

Description

Compassionate and Safe Home Birth Transfer

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Summary

This article aims to develop a recommendation by the National Institute for Health and Care Excellence (NICE), alluding to a more compassionate approach to home birth transfer. It overviews solutions towards this through operational planning and suggestions for core skills to enhance effective and compassionate homebirth transfer planning and preparation. It underscores the crucial role of midwives in planning and executing a transfer from home to hospital, making them feel valued and integral to the process.



Introduction

An organisation's preparedness and a midwife's role in facilitating predictable safety-critical events, such as transferring from a midwifery-led to an obstetric-led setting, are vital to improving outcomes.[1,2] The NICE intrapartum care guidelines [3] provide a framework of recommendations for transfers, explicitly referencing robustly planned relational two-way dialogue, risk assessment, antenatal education and an acknowledgement of the psychological and emotional needs of the birthing woman or person. This recognition moves one step beyond the hard clinical skills and competencies required to safely transfer from home to hospital, emphasising a need for compassion in what can be a frightening and traumatic experience. While this article focuses on arrangements for planned births at home, the principles of resource and personalised care planning are equally applicable to unplanned home births.

Why transfer at all?

Transfers occur for various reasons but should always be based on a combination of clinical findings and in discussion with the woman or birthing person. Evidence shows that transfer rates vary according to geographical location, parity and complex medical and obstetric factors[4,5,6,7,8] and that a failure to recognise the need for or a delay in timely transfer can impact perinatal mortality.[2] Research suggests that around 40% of primigravida and 10% of multigravidas will require a transfer, with local variations requiring personalised consideration in antenatal discussions.

Indications for transfer are also broad. However, they can be divided into two main themes: potential or actual life-threatening emergencies and urgent *(see Figure 1).*

Figure 1: **Examples of indications for transfer**

Life-Threatening Emergencies	Urgent Transfer
• Ante-partum or postpartum haemorrhage • Shoulder dystocia • Cord prolapse • Deterioration, collapse and cardiac arrest (maternal or neonatal) • Suspected or actual sepsis (maternal or neonatal) • Retained placenta • Fetal distress • Concerns around maternal, fetal or neonatal observations being outside of normal range	• Maternal request • Delay in any stage of labour • Suturing/suspected obstetric anal sphincter Injury • Certain types of pain relief • Fetal malposition

Pre-birth planning and preparation

Pre-birth planning and preparation for transfer involves a nuanced approach to providing a safe, positive and comfortable environment. Building a trusting relationship between all parties is vital, permitting confidence in caregivers when a transfer is required. Local arrangements for well-coordinated and rehearsed transfer protocols should be available, serving as a critical framework for midwives to manage the transfer efficiently and effectively. Maternity services do not and should not work in isolation, therefore embracing a multidisciplinary approach in consultation with local ambulance services in service planning is critical, involving resource management and robust guidelines to support initial and ongoing risk assessment, personalised care planning and informed decision- making. Consider:

- Acuity and escalation (maternity and paramedic).
- Evidence-based guidelines for transfer.
- Regular mandated multidisciplinary training, skills, and drills held in community settings.
- Audit of local transfer rates and times.
- Standardised risk assessment to support rapid identification and escalation.

Critical conversations with the birthing women and people centred around a personalised risk assessment and care planning should also be routine. Consider:

- Existing or evolving complexities and immediate emergency management.
- Anticipated transfer times.
- Complicating transfer factors (e.g. geography, local infrastructure, ambulance availability).
- Limitations of management in a community setting and implications on potential outcome.

Midwifery skills and competencies

Outside core standards of proficiency for midwives,[9] evidence suggests a need for a nationally mandated requirement of core skills and competencies specifically for pre-hospital settings.[10] This remains an elusive outside guideline for newborn life support.[11] Notwithstanding, those attending homebirths must be able to summon emergency transfers and must have emergency care provided promptly in the meantime.

Suggested core skills and competencies include:

- Cannulation.
- Suturing.
- Prepare and administer emergency drugs, including fluids.
- Emergency care within the scope of midwifery practice (shoulder dystocia manoeuvres, unplanned breech birth, bimanual uterine compression).
- Advanced decision-making.
- Monitoring during transfer.
- Manual handling in emergencies.
- Communication and handover.
- Mentoring less experienced/confident clinicians.

Enhancing transfer with compassion

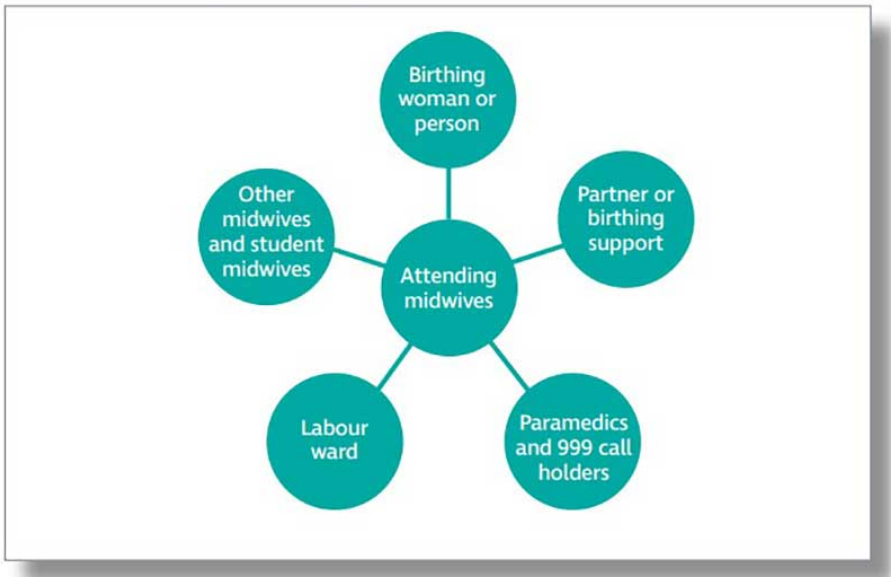
The following are proposed as additional considerations for compassionate transfer planning and execution:

Personalisation and continuity of care: Respect for the choices and preferences of the birthing woman or person to ensure they remain the centre of care and decision-making, retaining a sense of control throughout, ideally with a familiar midwife. This also helps with handover between paramedics once transferred to the obstetric unit.

Clear and effective communication: Detailed documented antenatal discussion about the transfer process. Use simple, non- technical language and offer opportunities to ask questions. Anticipate challenges and barriers, including language *(see Figure 2).*

Privacy, dignity and emotional support: Remain alert to privacy and dignity, including pain management during transfer, and provide reassurance and emotional support throughout. Acknowledge fear around the transfer and the vulnerability of birthing women and people, especially if separated from a partner or neonate. Always offer follow-up care and debriefing for the family and colleagues.

Figure 2: **Routes of communication**



Conclusion

This article emphasises the importance of personalised, continuous care and informed decision-making alongside a multilayered approach to service planning in the event of a home birth transfer, enhanced by a framework embedding a holistic, compassionate approach.

Compassionate homebirth transfer – putting it into practice

Rena has just experienced an uncomplicated birth at home to her second baby. Rena's midwife Tom arrives in time with second midwife Angela and third-year student midwife Jess. Tom notices that after the birth of the placenta, Rena is trickling blood per vaginum. Tom assesses Rena's uterus and finds it to be atonic.

Tom communicated this with Rena, asked her to lie flat, and gained informed consent to perform uterine massage, explaining that they would now arrange a transfer to the hospital to continue treatment for a post-partum haemorrhage. Rena had previously had a respectful discussion around indications for transfer and immediately agrees.

Tom asks Rena's partner to call 999 on loudspeaker. While continuing uterine massage, Tom tells the call handler, 'I am a midwife requesting an emergency paramedic transfer to the nearest obstetric unit for a postpartum haemorrhage.' The call handler asks questions, and Tom conveys the required information calmly. The call handler informs Tom that an ambulance will be with them in approximately six minutes.

Meanwhile, Angela communicates continuously with Rena's partner, requesting that he dress the neonate in preparation for transfer (according to local ambulance protocols for the neonate). She then calls the labour ward to advise them of the transfer. Angela prepares and administers, with consent, an oxytocic drug to Rena, explaining its indication. Rena was already familiar with this from her antenatal classes and pre-homebirth risk assessment at 36 weeks with Tom, which included emergency arrangements. Jess checks the placenta, confirms it appears complete, and then retains it; sheets and pads accurately measure blood loss by weight.

Angela sites intravenous access and commences fluid resuscitation while Tom continues uterine massage, knowing Rena passed urine just before the birth. Tom notes that the bleeding has now stopped. However, he still recommends a transfer for review.

Rena agrees as two paramedics arrive. Tom and Angela attended mandatory pre-hospital skills days and recognised one of the paramedics who was present. Tom provides a succinct SBAR handover, agreeing with the paramedics who will lead the emergency. Rena agrees to be transferred using a chair. All parties ensure Rena's comfort and dignity are maintained throughout conveyance, offering her a blanket and analgesia. Finally, Tom offers Rena an opportunity to ask questions and reminds her that he can provide support directly if she wishes to discuss her care. After ensuring Rena is clinically well and comfortable, care is handed over to the labour ward midwives by Tom and the paramedics.

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