Mid Essex Hospital Services NHS
NHS Trust

GUIDELINE FOR THE MANAGEMENT OF A HOME BIRTH	**CLINICAL GUIDELINES** **Register no: 08101** **Status: Public**

Developed in response to:	Intrapartum NICE Guidelines Review of Guideline
Contributes to CQC Standards No	C5a

Consulted With	**Post/Committee/Group**	**Date**
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1.0	Julie Bishop	October 2005

It is the personal responsibility of the individual referring to this document to ensure that they are viewing the latest version which will always be the document on the intranet

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A. Appendix A – Checklist for Homebirth or Delivery at Birthing Units for Women who do not meet Criteria for Low risk Care

1.0 Purpose of Guideline

1.1 This guideline is to aid midwives in providing information to enable women to make a choice about their care to birth at home and ensure safe and swift transfer to obstetric care in the event of complications.

1.2 To identify women that may require additional input and support to achieve their choice of birthplace.

1.3 To identify procedures to be undertaken in the event of an emergency.

1.4 To ensure contemporaneous documentation is completed.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Background

3.1 At booking women should be offered a choice of planning birth at home. They should be informed that it is generally very safe and has not been shown to be at greater risk than giving birth in hospital for women with a healthy pregnancy and fetus.

3.2 Research has shown that women are more likely to give birth normally at home with less pain relief, fewer episiotomies, and fewer instrumental deliveries. Maternal satisfaction with the birth experience is high.

3.3 In the event of serious complication the outcome may be worse for mother or baby than if they had been in an obstetric unit.

4.0 Suitability for Home Birth

4.1 Women are entitled to make an informed choice of where to deliver their baby but there will be some women who have medical or obstetric conditions indicating individual assessment when planning place of birth.

4.2 Requests for homebirth should be considered individually in consultation with the woman.
Refer to Appendix A for conditions requiring individual assessment when planning place of birth. (Refer to point 7.0)

5.0 Antenatal Preparation for Homebirth

5.1 Women should receive written information about homebirth at the booking appointment so they have time to make an informed choice about place of birth.

5.2 At 28 weeks gestation, an appointment should be made for an antenatal check at home to discuss in more detail the plan for the birth. There is usually insufficient time to do this in a routine clinic appointment.

5.3 In addition, a routine antenatal check, there should be discussion around the following issues:

- Birth plan
- Recognising signs of labour
- When to call the midwife – including ensuring women have contact numbers
- Pain relief available at home
- What happens if transfer to labour ward is necessary
- What happens if suturing is required
- Immediate post natal care and care of the baby
- Vitamin K administration to baby
- Preferred method of feeding

5.4 A preliminary evaluation of the suitability of the home for a birth should be conducted paying attention to:

- Location
- Access in an emergency
- Provision of light, heating and hot water

5.5 Advice can be given on preparation of the home for a birth:

- Protection of furniture
- Preparation of an area to set up the neonatal resuscitation equipment
- Suggestions of some equipment to have ready (also see antenatal notes)
- Towels
- Sheets
- Waterproof protection i.e. Shower curtains/ plastic dust sheets
- Torch/lamp for suturing
- Bucket/flannels
- Sanitary pads

5.6 Midwives should ensure the provision of oxygen and basic neonatal and maternal resuscitation equipment.

5.7 Midwives should ensure the provision of oxytocic drugs - syntometrine® and ergometrine for management of third stage or in case of bleeding.

5 .8 Waterbirth – women often request a waterbirth at home and should be offered the opportunity to labour in water. If the woman wants to hire/buy a birthing pool this should be facilitated following the guideline.
('Guideline for waterbirth, labour and delivery in water and third stage management'. Register number 04237)

5.9 Women are asked to call labour ward when labour has begun on 0844 556 9609 and state their team and that they are booked for a homebirth.

5.10 Labour ward to contact the community midwife on call with the woman's details. Midwife will then ring the woman or go straight to the home for initial assessment

5.11 The named midwife may make an arrangement with the woman to be called on her mobile.

5.12 A list of the homebirth preparation essentials is kept in the community midwives office.

5.13 There should be a discussion with the woman about complications which may require transfer into hospital in labour or after the birth and this should be documented in the woman's health care records.

6.0 Labour and Birth at Home

6.1 The first midwife to attend the woman at home should carry out the initial intrapartum assessment and formulate the care plan accordingly.
(Refer to the 'Guideline for the management of normal labour and prolonged labour in low risk patients'. Register number 09079)

6.2 Any requests for examination should be discussed with the woman and consent gained.

6.3 Intermittent monitoring of the fetal heart should ensue as per guideline (refer to the 'Guideline for fetal heart rate monitoring in pregnancy and labour'. Register number 04265).

6.4 When it seems as if second stage is imminent, the midwife will call for a second midwife to attend. (The second midwife may be called at any time to provide support or bring additional equipment).

6.5 At any point, if a woman requires transfer to the consultant-led maternity unit, this will be carried out following discussion of the risks and benefits with the woman and her partner.

6.6 The midwife should liaise with the labour ward co-ordinator stating the indications for transfer to alert the obstetric team. The midwife should complete the emergency transfer of patients in labour or sick babies' proforma.
(Refer to the 'Guideline for transfer of mothers and babies to different care settings'. Register number 06029)

6.7 Transfer to the consultant-led maternity unit is by paramedic ambulance. The midwife should ensure when speaking to the emergency services that they are aware you do **not** need a first responder.

6.8 The midwife should stay with the woman throughout the transfer process and care should remain within the midwifery team to ensure continuity.
(Refer to guidelines for the management of meconium stained liquor'; register number 04259, 'Guideline for the resuscitation of the newborn'; register number 07074 and 'Peripartum collapse'; register number 04252).

6.9 The woman should be made aware that in the event of an obstetric emergency, the outcome for mother or baby may be compromised if not in the obstetric unit.

6.10 Once the birth is complete, any suturing can be carried out, postnatal observations and the initial baby check performed.

6.10 The midwife should remain for between one and three hours depending on clinical need but at least long enough to help the mother into a bath and assist with feeding.

6.11 After a time, the lochia should be observed and the uterus palpated. When clinically stable the midwife can leave the family with contact numbers in the event of need and plan for a postnatal visit either later that day or the next day depending on the time of the birth.

6.12 The midwife should ensure all documentation is complete including a request for a hearing screen and the birth notification which should be returned to labour ward and a copy into the community midwives office.

6.13 Following discussion, the midwife should ensure that the woman has been given a child health care record booklet and a Bounty bag.

7.0 Contra-indications to Home Birth

7.1 Women who want to birth at home where there are contraindications i.e. women requesting a homebirth at over 40 weeks and12 days gestation or with a history of prolonged rupture membranes (PROM). For these cases an individual management plan should be formulated.

7.2 In established labour, the individual management plan should be escalated to the community midwifery manager, the consultant on call, the supervisor of midwives, the labour ward coordinator and the neonatal unit staff, if applicable.

7.3 There should be clear discussion and documentation in the woman's health care records between the woman and her midwife. The midwife should ensure that the woman is informed of the risks and outcomes of her decisions; facilitating choice as much as possible and taking care to maintain the mother / midwife relationship.

7.4 At the 28 week appointment the midwife should complete a 'Checklist for home birth or delivery at birthing units for women who do not meet the criteria for low risk care'

7.5 The original form should be placed in the patient's health care records and a copy should be filed in the patient's hospital notes.

7.6 The midwife should involve manager and supervisor of midwives for professional and personal support.

7.7 An opinion should be sought from a consultant obstetrician and paediatrician if appropriate.

7.8 Continuous risk assessment should be undertaken throughout antenatal, intrapartum and postnatal periods.

7.9 Midwives have a professional duty to provide care to women.

7.10 Ensure accurate documentation at all times in accordance with Midwives Rules and The Code of Conduct.

8.0 Staffing and Training

8.1 All midwifery and obstetric staff must attend yearly statutory training which includes skills and drills training, involving the management of obstetric emergencies i.e. postpartum haemorrhage.

8.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

9.0 Infection Prevention

9.1 All staff should follow Trust guidelines on infection control by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

9.2 All staff should ensure that they follow Trust guidelines on infection control, using Aseptic Non-Touch Technique (ANTT) when carrying out procedures i.e. vagina examinations and conducting deliveries.

10.0 Audit and Monitoring

10.1 The risk management lead will review all risk event forms and complaints. Any immediate training or educational issues relating to lack of compliance with this guideline will be addressed on a one to one basis.

10.2 All incidents and trends analysis will be reviewed at the Maternity Risk Management Group meeting.

10.3 Audit of compliance with this guideline will be undertaken annually in accordance with the Maternity annual audit work plan. The Audit Lead in liaison with the Risk Management Group will identify a lead for the audit.

10.4 A review of a 0.5 % of health records will assess compliance with the guideline.

10.5 The findings of the audit will be reported to the Risk Management Group and an action plan developed to address any identified deficiencies. Performance against the action plan will be monitored by this group on a monthly basis.

10.6 A survey will be undertaken by the Lead Midwife for Guidelines and Audit, at least annually, to establish staff awareness of how policies should be accessed and the document management process. Any deficiencies identified will inform the staff training programme.

11.0 Guideline Management

11.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

11.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

11.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

11.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

12.0 Communication

12.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

12.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

12.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

12.4 Regular memos are posted on the 'Risk Management' notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

13.0 References

National Institute for Clinical Excellence (2007) Intrapartum Care. NICE; Sept.

Nursing and Midwifery Council (2004) Midwives Rules and Standards.

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BJOG (2008) BJOG Release : Are booked homebirths safe?

BJOG (2008) BJOG Release Reasons for hospital transfers for women in labour.

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Campbell R and MacFarlane A (1994) Where to be Born – the debate and the evidence 2nd Edition. National Perinatal Epidemiology Unit. Oxford.

Association of Radical Midwives (2006) Women led homebirth group. Midwifery Matters. Issue no 108, Spring.

Nursing and Midwifery Council (2008) The Code of Conduct. NMC.

Magill-Cuerdin, J (2005) Report of issues arising from a document review to support recommendations for guidance for home births NMC.

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Appendix A

Checklist for Homebirth or Delivery at Birthing Units for Women who do not meet Criteria for Low risk Care

Name …….. **Gravida: …… Parity: ……..**

Address/Post Code…… **Hospital No……**

…… **EDD: ……**

…… **G.P. ……**

Telephone: …… **Named Midwife: ……**

It is essential that women who do not meet the **LOW RISK** birth criteria are given factual and evidence based information in order to make an informed choice regarding where to give birth.
Information must be given in a clear and unbiased way, with risk management issues openly discussed and accurately documented. Where risk factors are identified please refer to Team Leader/Community Manager
This is to be completed by named midwives at the time of home birth preparation visit (preferably 28 weeks gestation) in patient's home.

	Tick if discussed	**Risk Factors Yes/No**	**Action**
• Reason why Low Risk Criteria not met? • Referral to Consultant Obstetrician?			**Details of Obstetric Complication:**
• Arrangements for support • Arrangements for other children in household?			
Environmental Factors: • Smoke free zone • Heating/Lighting • Access-parking/identifying the home • Phones (signal for mobiles)			
• Social Issues/Child Protection • Social Services involvement			
• Midwifery on-call arrangements • Contact arrangements • Midwife availability i.e. sickness-multiple home births • Distance/time to hospital • Weather conditions • Midwives response time			
Management of emergencies/transfer to hospital • Warning signs • Complications in labour • Mother i.e. slow progress • Baby-fetal distress • Complications after birth • Mother- i.e. postpartum haemorrhage • Baby – resuscitation • Equipment available • Limitations of staff • Response times – i.e. paramedic – transfer to hospital times			
Special requests (please attach a birth plan)			
I understand that I do not meet the criteria for midwife led care and home birth / birthing unit birth. I fully understand the implications of choosing home or birthing unit as the place to deliver my baby	**Signature (Patient)** **Signature (Midwife)**		**Date:** **Date:**

The original form should be placed in the patient's health care records and a copy should be filed in the patient's hospital notes