Believe Midwifery Services, LLC

Title: Client Selection in the Homebirth Midwifery Practice

Effective Date: October, 2013

Policy Statement: The goal of risk assessment in a home birth practice is to select the client who, by all current medical and midwifery knowledge and standards, is a low-risk client with an excellent prognosis for a normal, healthy pregnancy, birth, and postpartum course. It is an on-going process, with factors presenting during pregnancy, throughout labor, and even in the postpartum period.

Informed decision-making is an essential characteristic of midwifery care. The core elements of informed consent include a discussion of the indications for the intervention, a description of the probable benefits and probable risks associated with the recommended intervention, a discussion of alternative interventions, and a description of the consequences of declining the recommended intervention. In the context of homebirth, the consequences may include conflict with community providers who prefer adherence to an established protocol.

Truly informed choice also requires that the client be informed when there is little or no evidence to support a particular intervention, or when there is a gap between evidence and standard community practice. This may become particularly relevant when discussing when and if to transfer to the hospital, and what can be expected. Many homebirth clients will have had both the time and inclination to research all options for care, and will be aware of community standards that do not follow the best available evidence.

The courts have repeatedly upheld a patient’s right to refuse treatment, even if not treating may result in serious morbidity or mortality, based on the belief that only the patient can understand her own priorities. Acknowledging this, the American College of Obstetricians and Gynecologists issued a committee opinion in 2004 on informed refusal, stating that once risks, benefits, and alternatives have been explained, a woman has the right to exercise full autonomy in making an informed decision, which includes informed refusal. An individual’s assessment of risk is based on both fact and emotion. Risk is most effectively communicated when the informant is perceived as being both competent and caring, supportive, and empathetic, all of which engenders trust. For the homebirth midwife, the development of mutual trust and a collaborative relationship with the family is an essential goal, developed over the course of pregnancy through prenatal visits that allow ample time for discussion of medical, psychosocial, and family issues. The joint plan for the intrapartum care of the woman and baby at home acknowledges the family and the midwife as the core health care team, and accounts for individual and cultural differences in priorities for management. Antepartum discussions about variations from normal, transfer protocols, and birth site selection can minimize the possibility of conflict when essential decisions need to be made during the intrapartum period.

Function: Care of Clients

Points of Emphasis:

“In contemporary Western culture, the concept of risk has transformed from an accepted life fact to an unacceptable element to be avoided, and today we live in a risk-adverse society that values control over and security from potential threats. In health care, if an unpredictable outcome happens, it can be perceived as a failure of the health care providers to monitor and intervene” (Jordan & Murphy, 2009, p 191).

Controversy exists concerning the value and sensitivity of risk assessment tools in predicting maternal and neonatal outcomes. To date, no tool has been designed specifically for the home birth setting. None of the current available risk assessment instruments account for the provider’s clinical or intuitive impression of the client’s profile. Most do not address the information and conditions that present after the onset of care. The ability or willingness of the client to accept responsibility for care is not assessed in commonly used instruments. Moreover, these tools do not assist in identifying those women who are good candidates for a normal birth. As the pregnancy progresses, changes in pertinent data that reduce a woman’s risk score usually are not analyzed by these instruments.
In the context of a planned homebirth, the designation “low risk” means that the woman is willing to accept responsibility for self-care, that she has an adequate social support network for the whole childbearing cycle, that her emotional state is conducive to natural birth, that she understands and agrees to the criteria specific to home birth (breastfeeding, preparation of participants and environment, no medication), and that she has no medical or obstetrical factors that require hospitalization. It does not mean she is free of any co-morbid diagnosis, such as gestational diabetes, hypertension, previous cesarean history, breech presentation or fetal anomaly. The hospital environment has not proven to offer improved outcomes in all “high-risk” scenarios; therefore, each client’s individual care management will be evaluated thoroughly with regards to client conviction, current evidence, clinical skill, and community resources. What might be socially acceptable is not always in the client’s best interest.

In many cases, the mother can alter or address risk factors to improve her profile. If she has the opportunity, but chooses not to accept this responsibility, then she may not be a good candidate for homebirth. Client selection for homebirth is a complex process involving skilled interviews prenatally, intrapartum and postpartum observations and measurements, ongoing midwife-client communication, provider judgment, and opportunities for the client to alter her risk profile.

Risk screening within a homebirth practice is unique and some aspects in particular assume greater significance when compared to institutional birth. The sum of the midwife’s knowledge, clinical experience, personal judgment, and intuitive sense may influence her decision to waive a specific contraindication in light of mitigating factors or a change in the client’s condition. In every instance, consideration should be given to the potential need for personnel and equipment that are only available in the hospital setting.

**Psychosocial Factors**
The medical and logistical criteria are generally more tangible and accessible than the psychosocial factors. The latter, however, are of paramount importance for several reasons. First, home birth by definition occurs in a setting in which the client is responsible for securing social and physical supports for the puerperium. The woman’s emotional environment during the prenatal period and at the birth can greatly affect labor progress, birth outcome, and postpartum health. Therefore, assessing its potential character is especially important for homebirth.

Psychosocial concerns are not absolute contraindications to homebirth, as many women view the home as a safe haven where confidence flourishes and anxiety abates. The midwife should take note of these issues and use the prenatal appointments to address them. If, however, the midwife determines that the client’s emotional state may seriously impair her labor, her communication with her care providers, or her willingness to transfer should the need arise, the plan to deliver at home should be reconsidered.

**Shared Responsibility**
A decision to avoid the risks of a hospital birth is at the same time a decision to accept the risks of homebirth. In choosing to do without hospital personnel, the family chooses to assume their role to some degree. In accepting these risks and roles, the family agrees to share responsibility for care and outcome with the attendants. The screening process must assist the midwife to determine the ability and willingness of a client and her family to do so.

**Initial Consult**
The first, and perhaps most important, opportunity for screening is during the initial consult. This meeting can be used by both the client and the midwife to assess personality and philosophy match and to discuss fees, schedule of care, expectations of roles and responsibilities, and screening criteria. The client may have questions regarding the practice as well, in determining if Believe Midwifery Services, LLC and their practitioner team is in fact, her most appropriate care provider.

**Home Visit at 36-37 weeks**
The home visit is an integral part of preparing for homebirth, as it allows the birth attendants opportunity to assess and become familiar with the birth environment, locate the birth place, and evaluate the gathered birth supplies from the detailed list outlined on our client access webpage. The client’s home should also be assessed for telephone,
electricity, plumbing, refrigeration, heat and water so that any adaptations that will be required can be thoughtfully addressed in advance of the birth. Preparations and a plan for the care of children and household pets should also be reviewed.

Midwives and their advocates often claim that midwifery services are unique and not the practice of medicine. However, juries will not necessarily accept a different standard of practice based on distinctions between midwifery and the medical model, no matter how well it is explained because the medical model of childbirth is so deeply ingrained in American culture. Spindel & Suarez, 1995

The home should also be evaluated for cleanliness and access to emergency services. Roles of attendants, including friends and family, should be reviewed to assure that the clinical team maximizes their opportunity to secure a safe homebirth experience while limiting their own liability.

GUIDELINES FOR CHILDBIRTH AT HOME:
The following list of criteria is to be considered when determining the need for consultation or transport. It is recognized that each situation is unique and nothing can substitute for the individual nurse-midwife's evaluation and judgment.

General Criteria
- Healthy physically and mentally
- Well-nourished woman
- Adequate social support before, during and after birth
- Primary participants mature and able to accept responsibility for outcomes of birth
- Commitment to maintaining a positive emotional environment for mother throughout process
- Care initiated within practice at or before 32 weeks of gestation
- Childbirth, homebirth, and breastfeeding education secured (books/classes)
- Commitment to breastfeed through postpartum period
- Preparation of persons planning to be present at the birth
- Complete records from previous provider for current and/or past pregnancies as necessary
- Arrangements made for emergency transport
- Home location within a defined service area (30 minutes) of a hospital that has an obstetrical unit
- Clean home and birthing room – supplies orderly
- Understanding that there will be no intervention unless medically necessary
- Understanding that there will be no use of labor pain medications in the home setting
- Agreement to use emergency medications when needed for the health of the mother
- Agreement to transfer mother and/or infant to the hospital at the discretion of the attendant at any time during labor, birth or postpartum
- Help available in home 24 hr/day for at least 1 week after the birth
- Fulfillment of the financial agreement commitment

Contraindications (screening done by history or exam)
- Rh incompatibility with a rise in titer
- Malnutrition, poor weight gain as determined by the nurse-midwife
- Smoking cigarettes
- Drug or alcohol addiction
- Insulin-dependent diabetes
- Intrauterine growth retardation
- Marked maternal anemia at term
- Moderate to severe preeclampsia
- Placenta previa
- Prematurity
- Primary herpes infection in labor
- Positive serology for syphilis
- Positive HIV titer
PRACTICE GUIDELINE

Prolonged pregnancy with documented change in fetal status under surveillance
Irresponsibility, unwillingness to change habits
Lack of compliance within necessary time frame
Dishonesty or intentional breach of contract
Unstable, unsanitary or dangerous home environment
Immaturity or questionable emotional status
Refusal to agree to necessary specified testing, emergency medical care, or transport
Unresolved conflicts of personality differences between client and midwife
Not honoring the financial agreement

*Labor and Birth Complications Requiring Hospitalization*
- Fetal heart rate persistently over 160 or under 100
- Abnormal intrapartum bleeding
- Prolonged labor with no evidence of progress and maternal exhaustion
- Cord prolapse
- Thick meconium stained amniotic fluid (depending on severity and stage of labor)
- Elevated maternal temperature with ruptured membranes
- Inability to stabilize postpartum hemorrhage
- Retained placenta
- Newborn health status unstable
- Discretion of attendant

*Termination of Care*
In the event care is discontinued, the practice administrator shall:
1. Document actions and supporting information in the client’s chart,
2. Notify the client in person if possible and/or send notification by certified mail,
3. Give referrals to other appropriate health care providers,
4. Upon consent, send all pertinent records to the woman or the the new health care provider,
5. Notify the client of required payment for services rendered in accordance with the financial agreement.
   Reimburse client, if applicable.

*REFERENCES:*

*Originated:* December, 2008

Penny Lane MSN, CNM    DATE: 8/26/2011

January Gilley    DATE: 9/1/2011

Holly Hopkins MSN, CNM    DATE: 8/27/2011

Ashley Kenyon RN    DATE: 11/3/2011
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<td>3/22/2012</td>
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<td>Michelle Burton</td>
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Anastasia Glassburn

Michelle Burton