



## **Out of Hospital Transport Guideline For Idaho Licensed Midwives**

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Created by the Home Birth Summit & modified by the  
Midwifery Education Liaison Committee*

*Idaho Midwifery Council*

*Committee:*

*Annette Lewis, CPM, LM*

*Krista Nichols, CPM, LM*

*Kendra Scarlett, LM*

*Paula Wiens, CNM, LM,*

*Jill Hennegler*

## **Introduction:**

This document speaks to our mutual interest in the health and safety of mother and baby in the event of a transfer from an out-of-hospital setting to a hospital setting. When complications develop during labor or the immediate postpartum period, access to a higher level facility with appropriate medical technology is an essential component in the achievement of good outcomes for mother and baby.

Although families are prepared in advance for the possibility of the need to transfer to hospital during labor, it is often an emotionally difficult transition. Even in emergency situations, it is important not to neglect the principles of family-centered care.

It is clearly in the mutual interest of both the transferring midwife and the receiving physician to avoid poor outcomes which could potentially lead to malpractice suits. This is likely a concern for the receiving hospital and staff who typically have never met the mother and have little knowledge of the midwife or her practice guidelines.

The clinical situation and the attitudes of the mother, her family, the physician and the midwife all play a part in how the transfer proceeds. It begins with good communication, continuity of care, as well as appropriate and timely medical attention. All these components have the potential to improve maternal and neonatal outcomes and client satisfaction.

This document will provide background regarding licensed midwives, define expectations and enhance the flow of information, ultimately allowing transfers to proceed more smoothly, efficiently and safely.

### **I. The Regulation of Idaho's Midwives:**

There are two types of midwives licensed for midwifery practice in Idaho: Certified Nurse Midwife (CNM) and Licensed Midwife (LM).

CNMs are advanced practice nurses specializing in midwifery care. CNM's are regulated by the Idaho State Board of Nursing.

Licensed Midwives are Certified Professional Midwives (CPMs) that are credentialed by the North American Registry of Midwives. The Idaho State Board of Midwifery oversees the licensing and practice of Licensed Midwives.

LMs in Idaho have completed the midwifery educational requirements set out by the North American Registry of Midwives (NARM), which can be viewed at [www.narm.org](http://www.narm.org). They have also successfully completed Board-approved courses in Pharmacology, Shock and IV Therapy, and Suturing Specific to midwives, Adult and Infant CPR and Neonatal Resuscitation. While many out-of-hospital deliveries are attended by CNMs, the majority are attended by LMs. Most LMs have independent practices, attending deliveries in homes and/or free-standing birth centers.

LMs are authorized to obtain and use the following:

Oxygen, oxytocin and misoprostol for postpartum hemorrhage, injectable local anesthetic for repair of first and second degree lacerations, antibiotics for GBS prophylaxis (Penicillin, Ampicillin, Cefazolin Sodium, Clindamycin Phosphate), Epinephrine, IV fluids for stabilization of the mother, Rho (d) immune globulin, Vitamin K1 and eye prophylactics for the baby. (For complete information on Formulary Drugs and Usage in "Rules of the Idaho Board of Midwifery," go to Idaho Bureau of Occupational Licensing website [www.idol.idaho.gov](http://www.idol.idaho.gov).)

LMs are authorized to use the following devices:

Dopplers, syringes, needles, phlebotomy equipment, centrifuges, suture materials, urinary catheters, IV equipment, airway suction, oxygen supply, neonatal and adult resuscitation equipment, glucometers, breast pumps.

The state professional association for LMs is the Idaho Midwifery Council (IMC). LMs are able to apply for provider status and contract with Medicaid. There are other insurance companies that reimburse for LM fees depending on the individual deductible and in-network policies. Professional liability insurance is currently not carried by most LMs.

## **2. Indications for which LM Must Facilitate Transfer of Care:**

Every client receiving care with a LM must have a written Emergency Transfer and Transport document in her chart. Some conditions during pregnancy may be co-managed with a physician. When complications are detected, early consultation or referral is ideal. It is always preferable to avoid intra-partum emergency transport, and most transports occur long before the situation becomes emergent.

The vast majority of LM transports are still “normal” OB cases, resulting in vaginal birth. The most likely reasons for transport are prolonged labor, mother requests need for pain relief, and maternal exhaustion.

When initiating transfer of care, the LM must notify the hospital, accompany the client to the hospital if feasible, or communicate by phone with the hospital if the LM is not able to be present personally. The LM must also ensure that the transfer of care is accompanied by the client’s medical record which must include: the client’s name, address, phone numbers, next of kin information, a list of diagnosed medical conditions, a list of any prescription or OTC medications regularly taken and history of previous allergic reactions to any medications, the LM’s

assessment of the client's current medical condition and description of the care provided by the LM before transfer.

The following conditions require transfer of care to a hospital: –

- Maternal fever in labor of more than 100.4 degrees Fahrenheit in the absence of environmental factors;
- Suggestion of fetal jeopardy such as frank bleeding before delivery;
- Any abnormal bleeding with or without abdominal pain or evidence of placental abruption;
- Meconium stained fluid with non-reassuring FHT patterns when birth is not imminent;
- Abnormal FHTs with non-reassuring patterns where birth is not imminent;
- Non-cephalic presentation at the onset of labor or rupture of membranes, whichever occurs first, unless imminent delivery is safer than transfer;
- Second stage labor after 2 hours of initiation of pushing when the mother has had a previous cesarean section;
- Current spontaneous premature labor;
- Current pre-term premature rupture of membranes;
- Current pre-eclampsia;
- Current hypertensive disease of pregnancy;
- Continuous uncontrolled bleeding postpartum; bleeding that necessitates the administration of more than 2 doses of oxytocin or other anti-hemorrhagic agent;
- Delivery injuries to the bladder or bowel;
- Grand mal seizure;

- Uncontrolled vomiting;
- Coughing or vomiting of blood;
- Severe chest pain; or sudden onset of shortness of breath and associated labored breathing.

### **Communication and Expectations When a Midwife Transports to Hospital:**

The circumstances surrounding an intra-partum or postpartum transfer of a planned out-of-hospital birth heighten the need for clear and respectful communication among the transferring midwife, receiving physician, hospital personnel and the client. The midwife should do everything possible to promote understanding of any relevant clinical information. Each midwife should have a Transport Form with the client's pertinent medical information to provide a quick reference for hospital personnel, but verbal communication is the primary means of communication.

#### In General, THE HOSPITAL CAN EXPECT THE FOLLOWING:

1. A phone call to the nursing supervisor or labor and delivery charge nurse notifying him/her of incoming transfer, providing clear, concise clinical information about the mother and/or baby.
2. A phone call to the accepting practitioner will include reasons for transport, background clinical information, the condition of the mother and /or baby, the planned mode of transport and the expected time/location of arrival.
3. If the transfer is emergent, a phone call will be made to notify EMS of urgent need for transport, including the above information and any anticipated interventions necessary for stabilization during transfer.
4. The midwife will either provide photo copies of the relevant medical records or will provide originals which can be copied by the hospital and returned to the midwife.

5. If possible, the midwife will accompany the client to hospital to facilitate a smooth transfer of care and provide ongoing support for the client. This continuity of care has the potential to enhance the professional relationship between midwives and hospital practitioners and greatly improve client satisfaction with care.
6. After the delivery, follow-up communication in the form of compassionate debrief with the hospital practitioners will ideally occur. This could be in the form of "After Action Review." This highlights what happened, what went well, what could have been done better and what we learned from the event. This allows for feedback and helps correct any miscommunications, facilitating future transports.

In general, THE MIDWIFE CAN EXPECT THE FOLLOWING:

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

Ongoing Follow-up:

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