SAMPLE/DRAFT

MARYLAND HOSPITAL CENTER, LABOR & DELIVERY UNIT

CLINICAL PRACTICE GUIDELINES FOR ACCEPTING HOME BIRTH TRANSFERS

These Guidelines are intended to guide the practice of all healthcare providers involved in accepting transfer of care of a patient who has started to birth at home with a professional attendant, and has been transported to Maryland Hospital Center. As guidelines, they are intended for use in conjunction with clinical judgment, common sense, and compassion.

1. In case of life-threatening emergency, the midwife will have called 9-1-1 for an emergency transfer of the patient to the nearest acute-care hospital that provides obstetrical services. When that is our hospital, the steps in #2 will be followed.

2. In all non-life-threatening situations, and in emergent situations as time allows after calling 9-1-1, a midwife who is attending a planned out-of-hospital birth and needs to transfer a laboring woman, a postpartum woman, or a newborn to our hospital is asked to notify the Obstetrical Charge Nurse or Nursing Supervisor or other designated responsible party at (555) 555-5555 to notify the hospital about a perinatal transfer. This responsible hospital staff member will notify the following about the transfer:
   - A. Obstetrical Charge Nurse
   - B. Attending CNM or Physician (OB, FP, or Peds or Hospitalist)
   - C. Emergency Department (to inform that transfer will come directly to L&D)
   - D. Admitting Office

3. The transferring midwife should give the responsible hospital staff member (preferably the attending CNM or physician) the patient’s name, date of birth, reason for transfer, brief obstetrical history, brief medical and surgical history, medications and allergies, and any additional information that would help the hospital prepare for the transfer. The transferring midwife should describe the method of transfer (ambulance, private vehicle), and the approximate estimated time of arrival. The responsible hospital staff member should advise the transferring midwife where the patient should be brought to the hospital (preferably directly to Labor and Delivery).

4. The transferring midwife should accompany the patient to the hospital, and then transfer the care of the client to the hospital team. The transferring midwife should provide hospital staff with a complete copy of her client’s antepartum record and intrapartum transfer form, (and postpartum record, if applicable), including all laboratory and ultrasound reports. If the transferring midwife only has the originals, the hospital will make a copy, and return all of the originals to the transferring midwife. If the transferring midwife has electronic records, she will transfer them to a memory stick to be printed by the unit clerk. The transferring midwife will also give a verbal report about her client’s status to the nursing staff and the receiving physician or midwife.

5. Once admitted to the hospital, the patient's care is transferred entirely to the hospital staff, with the transferring midwife's role changing from that of primary care provider before arrival at the hospital, to support person/advocate after arrival at the hospital.

6. Respectful recognition of all parties' roles can only facilitate patient safety and satisfaction. To this end, the transferring midwife will be expected to facilitate rather than disrupt communication and trust between the patient and the hospital staff. By the same token, hospital staff shall strive to foster and express a respectful and collegial attitude towards the transferring midwife as the patient's chosen care provider.

7. Upon arrival, the patient will be shown respect and compassion for her situation, and acknowledgement that this transfer was not in her original plan, that she has had to give up her original vision of her birth, and that she is welcome at our hospital, where she will receive excellent care. Attention will be given, when possible, to preserving as much of her plan as possible, for example, allowing her to wear her own clothes, use her own pillow or blanket, play soft music, or have her partner and/or midwife continue to offer massage, counter-pressure and other labor support. The patient will be informed that, while certain things she may have expected at home may not be feasible at the hospital, her preferences will be honored to the extent allowed by her medical condition and that of her baby.

8. Initial transfers procedures will include, if possible,
   - A. take report from the transferring midwife and review accompanying chart
   - B. rapid assessment of the status of the mother and/or fetus or newborn
   - C. insert an IV line if none is in place
   - D. place patient on electronic fetal monitor as appropriate
   - E. record vital signs and last time and dose of any medications given during labor/postpartum
   - F. record any relevant data on the appropriate record
   - G. notify appropriate physician, CNM, or other provider as needed

9. Care will be taken to respect the family unit to the greatest extent possible, and not to separate a woman from either her partner or her newborn unless unavoidable for health and safety reasons.

10. After delivery, if the condition of the mother and baby allows, the baby will stay with the mother at the very least until the pair have successfully breastfed. All routine newborn procedures will be performed with the baby in the mother's arms.

11. After delivery, or whenever the client and her newborn are both stable, the family will be offered informed choice for early discharge, providing that the home situation provides adequate care for both mother and baby.

12. After delivery, or at time of discharge from the hospital, four surveys will be distributed: one each to the patient, to the transferring midwife, to the nursing staff, and to the receiving provider, seeking feedback about the transfer process and how it could be improved. These surveys will be returned to Maryland Hospital Center's Perinatal Transfer Committee for review. The Perinatal Transfer Committee should meet several times a year, review the surveys, and report the cumulated results to the medical and nursing staff, highlighting the successes of the program and what steps should be taken to improve the program. Ideally, this Perinatal Transfer Committee should include leaders from obstetrical nursing, midwifery and physician staff, hospital administration, and representatives from the local midwifery community.

13. After the patient is discharged from the hospital, where possible, a copy of the dictated admission history and physical examination, operative report and pathology report if appropriate, and the discharge summary should be sent to the transferring midwife, and where appropriate, the woman should be returned to that midwife's care for postpartum follow-up.