October 2017

COMMISSION FOR THE ACCREDITATION OF BIRTH CENTERS

In 1998 a nurse mentor persuaded me to become an instructor for the Neonatal Resuscitation Program (NRP). I was intimidated at the time, thinking how little experience I had as a nurse: just six years, and only two in perinatal nursing. But she observed that becoming an instructor doesn't mean you're a master of something as much as it means you believe in continuous learning and improving one's skills.

I've been teaching in the birth center setting now for ten years. Home birthing midwives in my region have also come to the birth center for training, seeking an instructor who is willing to teach and learn and review without a judgmental attitude about scope of practice or experience. I know I have benefited by learning from midwives who are not nurses, practicing in settings with even fewer resources than we have at our birth center.

The Neonatal Resuscitation Program itself is clear that completion of the course does not "certify" one as competent. Determination of competency and role is defined by the institution at which an NRP provider practices, and state licensure regulations.

I've worked in hospital settings where it was determined that the NRP courses wouldn't provide the full spectrum of lessons to all learners. This decision was often based on a program director's opinion about scope of practice and roles, which may have been logical given some hospitals' services for 24/7 neonatology and respiratory therapy. But that stance has never been consistent with NRP's own assertion that all learners should practice all skills. In its 7th edition, the NRP insists that all learners test and practice all the skills that are part of the algorithm.

Meanwhile, the NRP algorithm has developed and changed. I have been delighted to see how physiologic birth and mother-baby dyad centered care is improving each time. The NRP steering committee's insistence on evidence to support the algorithm has made for great improvements with each edition. When I first started teaching NRP, we were routinely suctioning babies, moving baby to a warmer, intubating for any meconium, and expecting an abnormally pink color in the first minute of life. The 7th edition voices a strong preference to avoid separating baby from mother, and introduces theory about initiating resuscitation while leaving the umbilical cord intact.

In this issue:

A Commissioner's Perspective on Neonatal Resuscitation

By Olga Ryan, MS-NL, RN
Vice Chairperson, CABC

It's quite clear that our birth center industry IS making an impact.

It's quite clear that our birth center industry IS making an impact. In an NRP Instructor newsletter in 2016, the NRP steering committee expressed gratitude to its partners in the industry and included the American College of Nurse Midwives and the American Association of Birth Centers (Vol 25 Fall/Winter). There are three key factors to this major advance in the NRP program recognizing midwives: AABC board member Jessica Illuzzi's membership on the NRP steering committee as a representative of ACOG, the steering committee chairperson's participation in our Standards of Birth Centers review, and the joint ACOG/SMFM statement on levels of maternity care that included birth centers.

The NRP needs us midwives and birth centers, and not just because we're experienced at initiating resuscitation while baby is still attached, but because we are the level of care more women and babies deserve! Too many hospital-based instructors continue to block access to our training based on misguided perceptions of a midwife's scope of practice. And, while NRP has two categories of training available—one for American hospitals and one for resource poor countries (Helping Babies Breathe)--neither are really well suited for birth centers with our more intimate staffing and intentional avoidance of expensive technology that doesn't

October 2017

COMMISSION FOR THE ACCREDITATION OF BIRTH CENTERS

support physiologic birth.

I know that neonatal intubation and administration of medications can make the best of us feel tense. While the chance that they are needed is very low for low risk births, the risk stratification we do for eligibility further reduces the chance that a baby born in a birth center may need the full cohort of resuscitation efforts. *Nobody is asking for a midwife or birth center to advance further down the algorithm when bag-valve-mask ventilation is effective*. Airway management and medication administration are higher risk/low frequency skills, and they are a challenge for birth centers who are trying to manage resources like staff time, meeting and training supplies.

Cord catheterization was a challenge for my birth center. Like most, we typically have just two attendants at a birth. It takes both of us to do chest compressions and ventilate, and a family member to call 911. We are only two minutes from a terrific NICU, with a skilled and professional urban emergency services for transport. Odds of us starting an IV are remote, and delaying transfer is usually the wrong thing to do. But we agree with AABC's stance that 1) an expectant family should not bear the responsibility of understanding or consenting to which parts of the NRP algorithm we are competent and 2) intravenous access and medication come very quickly on the NRP algorithm (within 3 minutes). Since birth center babies might only need this level of care for truly unexpected and sudden events like an abruption or cord avulsion, and we're the ones who will know the chain of events, it is reasonable for us to be initiating that care. So we've added regular drills with cord catheterization. Like many midwifery and nursing skills, it's less scary when you have a little muscle memory.

Thankfully, the NRP program is simplifying these sections, partly by bringing out-of-hospital tools into its algorithm. The laryngeal mask airway (LMA) has long been used by EMS teams, and has been included in NRP for over 10 years. For birth centers the LMA is useful in the rare possibility that bag-valve-mask ventilation does not work. Most experienced practitioners feel competent with its use after practicing just once on a manikin doll. Once a year practice as part of a simulation drill can maintain that feeling of competency.

Intraosseous access is our next frontier. NRP has included intraosseous access in its 6th & 7th editions, but it is a skill more commonly used by EMS and trauma providers than in perinatal settings. I am eager to adopt this skill and tool into my NRP teaching program, because I think it's simpler than umbilical cord catheterization. I, like many birth center leaders around the US, am having to find an experienced practitioner who is willing to train me and my staff—at least initially. This barrier to training is too common for birth centers. But there are other instructors like me who are interested in helping birth centers overcome these barriers. CABC and AABC are both committed to helping our birth centers overcome these challenges so that we can all continue to improve our resuscitation skills and readiness.

Nobody is asking for a midwife or birth center to advance further down the algorithm when bag-valve-mask ventilation is effective.

Further reading on this topic:
Which Airway and Vascular Access Procedures Should New Neonatal Resuscitation Program Trainees be taught? Byrne BJ, Patel RS, Johnson CS, Wetzel EA. Open Journal of Pediatrics and Neonatal Care. 2017;2(2): 031-037.

About the Author: Olga Ryan has been a birth center nurse since 2006, and is the Nurse Manager of the El Rio Birth & Women's Health Center in Tucson. Her degree is in Nursing Leadership. She has been a CABC volunteer since 2007, as a Site Visitor and now a Commissioner.

Contact Us:

admin@birthcenteraccreditation.org
Phone: 877.241.0262
www.birthcenteraccreditation.org

Find us on