NHS
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DOCUMENT CONTROL PAGE

Title:	Home Birth
Version:	1.1
Supersedes:	Legacy guidelines; Home Birth Guideline V7 (SMH – Oxford Road Campus), Home Birth guideline V3 (UHSM) and Home birth guideline including BBA (North Manchester)
Changes:	Harmonised to reflect practice across site. Adjustments throughout the guideline including but not limited to the inclusion and exclusion criteria for home birth
Application:	All Staff at Manchester University NHS Foundation Trust (MFT)

Originated /Modified By:	Jenny Kelly, Emma Collins, Chris McKay, Kylie Watson, Lisa Dennison
Designation:	Community Matron (CM), Community Midwifery Managers (JK, EC),Consultant Midwife (KW), Community Matron (LD)
Ratified by:	Site Obstetric Quality and Safety Committee
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Responsibility of:	Clinical Governance Team Maternity

* Policy review date extended to support the review and harmonisation of policies to allow for Hive implementation. Decision approved by IRGC April 2023.

Minor Amendment (If applicable) Notified To:	Amendments made to be applicable at North Manchester
Date notified:	13/01/22

EqIA Registration Number:	2020-122

1. Introduction

All women have a choice of birth setting and should be supported in their choice following careful risk assessment (NICE, 2014).

All midwives should ensure that they are able to provide unbiased advice and professional support to all women wherever they choose to give birth and ensure professional guidelines are followed.

2. Details of the Guideline

2.1. Provision of care for women planning a home birth

Care will be provided to women living in the zoned postcodes of Manchester Foundation Trust.

Women who receive care from MFT community midwives but who live outside these zoned postcodes will be referred to their local maternity unit.

2.2. Booking Appointment

The midwife should provide relevant information and advice about all available birth settings at booking so the woman can make a fully informed decision.

2.2.1. Women at low risk of complications

The midwife should explain to both nulliparous and multiparous women who are at low risk of complications that giving birth is generally very safe for both the woman and her baby and that they may choose any birth setting (home, midwifery led unit or obstetric unit). For inclusion and exclusion criteria for home birth please see *Appendix 1*.

The midwife should:

- Advise low risk multiparous women that planning to give birth at home or in a midwifery led unit is particularly suitable for them because the rate of interventions is lower and the outcome for baby is no different compared with an obstetric unit (NICE, 2014)
- Advise low risk nulliparous women that planning to give birth in a midwifery led unit is particularly suitable for them because the rate of interventions is lower and the outcome for baby is no different compared with an obstetric unit. Explain that if they plan to give birth at home there is small increase in the risk of an adverse outcome for the baby (these risks should be detailed and recorded as part of the discussions in the handheld notes – see NICE intrapartum guidelines (2014) for details on neonatal outcomes in each setting).

2.2.2. Women with medical conditions and other factors that may affect planned place of birth and require individual assessment

There may be women with medical and obstetric history where an individualised assessment is required regarding place of birth. Referral to a consultant obstetrician should be made and an individualised plan made which is documented in the maternal handheld notes.

2.3. Women choosing home birth contrary to advice

2.3.1. Where a woman chooses a home birth contrary to midwifery advice, the midwife should contact her Community Team Leader for support andarrange an appointment with the woman. The Community Team Leader can gain further support from a Professional Midwifery Advocate or the Consultant Midwife.

2.3.2. The woman must be offered an appointment with the named Consultant Obstetrician for review and further discussion with a view tofacilitating an informed decision. If the woman does not have a named consultant, refer to any available consultant obstetrician.

2.3.3. A management plan must be documented in the maternal records ensuring:

- The woman has been informed of any risks and their possible consequences.
- Two midwives are available to provide care during labour and birth.
- Liaison with obstetric and neonatal teams where applicable.
- The plan of care is carefully recorded and communicated to all those involved, including the woman. Accurate records should be kept of the risk assessment and any discussions with the woman. At all times, great care should be taken to preserve the quality of the woman-midwife relationship and to sustain as much mutual trust and respect as possible.
- The risk assessment should be reviewed at regular intervals to ensure that any new risks are acknowledged and considered. When apparent risks develop, the woman must be referred to the multi-disciplinary team as appropriate.

- If it is confirmed that the woman is continuing to have a home birth and risks have been identified then an updated individualised care plan should be distributed to the named Consultant, Intrapartum Matron, Consultant Midwife and Head of Midwifery. A copy should also be placedin the maternity bleep holder file.

2.4. 36-week appointment

The midwife will undertake a home visit at 36 weeks gestation to discuss the plan of care with the woman ideally with her birthing partner present. The midwife will:

- Perform a risk assessment (NICE 2014) and clearly document in the handheld notes. The risk assessment proforma (*Appendix 2)* should be completed and placed in the handheld notesand homebirth file. The notification for booking a home birth should also be completed (*Appendix 3*).

- Take a full blood count and document result in handheld notes once available.
- For Saint Mary's at Wythenshawe, arrange delivery of Entonox to the woman's home. For Saint Mary's ORC and North Manchester, midwives are to bring Entonox with them when attending in labour.

2.5. Intrapartum care

2.5.1. The woman must be advised to contact their local maternity department;

- Triage department at Saint Mary's ORC (0161 276 6567)
- Triage department at Saint Mary's at Wythenshawe (0161 291 2724).
- Birth Centre at North Manchester Centre (0161 625 8043).

The triage / birth centre department will contact the community midwife/continuity team (where applicable) who is on-call who will contact the woman, assess the situation and plan care accordingly.

2.5.2. Care in labour should be provided in accordance with local guidelines.

2.5.3. The midwife must undertake a full risk assessment on arrival at the woman's house, ensuring that the woman's existing clinical risk status and the home still fit the criteria (See *Appendix 1&2*). All findings must berecorded.

2.5.4. It is the responsibility of the midwife conducting the birth to ensure that all equipment is checked and that the necessary drugs and resuscitation equipment are available.

2.5.5. Both the first and second attending midwives must inform triage at ORC (0161 276 6246) or at Saint Mary's at Wythenshawe (0161291 2945) or Birth Centre at Saint Mary's at North Manchester (0161 625 8043) on arrival at the woman's address.

2.5.6. When labour is advancing, the midwife must request the assistance of a second midwife via triage (ORC) or at Saint Mary's at Wythenshawe and North Manchester, ring second midwife directly themselves. Two midwives should be in attendance for the birth; the midwives must be competent in adult and neonatal resuscitation.

2.5.7. Midwives must request relief as appropriate in order to avoid working continually beyond 12 hours without rest.

2.5.8. Midwives may call the second midwife, or the maternity bleep holders at ORC (6060) or Saint Mary's at Wythenshawe (2099). At North Manchester, Midwives may contact Birth Centre on 0161 625 8043 for clinical advice at any time during the labour. This may not be due to any deviations from the normal occurring but to discuss the overall care of the woman including progress, ongoing risk assessment and monitoring of the woman and fetal wellbeing.

2.6. Postnatal Care

2.6.1. Care should be provided according to local guidelines.

2.6.2. Babies requiring resuscitation should be resuscitated in accordancewith Trust guidelines.

2.6.3. The placenta should be placed in an appropriate container and removed to the hospital for incineration, unless the woman wishes tokeep this.

2.6.4. Maternal blood must be taken for Kleihauer test if appropriate, and where necessary an Anti-D injection must be administered in accordancewith Trust guidelines.

2.6.5. Cord blood must be taken for Coombs' test (DCT) where appropriate.

2.6.6. A midwife should remain in attendance for at least two hours following the birth. Prior to leaving the house a midwife must ensure the woman has written information of how to contact midwifery staff and what to do in the event of an emergency. The midwife must also discuss safe sleeping and infant feeding.

2.6.7. All care should be recorded on the respective computer systems as appropriate. The midwife attending the birth should request that the woman's main hospital records are available on return to the hospital. Once the baby is safely born, the community midwife must request thefollowing from the ward clerk:

- A case note number (Unless this has been generated by electronic maternity data system I.e E3)
- Appropriate neonatal consultant
- Case notes for the newborn baby

2.6.8. The examination of the newborn should be performed by a suitably trained community midwife within 72 hours of the birth, with referral to the GP/neonatologist as appropriate. On completion of the examination of the newborn, all documentation must be returned to the hospital and filed appropriately. The community midwife should also ensure that the correct details are completed on to the NIPE Smart computer system.

2.6.9. If the baby has not received a full examination of the newborn (ENB) prior to the midwife leaving the home, neonatal oxygen saturations should be recorded. If abnormal the midwife will arrange immediate transfer to local delivery unit/labour ward for review.

2.6.10. Hearing screening following the birth of the baby - an appointment will be sent to the mother by the Newborn Hearing Screeners to have their test undertaken in a community clinic.

2.7. Equipment

See *Appendix 4* and Appendix 5.

2.8. Indications for transfer to hospital (NICE, 2014)

- Observations of the woman that require transfer to hospital for obstetric-led care
    - Pulse over 120 beats/minute on 2 occasions 30 minutes apart
    - A single reading of either raised diastolic blood pressure of 110mmHg or more or raised systolic blood pressure of 160mmHg or more
    - Either raised diastolic blood pressure of 90mmHg or more or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart
    - A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg)
    - Temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive readings 1 hour apart
    - Any vaginal blood loss other than a show
    - Rupture of membranes more than 24 hours before the onset of established labour
    - The presence of significant meconium
    - Pain reported by the woman that differs from the pain normally associated with contractions
    - Confirmed delay in the first or second stage of labour
    - Request by the woman for additional pain relief using regional analgesia
    - Obstetric emergency including antepartum haemorrhage, cord prolapse, postpartum haemorrhage, maternal seizure or collapse, or a need for advanced neonatal resuscitation
    - Retained placenta
    - Third-degree or fourth-degree tear or other complicated perineal trauma that needs suturing

- Observations of the unborn baby that require transfer to hospital and obstetric-led care
    - Any abnormal presentation, including cord presentation
    - Transverse or oblique lie
    - High (5/5 palpable) or free-floating head in a nulliparous woman
    - Suspected fetal growth restriction or macrosomia
    - Suspected anhydramnios or polyhydramnios
    - Fetal heart rate below 110 or above 160 beats per minute
    - A deceleration in fetal heart rate heard on intermittent auscultation, or any other concerns such as a rising baseline rate
    - Reduced fetal movements in the last 24 hours reported by the woman

If any of the factors above are observed but birth is imminent, assess whether birth in the current location is preferable to transferring the woman to an obstetric unit and discuss with the appropriate delivery unit.

Transfer to hospital

2.8.1. In the case of an emergency, 999 should be called and transfer should be undertaken to the nearest maternity unit via ambulance.

2.8.2. Wherever possible the midwife should ring ahead to the receiving unit in advance and notify of the impending transfer. The midwife should also contact the coordinator on the Delivery Unit to advise that they are transferring the woman to hospital. Midwives must use the SBAR (Situation/Background/Assessment /Recommendation) approach. See: Guidelines for the *Transfer of Obstetric/Neonatal Emergencies from Saint Mary's Community and Antenatal Services to Saint Mary's Hospital including the process for born before arrival (BBA)* (ORC and Wythenshawe).

2.8.3. Whilst awaiting the ambulance the midwife will initiate emergency measures appropriate to the clinical situation.

2.8.4. The decision to transfer should be fully documented in the woman's handheld records, including time of decision, time of ambulance request,and times of update calls every 15 minutes, in situations of delay and time of ambulance arrival. The midwife should then inform the delivery unit coordinator of expected time of arrival. The midwife should always travel with the mother in the ambulance and remains the lead carer and decision maker.

2.8.5. If delivery occurs in transit then the ambulance should be asked to pull over at the roadside then the paramedic can assist the midwife as appropriate.

2.8.6. On arrival at the receiving unit a full verbal SBAR handover, should be given by the lead midwife to the receiving carer.

2.8.7. All records throughout should be maintained in accordance with professional standards.

2.8.8. An Incident form should be completed

2.9. Communication and Documentation

All women with learning disabilities, visual or hearing impairments or those whose first language is not English must be offered assistance with interpretation where applicable, and where appropriate a telephone interpreter must be used. It is paramount that clear channels of communication are maintained at all times between all staff, the women and their families. Once any decisions have been made/agreed, comprehensive and clear details must be given to the woman thereby confirming the wishes of the women and their families.

The contents of any leaflet issued must be explained in full at the time it is issued. All communication difficulties (including learning difficulties) and language barriers must be addressed as outlined in the previous paragraph atthe time the leaflet is issued.

Ensure the provision and discussion of information of the risks and benefitswith women during the antenatal, intrapartum and postnatal periods.

All details surrounding discussion of the risks and benefits together with explicit details of proposed management must be documented contemporaneously, in both handheld notes and the main notes as appropriate.

3. Equality Impact Assessment.

This guideline has been equality impact assessed using the Trust's equality impact assessment (EqIA) framework

The EqIA score fell into low priority (0-9); no significant issue in relation to equality, diversity, gender, colour, race or religion are identified as raising a concern.

4. Consultation, Approval and Ratification Process

During development, this guideline has been reviewed by senior obstetricians and midwives from Saint Mary's at Wythenshawe, Oxford Road Campus and North Manchester. It has been ratified by the Site Obstetric Quality and Safety Committee and the North Manchester guideline committee.

It will be formally reviewed 3 years following its ratification or sooner if there are significant changes in evidence-based practice.

5. References and Bibliography

NICE Intrapartum Care for Healthy Women and Babies CG190 2014

6. Associated Trust documents

- *Care of women in labour guideline* (ORC and Wythenshawe)
- *Birthing Pool for Labour and Birth guideline* (ORC and Wythenshawe) and *Birthing Pool During Labour & Delivery; Use of the* (North Manchester)
- *Transfer of Obstetric/Neonatal Emergencies from Saint Mary's Community and Antenatal Services to Saint Mary's Hospital including the process for born before arrival (BBA)* guideline.
- *Postpartum Urinary Retention* (ORC and Wythenshawe) and *Bladder care; Intrapartum & Post Partum* (North Manchester)
- *Management of Postpartum Haemorrhage* (ORC), *Management of Postpartum haemorrhage & Massive Obstetric Haemorrhage* (Wythenshawe) and *Misoprostol for postpartum haemorrhage & uterine atony and Primary postpartum haemorrhage* (North Manchester)
- *Resuscitation of the Newborn* (ORC and Wythenshawe)

7. Appendices

Appendix 1: Inclusions and exclusion criteria for home birth

Appendix 2: 36 Week Home Birth Risk Assessment

Appendix 3: Notification of booking for a home birth

Appendix 4: Equipment list for Home Birth

Appendix 1: Inclusion and exclusion criteria for home birth

Inclusion criteria for booking a home birth: Low risk pregnant women at term who have no known medical conditions or previous obstetric conditions and are suitable for midwifery led care during this pregnancy, labour and birth.

Exclusions to booking a home birth (this list is not exhaustive and if unsure please seek further advice)

Medical conditions

Cardiovascular
- Confirmed cardiac disease
- Hypertensive disorders

Respiratory
- Asthma requiring an increase in treatment or hospital treatment
- Cystic fibrosis

Haematological
- Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major
- History of thromboembolic disorders
- Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100 x 10^9/l
- Von Willebrand's disease
- Bleeding disorder in the woman or unborn baby
- Atypical antibodies which carry a risk of haemolytic disease of the newborn

Endocrine
- Hyperthyroidism
- Unstable hypothyroidism
- Diabetes pre-existing and gestational (diet controlled may require an individual assessment)

Infective
- Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended
- Hepatitis B/C with abnormal liver function tests
- HIV positive
- Toxoplasmosis – women receiving treatment
- Current active infection of chicken pox/rubella/genital herpes in the woman
- Tuberculosis under treatment

Immune
- Systemic lupus erythematosus
- Scleroderma

Renal

- Abnormal renal function
- Renal disease requiring supervision by a renal specialist

Neurological/Skeletal

- Epilepsy
- Myasthenia gravis
- Previous cerebrovascular accident
- Spinal abnormalities
- Neurological deficits

Gastrointestinal

- Liver disease associated with current abnormal liver function tests
- Crohn's disease
- Ulcerative colitis

Psychiatric

- Psychiatric disorder requiring current inpatient care

Previous Gynaecological conditions

- Hysterotomy
- Myomectomy

Obstetric exclusions

Previous complications

- Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty. An Individual assessment may be done for previous explained stillbirth.
- Previous baby with neonatal encephalopathy
- Previous baby affected with early onset GBS
- Pre-eclampsia requiring preterm birth
- Placental abruption with adverse outcome
- Eclampsia
- Uterine rupture
- Primary postpartum haemorrhage (greater 750mls) requiring additional treatment or blood transfusion
- Retained placenta requiring manual removal in theatre
- Caesarean section
- Shoulder dystocia

Current pregnancy

- Parity > 4 (Para 5 or more)
- Multiple pregnancy
- Placenta praevia

- Pre-eclampsia or pregnancy-induced hypertension
- Preterm labour or preterm pre-labour rupture of membranes
- Prolonged rupture of membranes >24 hours prior to the onset of labour
- Placental abruption
- Anaemia – haemoglobin less than 90 g/L at onset of labour
- Confirmed intrauterine death (individual assessment may be made and woman's choice supported)
- Induction of labour
- Substance misuse
- Alcohol dependency requiring assessment or treatment
- Malpresentation – breech or transverse lie
- Body mass index at booking of greater than 35 kg/m2
- Recurrent antepartum haemorrhage
- Safeguarding issues which require input from the safeguarding midwife
- Severe and enduring mental health problems
- Large fibroids >5cm
- GBS in current pregnancy including positive swab at 36 weeks

Fetal indications

- Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound)
- Abnormal fetal heart rate (FHR)/Doppler studies
- Ultrasound diagnosis of oligo-/polyhydramnios
- Reduced fetal movements within the last 24 hours
- Fetal abnormality
- Any complication for which the neonatal team would be requested to attend birth

Appendix 2

36 Week Home Birth Risk Assessment

To be completed at the home visit at 36 week gestation. Sign and file in handheld notes. Re-assess when woman is in labour to ensure there are no changes.
If 'NO' to any of the assessment, please state actions appropriately.

Woman's Name……

Hospital no……...

36 WEEK ASSESSMENT	Yes ☐	No ☐	Risks or potential risk identified	Actions/ contingency plans	Signature/Date
Is the woman low risk?					
Hospital records, previous medical/ surgical/ obstetric history reviewed					
ENVIRONMENT					
Possible reasons for transfer and distance from unit/ time discussed?					
• Suspected fetal distress					
• Delay in labour					
• Meconium					
• PROM>24 hour/Term IOL					
• Maternal request for epidural					
• Antenatal or postpartum Haemorrhage					
• Shoulder dystocia					
• Cord prolapse					
• Retained placenta					
• Malpresentation					
• Abnormal maternal observation/ resuscitation					

• Significant perineal trauma requiring suturing in hospital (3/4th degree tears)					
• Neonatal complications (e.g. resuscitation/ grunting/ low APGARS/ Temp)					
LOCATION					
Parking issues?					
Safety/ suitability?					
Stairs/ lifts?					
Easily identifiable and accessible for midwife and ambulance crew?					
Has area/room for delivery been discussed? (Check adequate space/ access etc.)					
Health and safety aspects discussed? (e.g. water birth/pets)					
ENVIRONMENT					
Heat source					
Light source					
Running water/pool Electric sockets					
Phone availability (landline/mobile reception)					
Who else will be present in the house (e.g. children– consider childcare in event of transfer)					
STAFFING/MW ISSUES					
Discuss on call system					
Time it may take for midwife to attend (e.g. staff living >10 miles away)					
Service demands (e.g. attending other home birth)					
Extreme weather conditions					
Vitamin K consent					
Entonox consent					

Contact Telephone Numbers					

If risk/ potential risk is identified, discuss and document in handheld notes.

Midwife signature……Print Name……Date……..

Woman's signature……...Print Name……Date……

Appendix 3

Notification of booking for a home birth

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Women's addressograph only

Do not write in this space

Telephone number ……..

Mobile Number: …….

Team: ……

GP Name and Address: ……..

Para: …… EDC: ……

Any relevant History: ……

……..

……..

Options /risks discussed: ……

36/40 risk assessment Date: ……

FBC done …… Result: …….

Entonox Form: ……

Vitamin K Consent: ……

Notes/Stickers/ Box at home: ……

Signed: …… Date: …….

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Appendix 4 Equipment list

Homebirth Box/Bag

Delivery pack
Delivery Instruments
VE pack x 2
Large yellow rubbish bags
Placenta box
Sterile gloves
Non sterile gloves (box)
Purple lidded Sharps bin
Urinary catheter in/out x 2
Aquagel lubricating jelly
Aprons
Amnihook
Swabs
Green needles x 6
2ml syringes x 4
10ml syringe x 2
Syntocinon
Syntometrine
Konakion
Paperwork
Sanitary Pads x2
Tourniquet
Vacutainer
Vacutainer needle
Group and Save blood bottles x 2
Pink blood bottles x 2
Entonox mouth piece
Torch
Battery

Baby

Hat
Tape measure
Cord Clamps x 2
1ml syringe x 2
Brown needles x 2
Baby card

Delivery Box Paperwork

- Baby notes
- Red book
- Homebirth outcome sheet
- VTE assessment form
- Community notes
- New patient pack
- Patient stickers
- Blood forms – FBC + Blood transfusion service form

** Resuscitation equipment taken with midwife at time of labour and birth

Appendix 5
North Manchester GRAB BAG

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Stock within the MAIN BODY OF THE BAG includes individual labelled pockets:

Rh Negative Mother (Grey Pouch)	
CONTENTS	**QUANTITY**
Sterile Hypodermic Needle 21g x 40mm (Green)	1
Sterile 10ml Syringe	1
Blood Collection Needle with holder	1
Alcohol Pre-Injection Wipes	2
Sterile swab pack	1
Blood Forms	2
Blood Bottles (For Kleihower test)	1
Disposable tourniquet	1

3rd Stage / PPH Drugs (Grey Pouch)	
CONTENTS	**QUANTITY**
RED PAX ampoule wallet *containing:* - Syntometrine ampoule - Oxytocin ampoule - Lidocaine ampoule - Konakian ampoule	 2 2 2 2
Sterile Hypodermic Needle 21g x 40mm (Green)	6
BD Blunt Drawing Up Needle	6
Sterile Syringe – 2mls	6

Postnatal (Grey Pouch)	
CONTENTS	**QUANTITY**
Tape Measure	1
Sterile Tongue Depressor	1
Oral Syringe (1ml)	1
BD Blunt Drawing Up Needle	1
Sterile Hypodermic Needle 25g x 16mm (Orange)	1
Alcohol Pre-Injection Wipes	1
White Adult Name Bands	2
Red Adult Name Bands	2
White Baby Name Bands	2
Vitamin K Ampoule (in Red PAX wallet)	2

Adult Resuscitation (Black Pouch)	
CONTENTS	QUANTITY
Ambu Spur Single Use – Bag-Valve-Mask (Adult)	1
Guedel Disposable OP Airway Size 3 (Orange)	1
Guedel Disposable OP Airway Size 4 (Red)	1
Crib Card	1

Cannulation & IV Fluids (Orange Pouch)	
CONTENTS	**QUANTITY**
Cannulation Pack	2
Venflon IV Cannula 16g (Grey)	2
Venflon IV Cannula 18g (Green)	2
Disposable Tourniquet	1
Saline Flush	2
Sterile 10ml Syringe	2
Alcohol Skin Cleansing Swabs	2
IV Solution giving set	1
500ml Normal Saline	1
Needle Free adaptor	2

Labour (Green Pouch)	
CONTENTS	**QUANTITY**
Pinnard	1
Tape Measure	1
22.5cm Gauze Swabs	10
Sterile Lubricating Jelly Sachets	10
Amnihook	1
Umbilical Cord Clamp – Sterile	3
7 LED Headlight	1
AAA Pack of batteries (4 Pack)	1
0.9ml Normal Saline for irrigation	1
Stopwatch	1

Suturing (Yellow Pouch)	
CONTENTS	**QUANTITY**
Suture Pack	1
Sterile 20ml Syringe	1
Sterile 10ml Syringe	1
Sterile Hypodermic Needle 21g x 40mm (Green)	2
Sterile Hypodermic Needle 25g x 16mm (Orange)	2
BD Blunt Drawing Up Needle	2
Vicryl Rapide 2.0	2
Vicryl Rapide 3.0	2
22.5cm Gauze Swab	10

Catheterisation & Cord Prolapse (Green Pouch)	
CONTENTS	**QUANTITY**
Intermittent Catheter	1
Self-Retaining Catheter	1
Vaginal Examination Pack	2
0.9% Saline for Irrigation	2
IV Solution Sterile Giving Set	1
Catheter Spigot Large	1
Instillagel	1
500mls Normal Saline	1
Catheter Bag	1
Crib Sheet	1

Catheterisation & Cord Prolapse (Red Pouch)	
CONTENTS	**QUANTITY**
Ambu Bag-Valve-Mask(Paediatric) Single Use	1
Disposable Resus Face Mask Infant (Pink)	1
Guedel Disposable OP Airway Size 00 (Blue)	1
Guedel Disposable OP Airway Size 0 (Grey)	1
Guedel Disposable OP Airway Size 1 (White)	1
Laringoscope Handle – Small Size – AA	1
Laringoscope Blade – Size 0	1
5ml Sterile Disposable Syringe	1
Crib Card	1

FRONT POCKET OF MAIN BAG

PPE & Disposal (Blue Pouch)	
CONTENTS	**QUANTITY**
Yellow Clinical Waste Bag	2
Disposable Apron	10
Sterile Nitrile Gloves (Medium)	10
Safety Glasses / Eye Protection	2
Alcohol Free Hand Sanitiser	1
Cable Ties	3
Clinisafe Placenta Container	1
Small Sharps Bin	1
Orange Clinical Waste Bags	1
Non-Sterile Nitrile Gloves	1 box
Clinell Wipes	1 pack
Delivery Pack	1
Delivery Instrument Pack	1
Inco Sheets	10