Guideline

Home birth

Audit standards

1. All women choosing a home birth should have a planning meeting at 36 weeks (or as soon as possible if the woman makes a decision after 36 weeks) with a community midwife, where the midwife undertakes a risk assessment, completes the home birth checklist form and discusses the risks and benefits of planned place of birth.
2. If a woman does not fit the criteria for home birth, there should be evidence of an individualised agreed plan of care.
3. If a woman is transferred into hospital from home during a planned home birth, an obstetric review (if appropriate, and as per guidelines) by at least an obstetric registrar (years 3-7) should take place.

1 Scope

Local: This guideline is intended for use primarily by community midwives caring for women in the community who are considering, or who have requested, home birth. It is applicable to low risk women. However, midwives and obstetricians should be aware that a woman with a high risk pregnancy may also choose to give birth at home; in this situation the appropriate advice should be sought and guidelines followed.

2 Purpose

The purpose of this guideline is to:

- support midwives in facilitating women's choice of place of birth
- guide community midwives in the information that they should discuss with women to support their decision.
- provide a framework for midwives attending home births

3 Planning place of birth

All low-risk women should be offered the choice of planning birth at home, in a midwife-led unit, or in an obstetric unit. Women should be informed:

- That giving birth is generally very safe for both the woman and her baby.
- That the obstetric unit provides direct access to obstetricians, anaesthetists, neonatologists and other specialist care including epidural analgesia.
- Of locally available services, the likelihood of being transferred into the obstetric unit and the time this may take.
- That if something does go unexpectedly seriously wrong during labour at home, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care.
- That if she has a pre-existing medical condition or has had a previous complicated birth that makes her at higher risk of developing complications during her next birth, she should be advised to give birth in an obstetric unit.

4 Evidence for home birth

Both the NICE intrapartum care guideline (2007) and the recent Birthplace study (2011) acknowledge that among women who plan to give birth at home (or in a midwife-led unit) there is:

- a higher likelihood of a normal birth
- significantly less intervention in birth eg caesarean section, episiotomy, forceps, epidural.

The birthplace study, the largest prospective study on planned place of birth found:

- poor outcomes (ie perinatal mortality and intrapartum related neonatal morbidity eg stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus or clavicle) for low-risk women were rare (4.3 per 1000 births)

and for women planning birth at home, that:

- low-risk multiparae experienced no difference in adverse outcomes compared to women in an obstetric unit
- low risk nuliparae experienced a higher risk of an adverse outcome compared to women in an obstetric or midwife-led unit (1 in 110 vs. 1 in 190 for women in an obstetric unit)
- intrapartum transfer rates were around 40% for nulliparae and 10% for multiparae.

With respect to midwife-led units, both nulliparae and multiparae experienced the same perinatal outcomes compared to that in an obstetric unit, but again there was less intervention in birth.

The study concluded that the results support a policy of offering healthy women with low risk pregnancies a choice of birth setting. B

Low-risk women should therefore be offered a choice as to the place of birth during pregnancy and this should be a subject for discussion, along with the risks and benefits of each place of birth, at booking. The choice of place of birth, including home birth, should be documented at booking for all women in the hand-held notes on page 18 and agreed late in pregnancy on page 33. However, discussion is appropriate at any stage of pregnancy. ✓

The decision regarding planned place of birth should be made by 36 weeks to allow time for planning, or as soon as the woman has opted for a home birth if the decision is later than 36 weeks. ✓

5 Risk assessment

A risk assessment must be carried out by the community midwife when planning place of birth to agree with the women an appropriate place of birth. Refer to LR 1.6: Risk assessment and criteria for referral for obstetric-led care (or obstetric opinion) by midwives guideline.

Risk factors may change during pregnancy and so assessment must be carried out at each antenatal visit. Factors that may affect mother and baby include:

- previous obstetric complications,
- problems occurring in this pregnancy and
- risk factors in the medical history. B

Women who are not low risk may also choose home birth and appropriate guidelines must be followed for care of these women, eg women with a history of group B streptococcus (GBS) carriage. A consultant obstetrician, a supervisor of midwives and the community midwifery manager should become involved where there is a perceived risk or contraindication to home birth, and the woman intends to give birth at home. Evidence of discussion and the plan for care should be documented in the woman's hand held notes. A supervisor of midwives/ community midwife manager is available to give support and/ or advice. ✓

6 Planning for a home birth

6.1 Discussion with woman

When the decision has been made for a home birth, the home birth leaflet should be given and discussed. The following points should be discussed and documented on the home birth checklist which should then be signed by the woman and the community midwife: ✓

1. The benefits (and risks) of home birth – as described above in sections 2 and 3.

2. How and when to contact a midwife when in labour, that an on-call system is in operation and that she may not receive care from a known team midwife. Community midwives should also inform women that the Trust cannot provide an absolute guarantee that a midwife will be available to provide a home birth service.
3. The preparation of the woman's home for a home birth and any recommendations required to ensure a safe environment.
4. A list of equipment to obtain for the birth.
5. Inform a woman that emergency situations can arise during labour and immediately after birth. Whilst midwives are trained to deal with obstetric and neonatal emergencies, some situations may require rapid transfer to the nearest hospital. Women should also be made aware that community midwives carry only limited equipment to deal with emergencies.
6. Reasons for, and method of, transfer into hospital during labour. The discussion should include:

    - the distance to the nearest unit and probable journey time in case of emergency
    - accessibility
    - car parking in close proximity to the woman's house/ flat
    - help for the midwife to carry equipment. ✓

    The woman should be encouraged to be realistic in her expectations of the personnel attending the birth and the limitations that location can impose.
7. If the woman desires to have pethidine in labour, a prescription must be obtained beforehand from the woman's GP. The pethidine remains the property of the woman. If she wishes the baby to have oral vitamin K a prescription from the GP must also be obtained. This may have to be specially ordered by the local pharmacist.
8. If the woman has decided to give birth at home when she is high risk, the appropriate guidelines and plan for care should be discussed and the woman offered a copy of the relevant guideline(s), which should be clearly documented.

It is the responsibility of the midwife undertaking this discussion to either complete the booked home delivery form and to send this to the community secretary, or to send this information via e-mail. She will then collate the information on all impending home births and send this monthly to all community midwives, so that community midwives can familiarise themselves with any forthcoming home births, the women's address and any access issues and plans in place for specifically for that birth.

If there is a particular concern antenatally, eg for a high risk woman, it is recommended that the management of the case be discussed with the community team leader. A supervisor of midwives and/ or the clinical service manager for community may also be contacted for advice. All discussions with women should be documented regarding the risks.

6.2 Home birth documentation

It is recommended that the named midwife leave the homebirth paperwork 'pack' for a home birth with the woman, when a home birth is planned, ie: ✓

- Midwifery home or admission assessment tool
- Partogram
- Post-natal venous thromboembolism (VTE) assessment tool
- PROTOS (the maternity clinical information system) record sheet
- Transfer of care/ handover sheet
- Assessment of perineal repair
- Moving and handling assessment tool
- Intrapartum continuation sheets
- Post-natal notes
- Modified early warning score (MEWS) chart
- Adult drug chart
- Paediatric drug chart
- Post-natal advice leaflets/ booklets

7 Process for summoning a midwife when the woman is in labour

Women should be requested to telephone the maternity assessment/ delivery unit when they think they are in labour. An assessment should be made on the telephone by the hospital midwife using the telephone assessment tool and the decision made as to whether attendance is then required by a community midwife. A telephone handover should be given to the community midwife in accordance with the guideline on handover (HR 2.1 Multiprofessional communication in Maternity Services and staff handovers).

The midwife's attendance is arranged by the daily community coordinator during the day (08.00 – 17.00) and the delivery unit (DU) coordinator overnight and/ or 984 bleep-holder.

7.1 The daily community coordinator/ bleep-holder 984 role

The daily community coordinator/ 984 bleep-holder should be made aware when the midwife visits the home for her (or his) own safety (see the Trust's lone working policy and the lone working section of the Trust's violence and aggression management policy).

It is the responsibility of the daily community coordinator /984 bleep holder DU coordinator to record:

- the time the midwife is called to the house
- the name and hospital number of the woman
- the location the midwife is attending

The purpose or recording this information is to ensure safety for the midwife.

Following the birth and when leaving the house, the community midwife should notify the DU coordinator/ 984 bleep holder in order to comply with lone working recommendations.

7.2 Second midwife

Whilst the attendance of a second midwife is not a legal or professional requirement, it is recommended that a second midwife attend for the birth of the baby to provide support and assistance. The midwife should request the DU coordinator/ daily community coordinator to do so at an appropriate time.

If there is no community midwife available to attend as 2nd midwife for a home birth, the process in appendix 1 should be followed. ✓

8 Equipment and competency

8.1 Equipment and checking procedure

The Trust will provide equipment to all community midwives to enable them to undertake home births safely.

The community midwife **must** carry equipment at all times during her working hours to ensure adequate care and provision of emergency treatment (see appendix 1).

It is the midwife's responsibility to ensure that drugs carried are in date and stored appropriately. The midwife should be aware that syntometrine and ergometrine deteriorate at temperatures in excess of 25°C. A cool box is provided for use in hot weather and should be used when necessary.

It is also the midwife's responsibility to ensure that their mobile phone is adequately charged so that it is available to call assistance if necessary.

Each midwife is responsible for checking his/ her equipment and drugs monthly, and on arrival at the woman's home when called to give care in labour. Community midwives must sign their monthly activity report to confirm that they have carried out their monthly equipment check and then submit this monthly to the community secretary. This check will verify that the community midwife has undertaken the following:

- the equipment as set out in appendix 1 in her possession
- checked the equipment as defined above for functionality
- checked the resuscitation equipment in appendix 1 and that the drugs carried by the midwife, including oxytocics and resuscitation drugs, are in-date and stored correctly.

The completion of the 'equipment check' by community midwives will be checked each month on receipt of the activity form by the secretary of the community service manager (CSM), who will alert the CSM if there are any discrepancies. 

8.2 Use of Entonox in the community

Each community midwife will be issued with a cylinder of Entonox and be instructed in its use in a community setting.

Replacement entonox cylinders can be obtained via the Rosie Hospital porters. Telephoning in advance will ensure that the replacements are available on the midwife's arrival, extension 2696 (main hospital portering service - the Rosie Hospital porter will be bleeped by them).

Ideally, entonox should be stored at temperatures above 10°C. Separation of the gases may occur below 0°C. The cylinder may be gently agitated to recombine the gases. This will also help the entonox to last longer if the supply is running out.

8.3 Midwife competency

All midwives should be competent to attend a home birth. However, if any community midwife feels she lacks confidence in home birth, she must recognise her professional responsibilities with regard to the NMC framework and raise any concerns with their supervisor of midwives and line manager.

The midwife must also follow the requirements for updating in emergency procedures, namely:

- intravenous cannulation
- perineal suturing

- management of obstetric emergency eg postpartum haemorrhage, shoulder dystocia
- basic life support: Adult and neonatal resuscitation C

as identified in the Maternity Services training needs analysis (TNA).

9 Intrapartum care

9.1 Clinical care

Care of the woman in labour, and observations to be performed in labour, should be carried out according to the low-risk labour care guidelines (see Maternity Services documents on Connect). In particular, the following low risk intrapartum care guidelines are applicable:

- LR 2.3: positions for labour and birth guideline
- LR 2.4: pre-labour and the latent phase of labour: care, support and analgesia guideline
- LR 2.5: eating and drinking in low-risk labour guideline
- LR 2.6: fetal monitoring in low risk labour guideline
- LR 2.7: First stage pathway for normal labour guideline
- LR 2.9: second stage of labour - low risk women guideline
- LR 2.10: physiological management of the third stage of labour guideline
- LR 2.11: active management of the third stage of labour guideline

And high risk:

- HR 2.1: Multiprofessional communication in maternity services and staff handovers

Note: this list is not exhaustive.

If the woman has arranged to have a water birth at home, the midwife should refer to low risk intrapartum guideline 2.14: water birth.

The room should be adequately prepared for the birth, including available warm towels and a warm, draught-free area set aside for care of the baby. A hat is advisable to keep the baby's head warm. Consideration should be given to the preparation of the room to allow for the management of an emergency.

9.2 Ongoing risk assessment and seeking advice

Risk assessment must continue during labour, with appropriate actions taken and advice sought where necessary. The midwife should seek advice from the DU co-ordinator/ 984, the obstetric specialist trainee (year 3-7) or obstetric consultant on DU, if required.

The on-call supervisor of midwives may be contacted by calling Addenbrooke's switchboard and asking for the on-call supervisor.

9.3 Transfer to hospital

9.3.1 Calling an ambulance

Where transfer in labour or post-partum is necessary, it is the responsibility of the midwife to summon an ambulance (via a 999 call). The midwife must make it clear to the call staff that he/ she is a health professional and arranging a 'health care professional (HCP) admission'.

The call centre staff will ask a series of questions (location/ contact telephone number/ patient's age/ is she awake/ breathing?) which will prioritise the urgency of the ambulance request, as per the ambulance protocols. The call centre staff will then ask for the reason for admission and whether a health care professional is with the woman. If it is an emergency situation, it should be stated that it is '**an obstetric emergency'** and **a paramedic emergency ambulance** requested (as in the situation of, for example, maternal collapse, cord prolapse, post-partum haemorrhage, need for neonatal resuscitation, fetal heart rate (FHR) abnormalities). A paramedic ambulance should **only** be requested if skills are required that only a paramedic can provide (ie IV access, intubation, extended drug administration and more invasive techniques); if an emergency technician if first on scene and identifies that additional skills are needed, he will request these from the control room.

The call centre will ask whether the situation creates an 'immediate threat to life' of the mother and/ or baby (as in the example situations described above). The response will result in one of the following three options:

Is there an immediate threat to life?	**Ambulance response**
'No'	'*Normal road speed'* response within a four hours window unless sooner is specified. Unlikely to be appropriate in a home birth situation.
'No, but lights and siren are required'	'Blue light' response graded as a 'G1' call with a target response time of 20 minutes (*immediate response*)
'Yes'	'Blue Light' response graded as an 'R2' event with a target response of eight minutes without AED (automated external defibrillator) on scene ('*immediately life threatening'*) **Most likely to be needed for an obstetric emergency**

The midwife may delegate the request for an ambulance to another person, eg the second midwife present, student midwife or the woman's partner but where possible, the call should be made by the midwife. ✓

9.3.2 Maternal transfers

The mother should be transferred to the Rosie DU. The midwife should phone ahead to the DU to inform the coordinator of the reason for transfer, or request that the ambulance does so. If the woman is transferred from home and is being transferred from midwifery-led care to obstetric-led care, then the on-call obstetrician should be informed and this should be documented (see low risk antenatal guideline 1.1: responsibility for care). When an obstetric review is required, this must be specified and must be with a consultant or specialist trainee, ie a senior obstetrician. If appropriate, discussion should take place before transfer. All documentation should be continuous and contemporaneous in the intrapartum notes by both midwife and obstetrician

It may be appropriate for the midwife to hand over care to a Delivery Unit midwife on arrival on the unit. Such a handover must be in person, and documented on the handover form. All staff handovers should take place in accordance with the guideline: HR 2.1: Multiprofessional communication in maternity services and staff handovers.

9.3.1 Transfer of the baby

If the baby requires transfer to hospital in the **immediate neonatal period** following the birth (eg resuscitation was required at birth, baby 'unwell', preterm or small-for-dates), he/ she should be transferred to the delivery unit at the Rosie via ambulance (or directly to the neonatal unit if **active** resuscitation is still being given, when he/ she will be met by a neonatal unit team member).

The community midwife/ paramedic should notify the delivery unit of any baby born at home who requires transfer for resuscitation and/ or stabilisation. DU should then notify the NICU nursing bleep holder on 156 2279 which is carried 24 hours a day. The NICU consultant will be informed at the earliest opportunity by the NICU nursing staff of any baby potentially requiring admission from home.

A separate ambulance to the mother should be requested if both require transfer. If two midwives are present at the birth, one should accompany the baby in the ambulance. If there is only one midwife, he/ she should make an assessment as to whether she should stay with the mother or baby.

9.4 Documentation in labour

A community midwife is accountable for the written record of the care he/ she has delivered. If two midwives are present at the birth, it should be evident in the written record who has delivered care; each midwife remains accountable for the care she has given and for her respective written entry/ entries.

If two midwives are present during labour and/ or birth, they should agree which clock to use if both make written entries in the woman's notes.

9.5 Post-birth documentation

The ward clerk may be requested to obtain the woman's hospital notes and prepare the baby's pre-birth notes in advance of the midwife's arrival at the hospital. As with hospital births, a copy of the PROTOS delivery summary should be forwarded to the woman's GP via the woman and a copy provided for the health visitor in addition to the copy for the woman's notes.

It is the responsibility of the attending midwife to ensure the birth details are entered on the PROTOS computer system, thus ensuring that the birth is recorded and notified. The 'birth notification' must be completed within 36 hours, and is a statutory responsibility.

9.6 Newborn examination

A midwife skilled in examination of the newborn should be requested to perform the neonatal check on the baby within 72 hours of the birth (see low risk neonatal guideline 4.2: examination of the newborn).

10 Immediate postpartum care

The midwife should remain with the woman for approximately two hours following the birth of her baby. She should ensure that the woman is able to void urine post-delivery. However, if the woman is unable to do so, she should advise the woman what action to take, and when. Refer to low risk postnatal guideline 3.5: postnatal bladder care. ✓

For Rhesus negative women, the relevant samples must be taken to the DU. It is the responsibility of the midwife attending the birth to ensure that the results are obtained and that anti-D is given if required, either by herself or by a colleague (see low risk postnatal protocol 3.4: postnatal administration of anti-D immunoglobulin). ✓

The placenta may be retained by the woman or taken to the hospital for disposal. If removed from the house it must be transported in a placenta pot to avoid contamination of personnel or equipment. If it is retained the woman must be given advice as to its safe disposal, ie it should be burnt, or buried at least two feet deep, to avoid disturbance from animal wildlife.

The woman and her partner must be given contact phone numbers in case of emergencies and for help and advice before the midwife leaves the house.

The woman's community team should be informed of the birth by leaving a message on the answer phone of the relevant community team. Plans must be made for the next visit, which should be determined according to clinical judgement and the woman's needs as well as the time of day. The woman should be left with advice about basic safety and care principles in looking after the baby, including:

- sleeping positions
- environmental temperature
- analgesia
- what to expect in relation to her recovery from the birth.

The delivering midwife should write an individualised care plan to address any care needs until the woman and baby receive a visit from a community midwife.

11 Monitoring compliance with and the effectiveness of the guideline

The use and effectiveness of this guideline, in particular the audit standards, will be monitored through the following processes:

- **Risk management** – incident reports generated following any adverse outcome or 'near miss' will be reviewed by the obstetric risk manager, who will review the case notes of women according to the Perinatal Services incident reporting and investigation policy and procedure. Following investigation of incident reports and complaints, an action plan will be devised and reported to the perinatal clinical governance committee in a quarterly report. This committee will monitor the implementation of the action plan
- **Clinical audit** – an audit, co-ordinated by the patient safety department, will be undertaken in accordance with the annual audit plan for obstetrics using the audit standards on page 1. Recommendations will be written in the form of an action plan ('effectiveness trail'); each recommendation will have a nominated lead individual and a specified time frame for completion. The implementation of this action plan will be overseen by the patient safety department in conjunction with the clinical lead for audit. Any deficits in practice should be escalated according to the perinatal services risk management strategy.
- **Complaints monitoring** - relating to home birth will be co-ordinated by the patient advice and liaison service (PALS), reported and monitored quarterly to the perinatal clinical governance committee.

Any changes to this guideline will be initiated by any nominated person(s) within midwifery and/ or obstetrics and facilitated by the research and development midwife and taken through the guideline review process and approved by the perinatal management group.

12 References

Birthplace in England Collaborative Group (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal,* 343:d7400 doi: 10.1136/bmj.d7400.

CEMD (2004) *Why Mothers Die 2000-2002. The Sixth Report of The Confidential Enquiries into Maternal Deaths in the United Kingdom*. Midwifery Summary and Key Findings. RCOG Press, London.

MIDIRS (2008) *Informed choice leaflet 10: Place of birth*. MIDIRS, Bristol.

MIDIRS (2012) Home birth: protocols, guidelines. Available from: www.midirs.org

Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services - Maternity Standards*. DoH, London.

NICE (2007) *Intrapartum care: care of healthy women and their babies during childbirth*. NICE guideline. NICE, London.

Royal College of Midwives (2002) *Home Birth Handbook Volume 1: Promoting Home Birth*. RCM Trust, London.

Royal College of Midwives (2003) *Home Birth Handbook Volume 2: Practising Home Birth.* RCM Trust, London.

Royal College of Obstetricians and Gynaecologists & Royal College of Midwives (2007). *Home Births*. Joint Statement no. 2. Available from RCOG.

See also: LSA guidance regarding home birth – available via all supervisors of midwives.

13 Associated documents

- low risk intrapartum Maternity Services documents
- LR 1.1 responsibility for care guideline
- LR 1.6 risk assessment
- LR 2.14 water birth guideline
- LR 3.4 postnatal administration of anti-D immunoglobulin guideline
- LR 3.5 postnatal bladder care guideline
- LR 4.2 examination of the newborn guideline
- HR3.1 maternal/ neonatal collapse in the community procedure
- HR 2.1 Multi-professional communication in maternity services and staff handovers
- Home birth checklist
- lone working policy
- violence and aggression management policy

Equality and diversity statement

This document complies with the Cambridge University Hospitals NHS Foundation Trust service equality and diversity statement.

Disclaimer

It is **your** responsibility to check against the electronic library that this printed out copy is the most recent issue of this document.

Document management

Document control/change history					
Version	**Author (s)**	**Owner**	**Date**	**Circulation**	**Comments**
Draft 1*	G Pett, community midwife & SoM	Women's Services: The Rosie Hospital (Maternity)	Nov 2003	Polices & Procedures Group (Maternity); Obstetric Divisional Group	
Draft 2	As above	As above	Jan 2007	A Ryder, Community Midwife Team Leader & SoM; DU Forum group, Risk team; Supervisors of Midwives; Polices & Procedures Group (Maternity);	Several minor changes made; audit standards added.
Draft 3*	As above	As above	Feb 2007	Obstetric Divisional Group	
Draft 4*	As above	As above	Feb 2009	L Stark, Community Midwife; DU Forum; Polices & Procedures Group (Maternity); Obstetric Divisional Group	Minor changes made in line with RCOG (2007).
Draft 5*	J Ford & G Pett	As above	Nov 2009	J Gardiner, Acting CSM–Community; Policies & Procedures Group (Maternity); Perinatal Services Management Group	Changes made for CNST re checking resus. Equipment (needed monthly), links added to labour guidelines
Version 6*	J Ford & C Beven	As above	Jan – Nov 2012	J Butler, Cons Midwife & Lead for RBC & Community; L Poulter/J Taylor, community lead midwives; S Chinnock, CMW; S Woolley, Risk Manager & SoM; S Broster, Neonatologist; Policies & Procedures Group (Maternity); Perinatal Services Management Group	Several major changes including: amended responsibilities of 984; process for calling a CMW; process of readmission of the baby, evidence for home birth; introduction of 'check-list', inclusion of home birth pathway if 2 CMWs not available, process of summoning an ambulance.

* indicates drafts used as final versions/active documents

Approval:	Perinatal services management group- 5 December 2012		
Owning department:	Maternity Services		
Author(s):	Jane Ford		
File name:	2.13 Home birth version 7 Dec2012.doc		
Supersedes:	Version 6, January 2010		
Version number:	7	Review date:	December 2015
Local reference:		Media ID:	3097

Appendix 1: Pathway for Process when 2nd community midwife not available to attend a home birth

This pathway is for use in the **exceptional** situation when there is no community midwife available to attend as 2nd midwife for a home birth. The maternity service wishes to support home births (however it is acknowledged that at times this will not possible due to staffing and/or workload both within the hospital and/ or community).
The intention is that where a hospital midwife attends a home birth, this will be in the capacity of supporting the community midwife as the '2nd midwife'.

Situation arises whereby only 1 community midwife available to attend a home birth
Community co-ordinator (daytime) & 984 should monitor home birth activity at all times

STAGE 1: Risk Assessment:

If birth is imminent:

1. Community co-ordinator (daytime only) must review community workload and assess if any CMW can be redeployed or any clinic cancelled etc.
2. 984 to assess if hospital midwife can be provided as 2nd midwife to the home birth, by evaluating staffing & workload in each clinical area of Rosie. Risk assessment to be documented in 984 diary.

If birth is not imminent:

984 to decide if a risk assessment appropriate at this stage or whether should **move straight to stage 2** (depending on time frame involved)

STAGE 2: Following an early labour assessment at home

Documented explanation to woman to say:

- 2 midwives are advised for a home birth (the delivery) for the safety of mother and baby
- Service unable to **guarantee** provision of a 2nd midwife at the time of delivery woman offered to come in to MLBU or DU to give birth.

Woman agrees to change her planned place of birth to MLBU or DU

Woman wishes to continue with plan for home birth

STAGE 3: Repeat Risk Assessment (as above)

1. (Daytime only) Community co-ordinator must review community workload and assess if any CMW can be redeployed or any clinic cancelled etc.
2. 984 must assess if hospital midwife can be provided as 2nd midwife to the home birth

If hospital MW can be provided

Yes

1. Hospital MW collects phone from Senior Midwife office RBC (984 holds key) 07775 885468, 'grab bag' from Senior Midwife Office RBC, drugs from RBC fridge. Informs 984 on arrival and departure from house.
2. 984 arranges Taxi to collect midwife from the ATC (cost code 3615) and records time and name of midwife.
3.Should there be 2 CMWs present with a woman, and a 2nd home birth starts, the hospital MW should relieve one of the CMWs so that one can attend the 2nd home birth

No

If CMW already present with the woman → must continue to give care. SoM Informed. Complete incident form.
If CMW not already present with the woman. 1.984 & SoM to agree plan.
2.Complete Incident form which will automatically notify Senior staff.
3. Call for ambulance support if necessary

Appendix 2: Home birth equipment

Each community midwife must carry the following essential equipment in a suitable container for ease of use and portability. Additional stock may be carried according to the midwife's own discretion. This must all be checked **prior to attending a home birth** and at least **monthly**; the monthly check must be documented, as described in section 6.

- Tourniquet
- Needles:
  - orange x 2, green x 7
- syringes:
  - 20ml x 1, 10ml x 1, 5ml x 2, 2ml x 5, 1ml x 2
  - vitamin K syringe x 2
- blood bottles: 3 x 4.5ml blue blood transfusion (2 for mother, 1 for cord blood) + monovette needles x 2
- For cannulation:
  - Venflon cannula x 3 (size 14/16)
  - 500ml Hartmann's solution
  - intravenous (IV) giving set
  - venflon dressing
  - normal saline 5ml x 1
- for cord prolapse: IV giving set and 500mls normal saline, or 50ml bladder syringe
- vaginal speculum
- microbiology swabs x 2
- gloves (size as appropriate for the midwife):
  - non-latex x 2
  - other sterile x 2
  - non-sterile x 10

*Drugs held should include, at minimum:
- syntometrine (x2 amps),
- ergometrine (x2 amps), adrenaline 1:1000 (x1 ml),
- 20ml lidocaine 1% (x1amp),
- Vitamin K 2mg/0.2ml (x1amp)

drugs*
cord clamps x 2
vicryl rapide 2/0 suture x 2
vicryl 3/0 suture x 2
KY jelly
plastic aprons x 2
incontinence pads x 3
amnihook x 2
catheter x 1
waterproof torch & mirror (optional)
placenta pot
yellow clinical waste bags x 2
small clear bags x 2
delivery/suture pack(s)

pen
home birth documentation
'fetomaternal haemorrhage' form
microbiology form
specimen bags x 2
rubbish disposal box
thermometer
stationery

Neonatal resuscitation equipment:
500ml Marshall bag and tubing
Res Q Vac suction apparatus and catheters (size 14 flexible suction catheters & adult Yankaer suction)
Guedel airways size 00/0
Face mask size 0/1