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Document type: (Policy/ Guideline/ SOP)	Guideline	**To be followed by:** (Target Staff)	Midwives, Obstetricians, Paediatricians
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Consulted With:	Post/ Approval Committee/ Group:	Date:
Anita Rao/ Alison Cuthbertson	Clinical Director for Women's and Children's Division	12th February 2019
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Deborah Lepley	Warner Library	14th February 2019

Related Trust Policies (to be read in conjunction with)	04071 Policy For Standard Infection Prevention 04072 Hand Hygiene Policy 04237 Water birth labour, delivery in water and third stage management 04259 Management of meconium stained liquor 07074 Neonatal Resuscitation 04265 Fetal heart rate monitoring in pregnancy and labour 04252 Peripartum collapse 09079 Management of normal labour and prolonged labour in low risk patients 06029 Transfer of mothers and babies to different care settings 04234 Postpartum Haemorrhage 09127 Routine Postnatal Care of Women and their Babies

Document Review History:			
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1.0	Julie Bishop		October 2005
2.0	Kate Cook		October 2009
3.0	Carole Hughes		January 2013
4.0	Carole Hughes		1st March 2016
5.0	Carole Hughes/ Lina Kerbelyte	Full Review	6th March 2019
5.1	Su Poole	Clarification to Appendix D and addition of Appendix E	8th May 2019

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1.0 Purpose

1.1 This guideline is to aid midwives in providing information to enable women to make an informed 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.

1.5 This guideline is intended only as an outline in terms of additional aspects that are required to be in place for a homebirth. All other aspects of low risk antenatal intrapartum and postnatal will be the same whatever the care setting.
(Refer to the guideline entitled 'Management of normal labour and prolonged labour in low risk patients; register number 09079; Routine postnatal care of women and their babies; register number 09127)

2.0 Equality Impact Assessment

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.
(Appendix A)

3.0 Background

(Refer to Appendix B)

3.1 When discussing place of birth with women, the results of the birth place study provides useful information for women to make an informed choice.

3.2 The Birthplace national cohort study was designed to answer questions about the risks and benefits of giving birth in different settings, focusing in particular on birth outcomes in healthy women with straightforward pregnancies who are at 'low risk' of complications.

3.3 The study collected data on care in labour, delivery and birth outcomes for the mother and baby for over 64,000 'low risk' births in England including nearly 17,000 planned 'low risk' home births, 28,000 planned 'low risk' midwifery unit births (AMUs and FMUs) and nearly 20,000 planned 'low risk' obstetric unit births.

4.0 Criteria for Home Birth

- 37 completed weeks and under 42 weeks of pregnancy;
- Low-risk obstetric history;
- Absence of maternal disease that affects birth;
- No evidence of pre-eclampsia or pregnancy induced hypertension;

- Haemoglobin >10.5g/dl;
- Singleton pregnancy;
- Cephalic presentation;
- Clinically well-grown baby – no evidence of SGA/ LFD;
- BMI 18-35;
- Normally sited placenta;
- Absence of abnormal bleeding /meconium.

5.0 Antenatal Preparation for Homebirth

(Refer to Appendix C and D)

5.1 Place of birth should be discussed at booking to facilitate informed choice.

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5.2 At 36-37 weeks gestation, an antenatal appointment should be made 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 to a routine antenatal check, the following should be discussed:

- 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 postnatal care and care of the baby;
- Vitamin K administration to baby;
- Preferred method of feeding;
- NIPE and hearing screening;
- On rare occasions the homebirth service may be suspended due to unforeseen factors such as weather conditions, staff sickness or overwhelming demand.

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

- Location Parking;
- Access in an emergency;
- Provision of light, heating and hot water;
- Safeguarding concerns;
- Personal safety of midwife.

5.6 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;
- Towels;
- Sheets;
- Waterproof protection e.g. shower curtains/ plastic dust sheets;
- Torch/lamp for suturing;

- Sanitary pads.

5.7 Midwives should ensure that their equipment is checked regularly and serviced annually. Neonatal equipment needs checking daily.
(Refer to Appendix D and E)

5.8 Midwives should ensure the provision of basic neonatal and maternal resuscitation equipment.
(Refer to Appendix E)

5.9 Midwives should ensure the provision of oxytocic drugs - syntometrine® and ergometrine for the management of third stage or in case of bleeding. Syntocinon 40 units in Hartmanns 500 mls and hemabate 250 mcg in case of postpartum haemorrhage.
(Refer to Postpartum Haemorrhage; register number 04234)

5.10 Water birth – women may want a water birth at home and should be offered the opportunity to labour and deliver in water.

5.11 If the woman wants a water birth it is her responsibility to hire/buy a birthing pool and follow the manufacturer's safety and hygiene instructions
(Guideline for water birth, labour and delivery in water and third stage management; register number 04237)

5.12 Women are asked to call the Labour Ward if in Chelmsford or the Midwife-led Birthing Units if in Maldon or Braintree when labour has begun and state that they are booked for a home birth.

5.13 Labour Ward to contact the community midwife on call with the woman's details including address and phone number. Midwife will then ring the woman or go straight to the home for initial assessment

5.14 A list of women requesting a home birth is kept in the community midwives office. Any women who fall outside guidelines should have a personalised care plan which should be sent to the Professional midwifery advocates (PMAs) via email.

5.15 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

(Refer to Appendix D)

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 '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 'Fetal heart rate monitoring in pregnancy and labour'; register number 04265).

6.4 When 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). Maternity Care Assistants should not take the place of a midwife but may provide support in bringing additional equipment or helping with feeding.

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.

6.7 Transfer to the consultant-led maternity unit is by paramedic ambulance. The midwife should ring 999 and ensure the emergency services know that it is an obstetric emergency. A midwife should travel in the ambulance with the woman.

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, 'Neonatal resuscitation'; 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.

6.11 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.

6.12 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.

6.13 The midwife should ensure all documentation is complete including a request for a hearing screen and the birth notification which should be returned to Midwife-led Birthing Unit and a copy into the community midwives office. The midwife is responsible for obtaining an NHS number for the baby.

6.14 Following discussion, the midwife should ensure that the woman has been given a child health care record booklet.

7.0 Contra-indications to Home Birth

7.1 Women who want to birth at home where there are contraindications e.g. women requesting a homebirth at over 42 weeks gestation or with a history of prolonged rupture membranes (PROM). For these cases an individual management plan should be formulated. This must be circulated to the PMA team and community team

7.2 In established labour, the individual management plan should be escalated to the community midwifery manager, the consultant on call 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 The midwife should involve the manager and PMA for professional and personal support.

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

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

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

7.8 Ensure accurate documentation at all times in accordance with The Code of Conduct.

8.0 Babies Born before Arrival of the Healthcare Professional (BBA) and Unplanned Home birth

8.1 In the event of a BBA or an unplanned home birth, where the woman is un-booked or unknown to healthcare professionals, transfer to hospital is required.

8.2 If a woman is known to service and there are no complications and she is happy to stay at home then community midwife will proceed as if it was planned home birth.

9.0 Staffing and Training

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

9.2 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.

10.0 Infection Prevention

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

10.2 All staff should ensure that they follow Trust guidelines on infection prevention, using Aseptic Non-Touch Technique (ANTT) when carrying out procedures e.g. vaginal examinations and conducting deliveries.

11.0 Audit and Monitoring

11.1 Audit of compliance with this guideline will be undertaken on an annual audit basis in accordance with the Clinical Audit Strategy and Policy and the Maternity annual audit work plan. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

11.2 The audit findings will be reported to and approved at the Women's and Children's Clinical Audit Group and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

11.3 The Women's and Children's Clinical Audit Group Report will be reported to the monthly Directorate Governance Meeting on a quarterly basis and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

11.4 Key findings and learning points from the audit will be submitted to the Patient Safety & Quality Committee (PS&Q) within the integrated learning report.

11.5 Key findings and learning points will be disseminated to relevant staff.

12.0 Guideline Management

12.1 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.

12.2 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.

13.0 Communication

13.1 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.

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

14.0 References

NPEU (2017) Birth place in England research programme [online]. Available at: www.npeu.ox.ac.uk/birthplace

National Institute for Clinical Excellence (2014) Intrapartum Care for healthy women and babies. Clinical Guideline (CG190). London: NICE.

RCOG/RCM (2007) Joint Statement no.2 Home Births.London: RCOG

Nursing and Midwifery Council (2015) The Code.Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates. London: NMC.

Appendix A: Preliminary Equality Analysis

This assessment relates to: (please tick all that apply)

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Carole Hughes	**Job Title**	Senior Community Midwife	**Date**	January 2019

Appendix B

The Cohort Study: Key Findings

The Birthplace cohort study compared the safety of births planned in four settings: home, freestanding midwifery units (FMUs), alongside midwifery units (AMUs) and obstetric units (OUs). The main findings relate to healthy women with straightforward pregnancies who meet the NICE intrapartum care guideline criteria for a 'low risk' birth.

Giving birth is generally very safe for 'low risk' women the incidence of adverse perinatal outcomes (intrapartum stillbirth, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, and specified birth related injuries including brachial plexus injury) was low (4.3 events per 1000 births).

Midwifery units appear to be safe for the baby and offer benefits for the mother

•For planned births in freestanding midwifery units and alongside midwifery there were no significant differences in adverse perinatal outcomes compared with planned birth in an obstetric unit.

•Women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions, including substantially fewer intrapartum caesarean sections, and more 'normal births' than women who planned birth in an obstetric unit.

For women having a second or subsequent baby, home births and midwifery unit births appear to be safe for the baby and offer benefits for the mother.

•For multiparous women, there were no significant differences in adverse perinatal outcomes between planned home births or midwifery unit births and planned births in obstetric units.

•For multiparous women, birth in a non-obstetric unit setting significantly and substantially reduced the odds of having an intrapartum caesarean section, instrumental delivery or episiotomy.

For women having a first baby, a planned home birth increases the risk for the baby

•For nulliparous women, there were 9.3 adverse perinatal outcome events per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric units, and this finding was statistically significant.

For women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after the birth

•For nulliparous women, the peripartum transfer rate was 45% for planned home births, 36% for planned FMU births and 40% for planned AMU births

For women having a second or subsequent baby, the transfer rate is around 10%

•For women having a second or subsequent baby, the proportion of women transferred to an obstetric unit during labour or immediately after the birth was 12% for planned home births, 9% for planned FMU births and 13% for planned AMU births.

Appendix C

HOMEBIRTH DISCUSSION NOTES

Date:	
Name:	**Hospital Number:**

Criteria for Homebirth

- 37 completed weeks and under 42 weeks of pregnancy;
- Low-risk obstetric history;
- Absence of maternal disease that affects birth;
- No evidence of pre-eclampsia or pregnancy induced hypertension;
- Haemoglobin more than 10g.5/dl;
- Singleton pregnancy;
- Cephalic presentation;
- Clinically well-grown baby – no evidence of SGA/LFD;
- BMI 18-35;
- Normally sited placenta;
- The absence of abnormal bleeding or meconium per vaginum.

Discussion Points

- Positive, relaxed environment which enhances normal birth through a woman centred approach and increased autonomy;
- All midwives are trained and equipped to deal with emergencies at home. If a transfer to Broomfield is required, the midwife will arrange a paramedic ambulance and accompany you;
- Your pain relief choices at home range from natural methods relaxation, massage, hypnobirth techniques, being mobile, water-birth and you can consider using TENS, we will bring Entonox If you find that you want an epidural at some point in your labour, you will need to be transferred to Hospital as it is administered by a doctor;
- Care in labour will be to monitor you and your baby and observe for deviations from normal, in an unobtrusive way, offering support and guidance.

Reasons for transferring to Broomfield Hospital

- Woman's choice;
- Increased pain management option, e.g. epidural;
- Changes from low risk to high risk for mother or baby, for example, maternal wellbeing – temperature, blood pressure etc;
- Baby – fetal heart abnormalities during labour;
- Slow progress in labour;
- Meconium stained liquor;
- Cord prolapse;
- Haemorrhage during labour or following delivery;
- Retained placenta;
- Perineal trauma requiring suturing by a doctor;
- Difficulties during delivery, e.g. shoulder dystocia, breech;
- Low apgar scores or resuscitation for baby;
- Any abnormalities noted in baby.

Following delivery

- Suturing as required;
- Midwife examination of baby;
- Feeding of baby;
- Mother's refreshments;
- Mother and baby observations;
- Mother's bath/shower;
- Full labour and postnatal documentation;
- Advice and contact numbers in case of concerns;

After at least 6 hours, often the following day if delivery is late in the day, you will be visited by a midwife who will carry out the initial examination of the newborn. If there are any concerns over baby, you may be asked to visit the postnatal ward for an examination by a paediatrician.

Appendix D

Homebirth Kit

Paperwork:
Labour Book
Maternal & Baby Postnatal Book
Baby red book
Adult & Childrens Drug Chart
Postnatal leaflets (brown envelope).

Delivery:
Plastic sheet
Inco pads
Green aprons x2
Sterile gloves
Non-sterile gloves
Speculum
Blue swab
Entonox mouthpiece
Instiller Gel
In/out Catheter
Amnihook
Delivery pack
Delivery instruments (or x3 cord clamps and scissors)
Pool Mirror
Towels

3rd Stage & Suturing:
RH Negative blood form & Bottles
Suture pack
Suture instruments
Vicryl rapide 2.0 x2
Vicryl rapide 4.0 x2
Normal Saline x6
Sharps Bin
Placenta Bin
Large Orange Bag

Baby:
Cot Card (pink & blue)
Hat (pink & blue)
Tape Measure
Tempadots
Labels (x2)
Cotton Wool & Plaster

NOTE: Entonox & drug box (containing needles & syringes) not to be left at the home address before or after delivery.

Appendix E

Community Midwives
Car Equipment

Adult resus:

Adult Bag/Valve/Mask
O2 mask with Reservoir
O2 cylinder CD size

Neonatal resus:

Towels x2
Hat x2
Neonatal Stethoscope
Neonatal BVM
Silicone masks size 0 & 1
Laryngoscope, single use
Guedel Airways: one each of size 000 (pink), 00 (blue), 0 (grey) and 1 (white)
Laminated Resuscitation Council Algorithm

Antenatal Observations Bag:

Tape measures, single use
Blood Pressure machine
Stethoscope
Multistix urine strips
Sonicaid
Pinard
Gel

BBA Rucksack:

Gloves: Sterile and non-sterile
Towels x2
Inco pads x6
Delivery pack
Delivery instruments (or x3 cord clamps and scissors)
Green apron
Orange bag
Baby hat