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Commission for the Accreditation of Birth Centers

In this issue:

Achieving Smooth Transfers

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Planning and Communication Make for Good Transfers

Transferring from a birth center to a hospital is one of most important decisions a provider and client can make together. Although transfer procedures for individual birth centers vary, this article reviews basic strategies to achieve smooth and seamless transfers. Doing so is critical for safety, a positive client and family experience, risk management, provider and staff well-being, and the birth center's reputation in the community.

Most importantly, remember that a transfer should never be seen as a failure on the part of the provider or the client. The culture of the birth center should be that there are never negative repercussions because a provider has initiated a transfer. This supportive environment is particularly important as providers less experienced with community birth settings work to gain experience and confidence. It will decrease the risk of birth center providers practicing "wish management" and delaying transfer in those ambiguous clinical situations.

1. A Good Plan is Critical

The key to smooth transfers lies in planning ahead. It is critical that your birth center have a detailed plan for how to conduct both non-emergency and emergency transfers so that all staff know what to do. This plan should be described in a written Policy & Procedure that is understood by all staff, both clinical and non-clinical. Sharing the plan with collaborative physician(s), hospital staff, and EMS personnel for their feedback can add to its value. The plan should be reviewed frequently and revised as needed. (See #8 on page 2)

2. Include your Clients and their Families in the Plan

Clients, families, and others accompanying a client during labor in the birth center should be aware of the transfer plan. This includes the indications for transfer, the hospital to which clients will be transferred for both emergency and non-emergency transfers, who will assume care at the hospital, and the role of the birth center midwife during and after transfer. This information should be given in late pregnancy and then briefly reviewed, circumstances permitting, when a transfer is initiated. Such preparation helps to avoid misunderstandings and facilitates smooth transfers.

3. Anticipate the Effects of Anxiety

When birth center providers and staff are nervous, they may not remember basic things like your address or hospital phone numbers. The 9-1-1 dispatcher will ask your location and the nature of your call. Post conspicuously the phone numbers and address of your birth center and name of the hospital to which you are transferring. Know whom to call and post the information so that it is readily accessible to staff. This includes the name (or position) and phone number for EMS, hospital personnel, and collaborative physician(s) for both childbearing client and newborn.

4. Use a Script for EMS

Be prepared to give a succinct report. Be brief, state who you are, your location, and the need to transport a client in labor, one who has just given birth, or a newborn. The 9-1-1 operator will then dispatch the call to the medical transfer line. You may be requested to remain on the line awaiting the arrival of the EMS team. If you cannot do this, because you are busy caring for the client or newborn, just tell them. They are accustomed to callers who want them to remain on the line for questions and

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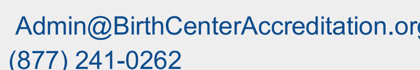
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reassurance until EMS personnel arrive. The role of one staff member should be to open doors, turn on outside lights, and meet EMS as they arrive. EMS policy generally dictates that they transfer to the closest emergency department. They will need to obtain permission to by-pass the ED and go to Labor and Delivery or NICU. (See #9 below) See the September 2019 newsletter for more tips on communicating with EMS.

5. Know Whom to Call at the Hospital

When calling a hospital or provider to accept a client in transfer, give your full name, your title, your location, and a brief summary of why are calling. Ask for the Attending or Resident physician, CNM, or NNP who will receive the client in transfer. For example, "Hi this is Cathy Gordon, I'm a certified nurse-midwife from The Birth Center and I have a woman in labor who needs to transfer to your facility. May I speak to the on-call physician/CNM?" Because a staff nurse cannot accept a client in transfer, you will need to talk to a physician or other provider, although you may want to speak with the Charge Nurse as well. Once the provider agrees to accept the client, you may ask, "Who would like the report?"

6. Use a Script & SBAR Technique for the Receiving Provider

Be prepared, and practice during drills, using SBAR format when communicating within the birth team or with collaborative EMS and hospital personnel. This concise and formalized communication tool can help to assure that adequate information from the birth center provider to the receiving provider and personnel.

7. Mode of Transport

Using an ambulance is often appropriate. It provides extra hands just in case the client unexpectedly gives birth enroute. Birth center staff may not view transporting a client in active labor in a private vehicle as risky, but the perspective of the client's family or hospital personnel may be different. You know your client's labor pattern, but the receiving facility or provider does not, so consider using EMS to avoid conflicts with the receiving hospital.

"Hi Dr. C., I have a G1P0 in active labor at 39 weeks' gestation, she is 6cm /100% /vertex -1 station, and is having periodic FHT decelerations to 90's during contractions on auscultation with recovery to baseline of 130's. She needs transfer for continuous electronic fetal monitoring. Will you accept this client in transfer?"

8. Hand-Off

If possible, accompany your client with printed copies of prenatal records or a transfer report summary sheet. If this is prohibited because of COVID, send a printed copy of the records with the client and also fax to the receiving unit and provider. It is NEVER acceptable to transfer a client without records. When giving your verbal provider-to-provider report, always inform them that records are being sent. Faxing records, in addition to hand-carrying them, allows the unit time to begin the admission process prior to arrival. If the IP, PP, or NB charting is incomplete due to time spent managing a emergency, at least provide critical information that hospital personnel will need to continue management upon arrival in their unit. Consider creating a concise transfer sheet that provides the basic information and uses the SBAR format.

Pregnancy: prenatal labs, antenatal course and issues, medications, basic ultrasound findings and dates.

Labor: significant times/dates, onset, progress, current labor status if client has not given birth, membranes and flue, medications and any other interventions, contraction pattern, FHT baseline and any periodic change.

Birth of newborn and placenta: time/date, any complications, EBL or QBL at the birth center, PP medications and interventions.

Watch for part 2 of this installment next month.

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