FAMILY BIRTH HOUSE

It is proposed that an out-of-hospital birth centre be established in Wellington. The overall goal of this venture is to develop an accessible, low cost perinatal service. Included will be a birthing service for low risk pregnancies,* antenatal education, postnatal education and support. This proposal is an expression of our belief of the following principles:

1. The acceptance of birthing as a normal process requiring the minimum of intervention is the first and perhaps the most important principle.

2. The conditions and place where a woman gives birth greatly affects the course of her labour, the normality of her birth, the health of the baby and the life long relationship between parents and child. We believe that this applies to the majority of women.

3. That the provision of a good birthing experience and the ensuing child/parent relationship can present an opportunity for increased self esteem and self confidence in mothers and a positive parenting relationship from mothers and fathers.

4. Active consumer participation is a necessary component in the planning and administration of a birth and education service.

OBJECTIVES:

1. To establish in Wellington an out-of-hospital birth centre complementary to existing services. It will provide comprehensive maternity care in a home-like atmosphere based on early discharge and follow up at home. This care will be for healthy low risk women who have participated in sound ante natal screening and who are anticipating a normal birth.

2. To develop a comprehensive perinatal education and counselling service that recognizes birth as a normal process.

*See attached Conditions precluding management at Childbearing Centre. Copy from Maternity Centre Association U.S.A. 1977. Guide only.

3. To develop a perinatal education which will support individual birth choice made and which will emphasize the mothers' responsibility for self-care through active participation both during and between each visit.

4. To provide birthing facilities for those families for whom high technological intervention is not a desired component of their birthing ritual.

5. To perform an ongoing assessment of the programme offered to evaluate such factors as outcomes of birth, both physical and psychosocial, costs, and the necessity of transfer. Such evaluation can be used as a guide for modification of this programme and to establish guidelines for further alternatives of birthing and parent education.

6. To ensure a high level of community participation in the planning and providing of the services above.

7. To recruit the services of registered midwives and support personnel who, in consultation with medical practitioners are primary providers of ante and post natal care and birthing assistance.

GENERAL OUTLINE OF PROPOSED FACILITIES/STAFFING/EDUCATION/ ADMINISTRATION:

FACILITY:

The guiding principles identifying a suitable facility to be used as a birthing centre are that it should:

- lend itself to a homelike atmosphere
- provide adequate space for birthing, and educational services
- be reasonably close to an acute care facility
- meet standards as required by local and government agencies

1. Provide a homelike atmosphere:

   This first premise suggests that a large house would be preferable to an office complex.

2. Provide adequate space:

   Given the range of services and anticipated participation it is reasonable to assume that the facility should be large enough to have:

   - two or more birthing rooms which are large enough to have: double bed, chairs, wash basin, work table, staff and family members.
   - a counselling/conference room large enough to accommodate group discussions and the use of educational materials.
   - a family/waiting room which provides a comfortable setting.
   - a kitchen with a sink, stove, refrigerator, and cupboards. (Meals will be the responsibility of families).
   - bathroom space. There should be separate bath/toilet facilities adjacent to the birthing rooms and for the waiting room and staff.
   - reception and records space.
   - utility room.
   - space for emergency supplies and equipment adjacent to birthing rooms.
   - parking space for staff and families.
   - a staff room.

3. Proximity to acute care facility:
Although the need for emergency transfer to hospital will be the exception rather than the norm, for the safety of the mother and baby the birth centre should be within ten minutes travel of hospital.

4. Administration:
The centre will be administered by the members of an incorporative society. The constitution would be written to ensure the principles of the centre were maintained. It is therefore important that the decision making body would consist primarily of individuals who are currently using the Centre. This would be achieved by having two levels of membership:

Full membership	annual subscription	$10.00
Associate membership	annual subscription	$ 5.00

Full membership would be required of anyone using the Centre for birth, ante or post natal education and care givers. The consumer may maintain full membership for three years only following their use of the Centre. This would ensure a dynamic membership.
Associate membership: any member of the public who is interested in the Centre.

Monthly meetings would be held. All members would be welcome.

The Committee would consist of eight elected full members, the majority of this committee being consumers. Any policy changes or additions must be presented at Committee meetings and discussed. Proposals may be made by any member - full or associate. Decisions may be made unanimously at monthly meetings - otherwise the Committee would make the final decision by a 75% majority vote. The Committee would be elected by members within 1 year of the Centre opening. Minutes of the meetings would be available at the Centre. Newsletters would be produced four times a year for members. From time to time it may be necessary for the Centre to invite members on an Advisory Board to help with the administration of the Centre.

Legal advice will be sought as a prerequisite to licensing and writing of the constitution.

ADVISORY BOARD: Skilled personnel such as a dietician, obstetrician, paediatrician, Le Leche, Plunket etc. will be asked to act in an advisory capacity to the Centre.

STAFF:

Initially two midwives will be employed.

STAFF RESPONSIBILITIES:

1. To ensure principles are being upheld.
2. To become familiar with the needs of all parents prior to birth.
3. To seek and co-ordinate voluntary and resource persons to offer a full and varied programme.
4. To care for labouring mother's family and provide ante and post natal care.
5. To act in an advisory capacity to the committee on matters concerning the growth and well being of the Centre.
6. To have regular communication and maintain good relations with members of the Wellington Women's Hospital.
7. To maintain efficient running of the Centre in all aspects.

SERVICES:

Ante and post natal care will emphasize preventive care, family participation, and screening. Ante natal care will be the responsibility of the woman's own doctor. A comprehensive health history to obtain medical, nutritional, obstetrical and family background would be completed by each family. Visits would include regular monitoring of overall health and the pregnancy progress. Families would be advised and assisted in arranging for further postnatal care and family planning.

During all phases of the ante and post natal period family participation will be encouraged in all aspects of care. Information concerning the woman's condition and progress would be openly explained and discussed. Participation in self monitoring of bodily responses such as weight would be an accepted practice.

Ante and post natal education:

The education programme would rely heavily upon continuous scheduled classes for group participation. Families can relate to others their problems and concerns. More informal one-to-one counselling, although utilized, would not be the principal mechanism for education but would be reserved for special situations. Every visit during the ante natal period would also involve brief educational sessions with the midwives and possibly the dietician.

A midwife would make a home visit at least once ante natally and post natally according to need and obstetric regulations working with other support persons during this time. Assistance would also be given in helping the family prepare the home for the additional member.

Essentials of the ante natal education programme include but are not limited to:

- Nutrition.
- Anatomy and physiology of pregnancy.
- Exercise and comfort in pregnancy.
- Preparation for breast feeding.
- Infant care.
- Infant feeding.
- Emotional changes of pregnancy.
- Fathers' and family needs in pregnancy.
- Preparing the home for the additional family member.
- Psychological and psychosexual aspects of birthing.

- Drugs in pregnancy, labour and birthing.
- Discussion of the changing role and expectations of parenthood.
- Self help techniques in labour, birthing and most partum recovery.
- Family planning.
- Sexuality.
- Possible prenatal and post partum emergencies.

SCREENING:

Screening would be a continuous process beginning with the completion of the health history and following through to the actual completion of birthing and post natal care. At any time it may be determined that a problem or risk situation exists that requires more specialized referral or a hospital setting for birthing.

Protocols must be established and adhered to as part of the process: an understanding of these protocols and possible outcomes must be clear to staff, consultants and participants. Families must be aware of the possible outcomes from the beginning. Part of the screening process includes the family's choice regarding birthing.

BIRTHING:

In most cases, birthing will take place at the centre as long as the status of pregnancy remains within the low risk criteria. Participants in the birthing, aside from the mother, would be a registered midwife and members of the family as previously arranged. The birthing rooms would be used for this purpose with a minimum of specialized equipment. Emergency equipment would be immediately available.

For those unable to use the birthing centre, whether by choice, determination of risk or emergency situation, the birthing would be performed in the hospital. Mechanisms for referral or transfer would be previously arranged or be available.

REFERRAL:

The maximum number of enrollees in the ante natal programme will be decided at a later date when the facilities are known. Control over the number of participants must be maintained. This is essential in terms of space and staff capabilities and also in terms of safety and the provision of quality care. It is anticipated that the centre will be able to cope with three to four births per week.

It is preferable for women to join the society from as early as 12/52 of pregnancy. For the first four months of operation participants will be accepted up to the sixth month (24 weeks) of pregnancy. Once established, this figure will be reviewed. Referral may be made by the woman's own Doctor, any organization or self referral. No one will ever be allowed to 'drop in' to give birth when they have not been involved with the entire ante natal programme.

Having control over the number of participants enrolled at one time would accommodate the timetabling of ante and post natal groups of a manageable size in the time available.

Comprehensive family records will be kept; one copy at the Centre, and one for the client. This latter copy will be taken to the doctor at each ante natal and post natal visit.

EMERGENCIES:

The sudden unanticipated emergency during birthing is always a concern. In order to accommodate this possibility, the following mechanism will be arranged.

1. The availability of equipment and procedures to handle emergencies. Not only must the necessary life support equipment be on hand, but all personnel of the Centre must be familiar with its use. Ongoing training and review is essential.

2. A planned system of transfer in emergencies:
   The local ambulance personnel must be familiar with the Centre's location and the situations that might be involved. Periodic meetings would be held to enhance communication and co-operation. The hospital will be notified in advance of what to anticipate. The mother and child will be accompanied with all necessary records to the hospital.

3. The woman's Doctor would be notified at her admission to the Centre, receive regular progress reports and be notified of pending birth.

LINK WITH THE WELLINGTON WOMEN'S HOSPITAL:

The Centre will offer to base hospital families:

1. Antenatal education for those who wish to prepare for natural childbirth and give birth in a hospital.

2. Nursing and Medical students may, at the committee's discretion, attend antenatal classes, take case studies at the Centre - (with the families' approval) and attend postnatal classes.

We see this Centre as a source of education in normal birth which is very important for the future administration of maternal and infant care.

Our aim is that no family will be transferred to the base hospital without understanding of the need for obstetrical management of some births.

3. The Centre facilities may be very suitable to meet the needs of various different cultural groups and their families. We would like to negotiate the possibility of the Centre facilities being available to Wellington Women's hospital Clinic patients for birthing.

4. The Centre will give every support to birth choice by individuals be it Hospital, Centre or Home birth. The Centre would supply a written detail of the family's wishes in this connection as well as the obstetrical progress of the women should they need to be transferred.

The Centre would like to discuss the following proposed arrangements with the Wellington Women's Hospital in the event of a transfer:

1. We would like those women who are transferred to the Hospital to have their individual preferences met as much as possible after immediate safety factors are attended to.

2. The Centre staff would like to meet with Hospital staff at regular intervals to discuss transfers, and also Hospital staff may wish to attend a Centre meeting where a woman who was transferred wishes to discuss her birth experience.

3. In an <u>extreme</u> emergency we would like the Hospital to send staff to help cope with a situation prior to transfer.

<u>FUNCTIONING OF THE CENTRE</u>:

Access available to all Wellington women.

<u>Referral</u>:

Self
G.P.
Obstetrician
Hospital team

Initial Interview:

Would include:
Tour of Centre.
Discussion of the philosophy of the Centre.
Discussion of birth choices (high risk patients would be identified at this level).

Self referral patients would then be required to register with a Doctor for antenatal care.
supervision of the birth.
post partum supervision.

Series of antenatal classes would be held for a family to become familiar with the Centre, to prepare for management of pregnancy, labour, birth and parenting.

At the onset of labour, the Centre staff would be notified and the family would then go to the Centre and settle in for the birth. This early settling in period would be encouraged.

Labour:
Each labour would be assessed on the individual needs of the mother and baby - not by the clock.

All effort would be made to avoid unnecessary
noise
drugs
episiotomy
artificially ruptured membranes
confinement to bed
restricted food and fluid intake
shaving of the perineum
enemas

Notification of the Doctor:

The Doctor would be notified of admission, progress and the impending birth.

First 24 hours after birth:

Would normally be spent at the Centre.
Breast feeding would be initiated and initial bathing of infant performed.
Both mother and infant's condition would be thoroughly checked during this period.
Families would bring their own linen and food - this may be stored prior to delivery. Families are responsible for their meal preparation.

Discharge home:

Would normally be after 24 hours. There would be daily post natal visits to the home for as long as necessary.

Home help would be established within a roster of volunteers and other agencies. Introduction to a post natal support group would be facilitated also.

Ros Capper
2a Rarea Crescent
Kelburn.

Pam Skelton
67 Montreal Grove
Kingston.

EQUIPMENT AND COSTS	COMMENTS	ESTIMATED COST $	$
Premises	Quotes from Newtown are for suitable buildings range $30,000 - $50,000 Renting may be considered.	40,000 & repairs 10,000	50,000
Furniture Bedrooms	1 double bed, dressing table, wardrobe, 1 easy chair, mat, lamp, coffee table, heater, basinette, electric jug, crockery - all new prices	2,500 for 3 rooms	2,500
Sitting Room	2 large sofas 3 easy chairs pictures, odds and ends	 900 100	 1,000
Kitchen/Dining	Dining room suite (new) Refrigerator - assuming it is not already installed Crockery, cutlery, electrical appliances	 1,000 200	 1,200
Utility & Bathrooms	Basins installed in all bedrooms) Disposal unit) 2 stainless steel benches Washing machine Dryer	quote approx. 3,000 450 200	 3,000 650
Linen	Spare only. Towels, sheets, pillowcases, napkins, cot sheets, baby gowns etc. For autoclaving delivery bundles towels, sheets	400 200	400 200

SURGICAL & PHARMACEUTICAL SUPPLIES

				$
Ante & Post Natal	Stethoscope	(2)	$15 each	30
	Stethoscope foetal	(3)	2 each	6
	Sphygmomanometer	(2)	54 each	108
	Thermometers	(1 doz)	6 doz	6
	Touch	(1)	2 each	2
	Baby scales	(2)	5 each	10
Delivery	Bowls (stainless steel) (small)	(6)	5 each	30
	Kockers forceps	(6)	20 each	120
	Surgical scissors	(6)	5 each	30
	Cord clamps	(100)	8 per box	8
	Needle holders	(2)	20 each	40
	Tooth dissecting forceps	(2)	20 each	40
	Mayo scissors	(2)	20 each	40
	Sponge forceps	(2)	20 each	40
	Syringes 2cc	(100)	15 box 100g	15
	Syringes 10cc	(100)	15 box 50	15
	Suture material 2^{o} chromic	(100)	40 box	40
	Mucous extractors	(50)	50c each	25
Emergency	1 pair neville Barnes forceps	1		
	Wall suction	1		
	Infant laryngoscope	1	58 each	58
	Penlon bag	1	60 each	60
	Airways 0.00 size	1	1.60 each	4
	Suction catheters	(1 doz)	1 each	12
	Urinary catheters	(1 doz)	1 each	12
	O_2 & flow metre	1	175 each	175
	Adult resus tube	x2	1 each	2
	IV giving set with needle	10	48c each	5
Fire equipment				
Stationery	Family Record	200	75c each	150

DRUGS

Routine Use	Lotions etc.		
Emergency	Drugs Infusion equipment		
Extra	Sterilizer		
	Drip Stand	$200 (small water type)	$200
	Telephone answer service	$355 & $20 for installation)	$375

Maternity Center Association

Demonstration Project in Out-of-Hospital Maternity Care

Conditions precluding management at Childbearing Center

The following Criteria will be applied to all women by professional staff during the antepartum, intrapartum and postpartum periods.

A cumulative score of 2 points on the Initial Score Sheet indicates the women is at a risk incompatible for project care. Accepted women will be continuously evaluated for presence of any listed antepartum, intrapartum or postpartum criteria and be referred or transferred to the back-up facility or physician.

Developed by the Medical Team Staff of the Childbearing Center; originally approved for distribution by the Medical Advisory Board of Maternity Center Association, November 15, 1976.
Subject to change based on experience.

Revised 11/22/77

Score	Problem Description
	I. Initial Data Base
	Socio-Demographic Factors
2	1. Chronological Age: 35 & over primigravida
2	40 & over multigravida
2	2. Permanent residence outside specified target area
	Documented Problems in Maternal Medical History
	A-Cardio-vascular
2	3. Chronic Hypertension
2	4. Heart Disease
2	5. Pulmonary Embolus
	B-Urinary System
2	6. Renal disease moderate to severe including nephritis or 1 episode of chronic renal disease
1	7. One episode of pylonephritis prior to this pregnancy
2	8. Two episodes of cystitis prior to this pregnancy and evidence of asymptomatic bacteruria (≥ 100,000 colony count)
	C-Psycho-Neurological
1	9. Previous psychotic episode adjudged by psychiatric evaluation
2	10. Current mental health problem adjudged significant by psychiatric evaluation and/or required use of drugs related to its management
1	11. Epilepsy or seizures
2	12. Required use of anticonvulsant drugs
2	13. Drug addiction (heroin, barbiturates, alcohol etc.), current use of addicting drugs, or current therapy related to these additions
2	14. Severe recurring migraines
	D-Endocrine
2	15. Diabetes Mellitus and/or gestational diabetes
1	16. Thyroid disease a. History of thyroid surgery
2	b. Enlarged thyroid gland with symptoms of thyroid disease based on T3 or T4
1	c. Current use of thyroid related medications
	E-Respiratory
1	17. Asthma and/or chronic bronchitis within the last 5 years
	F-Other Systems
2	18. Bleeding disorder and/or hemolytic disease
1	19. Sensitivity to local anesthetics ("caines")
2	20. Previous radical breast surgery
2	21. Other serious medical problems
	Documented Problems in Maternal Obstetrical History
2	22. EDC less than 12 months from date of previous delivery
2	23. Previous Rh sensitization
2	24. Parity of 4 or more
	25. Infertility problems
1	a. Workup and counseling more than 3 years prior to this pregnancy
2	b. Use of fertility drugs to achieve this preg.
	26. Previous abortions:
2	a. 3 or more spontaneous (< 28 weeks)
2	b. 1 septic
2	27. Previous uterine surgery including C-section and cone biopsey (if previous tubal pregnancy & enrollment before 16 weeks accept conditionally)
2	28. Previous placenta abruptio
1	29. Previous placenta previa and/or significant third trimester bleeding
2	30. Severe hypertensive disorder during previous preg.
2	31. Postpartum hemorrhage apparently unrelated to management
	32. History of prolonged labor:
1	a. Primipara-Stage I > 24 hrs; Stage 2 > 3 hrs; and/or Stage 3 > 1 hour.
1	b. Multipara-Stage I > 18 hrs; Stage 2 > 2 hrs, and/or Stage 3 > 1 hr.

Score	Problem Description
	Documented Problems in Previous Infants
1	33. Stillbirth (>28 weeks gestation)
	34. Birthweight:
1	a. < 2500 grams
1	b. >4000 grams
1	35. Major congenital malformations
2	36. Genetic/metabolic disorder
	Maternal Physical Findings
2	37. Gestation more than 22 weeks
2	38. Weight for height outside intervals on attached chart
2	39. Clinical evidence of uterine myoma or malformations, abdominal or adenexal masses
2	40. Polyhydramnios or oligohydraminos
2	41. Cardiac diastolic murmur, systolic murmur grade III or above and/or cardiac enlargement
2	42. Pelvimetry indicative of inadequacy to deliver an infant of 3100 gm.
	Laboratory/Radiologic Findings
1	43. a. Hct less than 31%
2	b. Hct less than 28%
2	44. SS Hemoglobin
2	45. Pap smear class 3 or greater with positive colposcopy
2	46. Evidence of active tuberculosis
	II. Antepartum Referral Factors
2	47. Hct less than 34% if entering the 37th week of gestation
2	48. Multiple gestations affirmed by sonogram
2	49. Evidence of fetal chromosomal disorder in amniotic fluid
2	50. Development of symptoms of pre-eclampsia
2	51. Intrauterine growth retardation
2	52. Thrombophlebitis
2	53. Pylonephritis
2	54. Symptoms of gestational diabetes affirmed by abnormal glucose tolerance curve
2	55. Development of unexplained vaginal bleeding
1	56. Abnormal weight gain (<12 or >50 lbs.)
1	57. Non-vertex presentation persisting past 37th week of gestation
2	58. Laboratory evidence of sensitization in Rh negative women
2	59. Postmaturity (42 weeks/294 days gestation)
2	60. Development of any other severe obstetrical, medical and/or surgical problem
2	61. Development of genital herpes affirmed by culture
	62. Circumstantial factors: Medical Team Staff decision, after taking into account and review of all of the family circumstances, including make-up, general physical condition, and total situation, that the childbearing in this case would be best accomplished under the supervision of a physican in a more traditional medical setting, i.e.,
2	a. Lack of available support person to be in the home during the first 3 postpartum days
2	b. Lack of source of pediatric and/or obstetrical follow-up after 28 weeks of gestation
2	c. Consistent non-attendance at classes and/or office hours
	III. Intrapartum/Postpartum Transfer Factors
2	63. Premature labor (less than 37 weeks gestation)
2	64. Premature rupture of membranes (greater than 12 hours before onset of regular contractions)
2	65. Non-vertex presentation
2	66. Evidence of fetal distress a. Abnormal heart tones b. Meconium staining
2	67. Estimated fetal weight less than 2500 gm. or greater than 4000 gms.
2	68. Development of hypertension
	69. Failure to progress in labor:
2	a. First stage: lack of steady progress in dilitation and descent (Friedman graph) after 24 hours in primipara & 18 hours in multipara

MATERNITY CENTER ASSOCIATION CHILDBEARING CENTER

Score	Problem Description
2	b. Second stage: more than 2 hours without progress in descent
2	c. Third stage: more than 1 hour
2	70. Prolapse of cord
2	71. Soft tissue problems
	a. Severe vulvar varicosities
	b. Marked edema of cervix
2	72. Intrapartum blood loss greater than 500 cc and/or postpartum hemorrhage
2	73. Development of other severe medical/surgical problem
2	74. Evidence of active infectious process
2	75. Any condition requiring more than 12 hours of postpartum observation
	IV. Infant Transfer Factors
2	76. Apgar score less than 7 at 5 minutes
2	77. Signs of pre or post maturity
1	78. a. Weight between 2200 and 2499. (Pediatrician to determine whether hospitalization is necessary)
2	b. Weight equal to or less than 2199 grams
2	79. Respiratory problem
2	80. Jaundice
2	81. Persistent hypothermia (less than 97°F, rectal after 2 hours of life)
2	82. Exaggerated tremors
2	83. Major congenital anomaly
2	84. Any condition requiring more than 12 hours observation post-delivery

Acceptable Weights for Women Over 25* at LMP

Height without Shoes	Type of Frame: Small	Medium	Large
4'8" (56")	92-98	96-107	104-119
4'9" (57")	94-101	98-110	106-122
4'10" (58")	96-104	101-113	109-125
4'11" (59")	99-107	104-116	112-128
5'0" (60")	102-110	107-119	115-131
5'1" (61")	105-113	110-122	118-134
5'2" (62")	108-116	113-126	121-138
5'3" (63")	111-119	116-130	125-142
5'4" (64")	114-123	120-135	129-146
5'5" (65")	118-127	124-139	133-150
5'6" (66")	122-131	128-143	137-154
5'7" (67")	126-135	132-147	141-158
5'8" (68")	130-140	136-151	145-163
5'9" (69")	134-144	140-155	149-168
5'10" (70")	138-148	144-159	153-173
5'11" (71")	142-152	148-163	157-177
6'0" (72")	146-156	152-167	161-181
6'1" (73")	150-160	156-171	165-185

*For women less than 25, subtract 1 pound for each year under 25

Underweight - prepregnant weight 10% or more below standard weight for height and age+

Overweight - prepregnant weight 20% or more above standard weight for height and age+

+Pitkin, Roy M. "Risks Related to Nutritional Problems in Pregnancy" Risks in the Practice of Modern Obstetrics, 2nd Ed., Editor: Silvio Aladjem, St. Louis: 1975; C. V. Mosby Co., pg. 168.

ONGOING ANNUAL COST

Staff	2½ midwives $12,000 per annum, full time) $ 6,000 per annum, part time)	Depending on work load travel and mileage allowance may need to be added.	$30,000
Maintenance of premises	$500		900
Rates	$400		
Maintenance of Equipment	Repairs & replacement. New Equipment.		500
Maintenance of Pharmacy	Day to Day supplies $15.00 per week		780
Electricity	$150 2-monthly periods		900
Telephone	$20 for two months		120
Stationery	Newsletters etc.		200
Petty Cash	Day to day expenses i.e. coffee, tea cleaning equipment	$30.00 week	1,500
TOTAL:			

The Centre will be equipped to cater for 4 births per week.