

Emergencies During Birth

Midwives provide care during pregnancy, labour, birth and postpartum to low risk, healthy women and their babies. We see pregnancy and birth as normal, healthy processes, and we expect that things will go well. We also know that emergencies can happen and that we need to be ready for them. Midwives set up and double-check all emergency equipment and medications at every birth. We re-certify regularly in emergency skills, CPR and neonatal resuscitation. We believe that, although we do not expect an emergency at your birth, it is better to discuss them before you are in labour. That way you can ask questions and be prepared for situations so that we can have your full cooperation if they come up. Please feel free to discuss your questions or concerns with us. Know that in an emergency we may need to act quickly, and we may not have time for a detailed discussion as we do in clinic. Know that we will try to tell you what is happening during the emergency, and that we will talk more after the emergency has been dealt with.

A note about homebirth: Research has shown that homebirth is a safe choice for low risk healthy pregnancies when attended by Registered Midwives. When discussing emergencies and homebirth, we consider weather, distance to the nearest hospital and your individual situation. In general, the steps we take in any emergency situation are the same or similar at home and in hospital. We are always prepared to move to hospital by ambulance if necessary. If ambulance transport is necessary, the receiving hospital will send you a bill for approx. \$45.00. We have tried to include a special note about each of these emergencies and homebirth to illustrate what is the same and what is different. Please feel free to discuss any of this with your midwives.

- 1. Abnormal fetal heart rate:** We will be listening to the baby's heart rate regularly to tell us how the baby is coping with labour. There is a normal range for fetal heart rates, rhythms and patterns. If we hear something that is abnormal, we will want to monitor the baby more closely. We may use the electronic fetal monitor if we are at the hospital. If there is an abnormal heart rate we will do things to try and correct it: directing you into position changes, getting you to breathe oxygen through a mask, placing a wedge under one hip, or starting an IV. If the baby's heart patterns improve we stop. If we are still concerned or the heart rate worsens, we will consult with an OB. If the birth is about to happen and the heart rate is not normal we may cut an episiotomy to speed up the birth of the baby. We will talk to you about what we are seeing and hearing while this is happening.

Homebirth: *An abnormal fetal heart rate is a reason we would move from home to hospital. Usually we would move by ambulance.*

- 2. Shoulder dystocia:** Shoulder dystocia happens when the baby's shoulders get stuck behind the mother's pubic bone after the birth of the baby's head. Shoulder dystocia is more common with bigger babies, but it can happen with babies of any size. Because it can happen at any birth we are ready for it at every labour and we discuss it with our clients in pregnancy. There are a number of things that we can do to release the stuck shoulder. We may need you to change positions by moving onto your hands and knees or laying flat on your back with your thighs bent up to your chest. We will do our best to tell you what is happening, what position you need to be in, and we will help you to move as quickly as possible.

Homebirth: *Shoulder dystocia is usually resolved within minutes, but we may call an ambulance right away once we have seen this problem. Although the ambulance would likely arrive after the birth, they will be on their way in case the baby needs additional help or needs to go to a hospital.*

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- 3. Post partum hemorrhage:** Post partum hemorrhage (PPH) is any amount of bleeding following birth that causes a woman to show signs and symptoms of shock. PPH happens in about 5-15% of births. The most common cause is the uterus not contracting strongly enough after the birth. We will be checking your uterus regularly after you give birth to assess how well it is contracted, and we will be watching the amount of bleeding you have. If needed, we will massage your belly to start a contraction and to push out blood clots from your uterus. If you lose too much blood and/or your uterus is not well contracted, we will use medications, such as oxytocin and ergometrine, to contract your uterus, and we may need to start an IV. We will consult with an obstetrician if bleeding continues after these steps. Again, we will keep you informed of what we are doing and why. Active management of the third stage of labour can reduce the amount that you bleed and your risk of PPH, and this is an option for you. Your midwife can discuss this choice with you in detail at a clinic visit.

Homebirth: *The initial things we do for a PPH are the same at home as in the hospital including using medications and starting an IV. We would move to the hospital by ambulance if these steps are not enough and we need the assistance of an obstetrician.*

- 4. Newborn resuscitation:** We will be assessing the baby from the moment of birth to check their heart rate, breathing, colour and muscle tone. If we are concerned about how the baby is making the transition to “life on the outside” we may move the baby to a pre-prepared warm area for closer assessment and possible resuscitation. One in ten babies needs some assistance to begin breathing well. These babies usually require no special care once they begin breathing. One in one hundred babies will need more help to breathe. There are often signs during the labour that a baby will need more support at birth. Any of those signs, such as meconium (poop) in the amniotic fluid, would be reasons for us to recommend moving to hospital from a planned homebirth. Babies, who require resuscitation, may need to be admitted to the special care nursery at the hospital for a period of observation.

Homebirth: *We carry with us to homebirths the same resuscitation equipment used for routine deliveries in the hospital, including suction, oxygen and a bag and mask to inflate the baby’s lungs. It is rare that babies will need more than this routine equipment. Intubation is one step that may be taken for babies needing longer resuscitation. Midwives do not intubate babies. This is a step that can only be done in hospital by a pediatrician. When we deliver a baby at home who requires resuscitation we may call an ambulance to move the baby to the hospital.*

Vacuum or forceps delivery: Most women push their babies out with no complications. Where there is not good progress during the pushing stage, we will consult with an obstetrician in hospital. In some circumstances, they will offer a trial of vacuum or forceps. These are used together with women’s pushing efforts to rotate the baby and/or bring the head down.

Cesarean section: Cesareans may be recommended because of a baby’s position, like face, a labour that is not progressing, a abnormal heart rate in the baby, or serious concerns for the mother. Usually cesareans are done with a spinal anesthetic, which freezes more deeply than an epidural and only lasts for the length of the surgery. Women can have a support person with them once they have been prepared for surgery. Women who require a general anesthetic may not have a support person with them. One of your midwives can be with you throughout the procedure in either case. We usually receive the baby after birth or we will help a pediatrician if there are special concerns about the baby.