to the hospital by 36 weeks
- notify the hospital staff that labour is established and a planned home birth is underway
- notify the hospital staff when the birth has been completed as planned
- inform the hospital staff of the circumstances and come to the hospital if there is a need to transport

Hospital agrees to:

Professional (staff position) responsible for receiving an emergency transport telephone call:	Professional responsible for initiating emergency measures (e.g. calling necessary medical and nursing staff, arranging for equipment, etc.)
_____	_____
_____	_____
_____	_____

Any additional arrangements for special circumstances:

Date filed with CMBC: _____