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Laboring at Home: Reasons to Transfer into Hospital

Adapted from Pomegranate Midwives

Whether you are planning a home or a hospital birth, unless you plan on being induced or having a booked caesarean (i.e. being in the hospital before contractions start), this handout is for you.

Parents planning either to birth at home or to experience the majority of their labors at home, often inquire about the situations in which we would recommend transport to hospital. Once labour is established, we monitor you and your baby carefully during labour and then the immediate postpartum, with the aim to act on concerns before a serious problem arises. Both research and experience tell us that when care providers transport a client to the hospital it is almost always for a non-emergent indication.

Described below are the most common reasons for hospital transfer, listed loosely in order from most to least common. We recognize that it can be frightening to think about what could go wrong, so while reading, try to remember that the incidence of these complications is quite low. Fortunately, a vast majority of the time the birth process remains normal for healthy people. Please speak to your care provider if you have any questions.

Non-emergent transports (usually by personal car)

Slow or no progress in labour

This is the number one reason for people who are pregnant for their first time to transport to hospital, and includes over half of our transports.

Early labour (<4cm dilation)

Duration of early labour varies—there is no "time limit". There are many strategies for coping with a long early labour. Sometimes this includes using medications to help the pregnant person to get rest. These must be prescribed and administered in hospital, but the pregnant person can return home afterwards.

Active labour (First stage: dilation from 4-10 cm)

Everyone's rate of progress through labour will be different. Care providers have many tools to assist labour to progress. If none of these has worked and progress is truly stalled, then transport to the hospital will be recommended — for medications to facilitate pain management/rest and for labour augmentation with oxytocin. In cases of prolonged labour (very slow but still progressive), there may be a small associated increase in risk to the pregnant person and the baby, and increased monitoring in the hospital may be appropriate.

Pushing (Second stage)

The average person who is pregnant for their first time pushes for 1-2 hours. For some pregnant people, second stage is prolonged, or progress may be completely stalled. In these cases, physician consult for labour augmentation with oxytocin or for assisted delivery (vacuum/forceps/caesarean) may be recommended. Sometimes the baby is found to be presenting in a position that is unlikely to successfully deliver, in which case a physician consult to manually turn the baby may be recommended before pushing any further – and after which, if successful, the birth would continue as a low-risk planned-hospital event.

If you have had a previous vaginal birth, it is average to push for 20-60 minutes. Because second babies come so much faster and easier, it would be exceptionally rare to recommend transport in the pushing stage as there would be a good chance of baby being born en route.

Meconium

This is the second most common reason to transport to hospital and the number one reason for people who are pregnant for the second time.

This reason for transport is that meconium is found in the amniotic fluid. This means that the baby has had a bowel movement before or during labour, and it may be a sign that the baby possibly is, or has been, stressed. Or it may also indicate that the baby has a mature gut which already started working (which is why this is more common in overdue babies that are more neurologically mature). Whatever the reason, if the baby inhales the sticky meconium with its first breath, then this may make it difficult to fully inflate its lungs. The risk of this happening increases according to the amount of meconium in the fluid but can happen to any baby. If the birth is not too imminent for safe transport, then your care provider will recommend transport into the hospital; once there, continuous monitoring will be recommended to assess if the labor is stressful to baby, and a Peds team will be called to attend the birth.

If the birth is imminent, then your care providers will prepare to suction the meconium out of baby's mouth and nose, if possible, before the baby takes its first breath – although if your baby comes out crying and vigorous, then obviously this will not happen!

Atypical baby heart rate concerns

We monitor your baby at home in the same way as we do in the hospital for normal birth. This includes assessments of your baby's heart rate frequently once you are in active labor, and even more so once you are pushing. If we hear something that is atypical during one of these checks, we will increase our assessments to verify if this is a pattern versus a one-time event.

If there is a pattern of atypical heart rates – which could potentially indicate future problems – we may recommend transport in order to have access to increased monitoring and interventions if they become necessary. We usually transfer by private car. The exception to this is if the birth is imminent (in which case we would take measures to expedite the birth, and possibly have an Infant Transport ambulance standing by with us at home).

Because we are trying to make the decision about transport early, i.e. before a true problem arises, sometimes we overestimate it's seriousness, and thus it is not uncommon in these transports for the heart rate to have stabilized en route, and then the birth proceeds at the hospital as a low-risk planned-hospital event.

Maternal vitals

Blood pressure

High blood pressure (>140/90) is associated with an increased risk for the pregnant person and the baby, and transport to the hospital allows access to lab work, extra monitoring of the pregnant person and the baby during labor, physician consultation and medications if necessary.

Temperature

Fever (>38.0 C) is a sign of infection. This would need to be treated in hospital with medications to combat infection (antibiotics, IV fluids), extra monitoring of the pregnant person's and the baby's health during labor, and potentially specialized pediatric care for an ill newborn.

Pain medications

It is rare for pregnant people to request pain meds until they are experiencing either a long and non-progressive labour, or they are having an exceptionally rapid birth. In the first case, usually by the time the pregnant person wants pain meds the care provider has tried ever other trick they have to help labour progress. In these cases, pain meds are actually a recommended option, usually in combination with oxytocin augmentation. These are only available in hospital.

In the second case, usually the birth is too imminent for transport or pain medications, and the best strategy is to reassure the pregnant person that it will be over with momentarily, while quickly getting ready for the birth.

Third- or fourth-degree tears

These large vaginal tears are rare, and most commonly associated with instrumental deliveries. Since management requires special instruments and clinicians experienced in advanced repair, transport to hospital and physician consultation would be indicated. Often it is done as an outpatient, so that you are only in hospital for about an hour and can come home directly afterwards.

Previously undetected twins or breech presentation (baby is coming bottom first)

All care providers are trained in how to deliver twins/breeches, but obstetricians have more experience with this. There are associated risks for these babies, so if there is time we recommend transport to hospital for the birth in order to have access to specialized obstetric and pediatric care.

The pregnant person's instinct

We have a high respect for maternal instinct. Any time the pregnant person decides they want to go to the hospital, we go. The exception is if the birth is so imminent that it is unsafe to do so.

Emergent transports by ambulance

Abnormal fetal heart rate

If the fetal heart rate is more than atypical – what we would consider abnormal – we would transfer to hospital by ambulance, to allow prompt access to obstetric and pediatric support.

Excessive bleeding

During labour

The occasional person has a cervix that bleeds heavily during labour as part of the normal dilation process. Almost all pregnant people have bleeding in the last few centimetres of dilation. But if the amount of bleeding is assessed as excessive in volume, especially if combined with sudden fetal heart concerns, this could indicate one of a few possible concerns including the start of a placental abruption (placenta coming away from the uterine wall). Due to potential risks to the pregnant person and the baby, emergency transport to hospital for further monitoring and assessment would be advised.

After birth

Most postpartum hemorrhages can be managed at home with good outcomes, as we carry a number of anti-hemorrhagic medications and IV fluids. Serious blood loss, although rare, requires transport by ambulance to hospital, allowing increased access to obstetric support and maternal stabilization interventions.

Even if the amount of blood loss is within normal range, sometimes people cannot tolerate even this much and their blood pressure will not stabilize postpartum. If you cannot sit or stand without passing out within a few hours of the birth, despite whatever measures we have used to stabilize you, then we would recommend transport to the hospital. Although this is not a true emergency, we would still want to call an ambulance because of the need to move you by stretcher.

Cord prolapse

In the very rare event that the umbilical cord prolapses (falls down) in front of the baby's head, blood flow to the baby can be compromised and a caesarean is required promptly to safely deliver the baby. The care provider inserts their hand into the pregnant person's vagina to lift the head up and off the cord to prevent or decrease cord compression during transport, and obstetric and pediatric support are notified prior to arrival to the hospital to prepare a team to

receive the transport. These transports, while awkward with the pregnant person and the care provider on the stretcher, usually have good outcomes.

Newborn having difficulty transitioning

Acute

Immediately after birth, most newborns transition quickly and easily to breathing air; some cry vigorously, others are quietly calm. About 1 in 10 babies need some assistance transitioning — usually this will be in the form of vigorous rubbing, suction and/or oxygen by mask for 1-2 minutes. In rare situations it can mean full CPR up to and including intubation. Our care providers are trained in neonatal resuscitation, carry oxygen and emergency resuscitation equipment, and are skilled in responding quickly if a baby has difficulty breathing at birth. A small percentage of babies needing resuscitation will require specialized pediatric care and ongoing observation, and these babies will be transported to hospital by ambulance. If the pregnant person is stable, they will be allowed to come with baby.

Ongoing

Sometimes newborns are vigorous at birth but do not completely stabilize in the next few hours – their breathing is labored and fast, their temperature is unstable or too cold, etc. In this case, transport to hospital is advised for further pediatric observation and supportive care. This may not involve an ambulance if they are mostly stable but just need further observation.

Please feel free to discuss any specific concerns you may have with your care provider. They will be happy to answer any questions you may have.