

Standard:	Guidelines for Emergency Transport
Approved By:	CMNL
Date Approved:	May 2018
Date to be Reviewed:	
Effective Date:	September 2016



GUIDELINES FOR EMERGENCY TRANSPORT for Midwives Practicing in Newfoundland and Labrador

Introduction

Attending at any birth is the primary midwife and a second midwife/attendant. The primary midwife takes over authority and provides emergency care in the absence of medical help. The primary midwife is the most responsible care provider present, coordinates care and directs others to provide assistance. It is the responsibility of the primary midwife to communicate clearly with the second midwife/attendant. There should be a clear plan of action in an emergency and the primary midwife and the second midwife/attendant should know their roles.

An essential component of maternal and newborn care is the ability to transport pregnant women and newborns who have complications, as outlined in the *Indications for Consultation and Transfer* guidelines, to an appropriate care facility. When emergency transportation is necessary maternal transport with the baby in utero is preferable to neonatal transport when possible and should be the primary goal.

Emergency transport places significant stress on the woman and her family. The following specific principles of family-centred care are critical in these situations:

- Women and families need information about their circumstances; they need to be active participants in decision making.
- Women and families need continuous, supportive care from qualified personnel.
- Family members need to be together to whatever extent possible, and to communicate with each other and with health care personnel if separation becomes necessary.

Midwives Attending Planned Out-of-Hospital Births

When a planned out-of-hospital birth is planned the midwife, prior to the expected birth, needs to check the birth place, including how the bed may be moved for access for a breech birth, or that there is a suitable firm wedge available, where to hang a bag of intravenous solution, whether the light and heating are adequate, and telephone access by a landline or mobile phone (not all locations have access to a cell phone tower). Having the phone numbers for the physician, and for emergency transport if the place is not in a 911 area.

Midwives must take into account factors such as distance, access to telephone, weather conditions including any risk of hypothermia, availability of emergency support systems, and use professional judgment in determining the most appropriate use of emergency support services and mode of transportation if a transfer is required. The midwife ensures that satisfactory transport service for mothers and infants can be initiated quickly 24 hours a day. It is recommended that planned out of hospital births are pre-registered with the Emergency Medical Services (EMS) and the nearest hospital advised when labour commences (and they both are notified after labour has ended). If the woman lives in a location with difficult or obscure access,

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clear directions should be given to the EMS regarding the location.

When leaving to attend the birth the midwife should check that all equipment is available and functioning. This includes the writing or other recording material is functioning (and that the black pen has not gone dry.)

Midwives Attending Unplanned Out-of-Hospital Births

A midwife may unexpectedly have to attend an out-of-hospital birth for a woman, whom she may or may not know, who was planning to have the birth in a hospital. Under these circumstances the midwife will provide care to the mother and newborn.

If the midwife is not present and EMS personnel are called, they will follow EMS protocols for care during childbirth, and for emergency transport, if this becomes necessary.

Consultation Regarding Transport

When a midwife has consulted with the appropriate physician and a decision is made to transport a woman and/or her fetus/baby to an emergency facility, the transportation would not be initiated until the following criteria are met:

1. The woman's condition is stabilized;
2. The fetus is in a condition where transportation would not further jeopardize the outcome;
3. Birth is not imminent and is unlikely to occur en route;
4. The neonate's condition is stabilized;
5. Weather conditions are safe for travel;
6. An experienced health professional accompanies the woman.

When the transportation of the woman and/or baby involves the Emergency Services

Whenever possible, at least one midwife accompanies the woman in transport situations. In such cases, midwives and emergency personnel collaborate in the best interests of the woman and/or baby, recognizing the individual expertise of each service provider. Midwives and emergency personnel at the local level are responsible for the development of appropriate protocols for handling transport of women and babies cared for by midwives. Decisions will be based on the availability of resources, professional expertise and local circumstances. Two vehicles may be required, one for the baby with an unstable condition and one for the mother with an emergency condition, such as bleeding.

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Transport personnel should have the collective expertise, technical skills, and clinical judgment to provide supportive care for the wide variety of emergencies that can occur during transport. Team members should be drawn from appropriately experienced physicians, midwives, nurses, respiratory therapists and emergency personnel. Composition of the transport team should be consistent with the expected level of need of the woman and/or baby being transported. It is the responsibility of all health care providers in the community to work together to ensure that the emergency needs of mothers and babies are met.

When Midwives are Transporting Women to Hospital

Midwives' responsibilities:

Midwives retain the responsibility for women experiencing childbirth related emergencies within their scope of practice until an appropriate physician takes over care of the woman and/or baby in person. Emergency skills training includes management of antepartum and postpartum hemorrhage, shoulder dystocia, twin birth, breech presentation, prolapsed cord and fetal distress. Midwives are also required to have current registration in neonatal resuscitation and certification in cardiopulmonary resuscitation.

It is the responsibility of midwives to:

1. Have a detailed protocol that includes emergency and back-up plans for their region;
2. Call the receiving hospital and notify the personnel as agreed in the protocol developed for that hospital, regarding the condition of the woman and/or baby before commencing the journey;
3. Check that the baby has two identification bands if the baby is being transported with or without the mother;
4. Remain with the woman at all times until transferring care to the appropriate physician has occurred;
5. Be aware of the training level and competencies of EMS personnel in the community where they practise¹;
6. Know and respect EMS protocols when asking for hands-on assistance;
7. Have knowledge of safety regulations (e.g. coding of calls) when providing care in the ambulance;

¹ From January 2002, in Newfoundland and Labrador the minimum training requirements for private ambulance services attendants are Paramedic-I. For community ambulance services, attendants are required to have Emergency Medical Training Program-II and to maintain current certification in Standard Level First Aid and Level-C Cardiopulmonary Resuscitation (*Ambulance Operations Standards* (Draft), pp. 8-9). Advanced Life Procedures is not the normal mandate of the Ambulance Services (Appendix C).

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8. Educate EMS personnel about the role of midwives and responsibilities during transport;
9. Educate EMS personnel about the need for adequate warmth when transporting a woman and/or baby;
10. Include the records/documentations;
11. Include the placenta for pathology (if delivered);
12. Include any blood and/or urine samples obtained.

Newfoundland and Labrador Ambulance operators are responsible for providing services that include:

1. Efficient communication with hospitals;
2. Ensuring that an appropriately trained attendant [e.g. the midwife] is in the patient compartment of the ambulance with the woman and/or baby;
3. Having equipment and supplies as listed in the provincial EMS standards. (refer to the *Ambulance Operations Standards (Draft)*, pp. 2-3, 15-21)

The ground ambulances in the province carry an OB kit that includes:

- 1 disposable sheet/receiving blanket
 - Exam gloves
 - 1 disposable sterile Scalpel
 - 2 umbilical cord clamps
 - 1 bulb aspirator
 - 4 (10cmX10CM) sterile Gauze pads
 - 1 plastic bag with ties
 - 2 disposable hand towels
- Supplies of syringes including 1cc, 3cc, Angios, and IO's.
 an infant sized BVM, all the small ET tubes, meconium aspirator, small suction caths, bulb syringes, and A large zip lock bag . (Mike Provencher, Advance Care Paramedic, e-mail correspondence to L. Burrage, April 5, 2016).

Specific Equipment Required for Transporting Pregnant Women, and/or Newborn Babies

When transporting a pregnant woman the midwife should be prepared for a birth and have the items listed in *Essential Equipment, Supplies and Medications required at all Births*. The pregnant woman should be lying on her left side if possible, so a wedge should be available for use on the stretcher. Before starting the journey an intravenous cannula should be in place with an IV lock to enable intravenous fluids or medications to be given as necessary.

When travelling by air only solution bags that expand and contract with pressure changes should be used during air transport. The woman and/or baby may require oxygen to stabilize their conditions, especially in unpressurized planes. Due to noise levels it may be impossible to

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auscultate the fetal heart with a stethoscope and so an ultrasonic doppler fetal heart detector and digital readout sphygmomanometer need to be available. Blood pressure can be assessed by palpation of the brachial artery to determine systolic pressure. The midwife must be cognizant of the effect of changing air pressure on a pregnant woman and on an ill baby.

If the midwife has to escort the mother and baby from an isolated community in the middle of winter, weather conditions may pose special considerations, particularly regarding thermoregulation.

Arriving at the Hospital

Clearly communicate transfer of care and document that the consultant has accepted care. Ensure that nursing staff are also aware of the transfer and the midwife's role as supportive caregiver. Continue to assist with clinical care and provide assistance as directed. Keep the client informed.

Emergency Resolved

If a reported emergency is resolved before emergency services arrive, consider whether follow-up is advisable and transfer should continue. If it is decided that follow-up is not required notify the emergency services, the hospital, and any other services that have been called of the outcome.

Responsibilities for Payment of Emergency Medical Services

During the pregnancy midwives and women should discuss the possible need for emergency transport. The midwife should inform the woman that costs related to transport may be covered by the Regional Health Authority, but in some cases the woman may be expected to bear the cost. This information must be available to the woman so that she can make an informed choice regarding place of birth.

Other Care

Midwives are only expected to care for women and babies when everything is progressing normally, but there may be times when an emergency occurs. An example is when the woman insists on an out-of-hospital birth contrary to the midwife's advice, but because the midwife may have the most expertise in the situation, there is an ethical responsibility to provide care. In these circumstances the midwife follows the guidelines in the document *Place of Birth*.

Record Keeping in an Emergency Situation

Records should be concise and factual (and not include unnecessary information such as state of bedding or uncertain what to do next.) Poor record keeping and gaps in the information may give the impression of lack of care. Included should be the name, title of the person keeping record,

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and the time, nature of emergency communicated and care plan, and the person to whom this is being told (physician, paramedic, nurse). Any late entries should be made as soon as possible, including the time of the late entry and the time of the initial event. Make it clear why charting at the time did not occur. If notes were initially made on pieces of paper preserve these in the chart.

References

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