WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

GUIDELINES FOR THE MANAGEMENT OF HOMEBIRTH

Amendments			
Date	Page(s)	Comments	Approved by
2/9/09	2	Added list of other relevant guidelines	Maternity Guidelines Committee
	2, 4, 8, 9, 11, 12	Appendices labels amended	
	2, 5	Abbreviation removed	
	6	Monitoring guidance updated	
	11	Space added for woman's name and hospital number. 'Date' added to information required.	
	13	Removed syntocinon from equipment list	
	2/3/4	Birth place cohort study Datix References	
2/4/12	6,8	Removal of reference to Supervisor of Midwives	Supervisors of Midwives
26/2/18	Whole document		Head of Midwifery
Sep 28	Whole document	Whole document review and update	Women's Health Guidelines Group

Compiled by: Theresa Spink & Luisa Micciche

In Consultation with: Women's Health Guidelines Group, Supervisors of Midwives

Ratified by: Supervisors of Midwives

Date Ratified: 22.05.12

Date Issued: 22.05.12

Next Review Date: Sep 2021

Target Audience: Community Midwives/Women Considering Homebirth

Impact Assessment Carried Out By: Theresa Spink

Comments on this document to: Luisa Jbira Community Midwife Team Leader

GUIDELINES FOR THE MANAGEMENT OF HOMEBIRTH

Contents

See also:

- Maternal Transfer guideline
- PROM:- Guideline for the Management of Pre-Labour Spontaneously Ruptured Membranes at Term
- Ante-natal Referral to maternity services, booking appointments and maternity care pathway including antenatal clinical risk assessment and missed antenatal and scan appointments
- Care of Women in Labour guideline
- Fetal Heart Rate Monitoring guideline
- Maternity Escalation Policy

Introduction

The Birthplace cohort study(1) states 'that for women having a second or subsequent baby, home births and midwifery unit births appears to be safe for the baby and offer benefits for the mother'. For women having their first baby at home there is an increased for the baby. For nulliparous women, there were 9.3 adverse perinatal outcome events per 1000 births compared to 5.3 per 1000 births for women who birthed in an obstetric unit. The study found that the transfer rate was 45% from planned home birth to an obstetric unit during labour or immediately after the birth.

Women who have had both a home birth and a hospital birth say they much prefer a home birth, and they feel they have achieved something 'deep and meaningful'. Women report feeling more relaxed and in control when in their own home (2).

The recommendation of Maternity Matters is that "depending on their circumstances, women and their partners will be able to choose where they wish to give birth." (3) One of the options should be birth supported by a midwife at home.

Midwives providing care for women must take care to identify possible risk. A midwife must be able to provide appropriate care to mitigate those risks regardless of setting, through care planning, knowledge of services, and communication with colleagues and the woman and her family (4).

The midwife needs to provide accurate and objective information and should enable the woman to make decisions about her care based on her individual needs, by discussing matters fully with her, to ensure that the mother and her partner make an informed choice about the place of birth (5).

Antenatal Preparation

During the antenatal period, the midwife should discuss the choices available to the woman regarding place of birth. All low risk women should be offered the possibility of considering a planned home birth. Advise low-risk multiparous women that planning to give birth at home or in the Midwife-led Birth Centre is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Advise low-risk nulliparous women that planning to give birth in the midwifery-led Birth Centre is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby (6).

All women should be directed to the leaflet 'Choosing where to have your baby' on the mothers Badgernet Portal.

There should be no pressure on the woman to make a decision regarding place of birth at booking, discussions should be ongoing throughout pregnancy and the woman should be able to change her mind at any time (4).

It should also be explained that occasionally there may be times when unexpectedly due to demand and capacity issues we are unable to support a home birth service,. In this event refer to Maternity Escalation Policy.

Preparation for labour

Preparation for labour should be discussed fully with the woman and her family at around 36 weeks gestation and a home visit should be arranged to assess the birthing environment, and discuss practical arrangements. A 'Home Birth Risk Assessment' should be completed (see Appendix 2) and returned to the Community Midwives office.
The leaflet 'Preparing for Homebirth' should be given to the woman prior to the visit.

Discussion at this visit should include the following:

1. Practical arrangements

- Consideration of the location the woman will labour, and how she would be evacuated if needing to be transferred, e.g. if upstairs, living in flats, on a narrow-boat and loft conversation.
- The woman and her family are fully prepared and in agreement
- Care of siblings (could be discussed earlier)
- Arrangements for any pets in the home
- The home is prepared and the woman is aware of the equipment she will need to provide, e.g. heating, lighting (angle-poise lamp, torch), protection for carpets and furniture (plastic sheets, inco-pads, rubber-backed shower curtain), sanitary pads, warm towels etc, and snacks/drinks.
- The woman knows when and how to contact the midwife – inform about on call arrangements for community midwives and response time.
- To ensure that the woman's home is easily identifiable by the midwife, e.g. at night put on house lights, house number/name is easy to see, or arrange for an adult to meet the midwife at the door, gate, or nearest accessible tarmac road.
- Parking for the midwife, and access for ambulance if required.
- To have a bag packed in case of need to transfer to hospital

2. Care in labour/Birth plan

- Explain what equipment the midwife will bring with her, e.g. resuscitation and emergency equipment, cylinders, suction.
- Check if the woman and her partner are happy to have students present at the birth or not.
- Fetal monitoring in the home environment – intermittent auscultation with handheld doppler (refer to Fetal Heart Rate Monitoring guideline).
- Assessment of progress and wellbeing, including maternal observations and vaginal examinations.
- Pain relief – TENS machine hire, birth pool hire, entonox. Explain that pethidine is not routinely used at home births, but is available if requested in advance – however, it may not be used if the woman will be using a water pool.
- Birth supporters – who the woman would like to have present at the birth.
- Management of third stage – active or physiological.
- Vitamin K for the baby – injection or oral.

3. Possible reasons for transfer to hospital in event of deviation from normal

As per Birthplace cohort study 2011 findings:

- Nulliparous women 45%
- Multiparous women 9%

Reasons why transfer to hospital should be advised:

- Concern re maternal wellbeing, e.g. raised blood pressure
- Slow progress in 1st or 2nd stage
- Need for further pain relief
- Prolonged rupture of membranes and delivery is not imminent
- Undiagnosed breech presentation
- Malpresentation, /face/brow
- Cord prolapse
- Significant meconium-stained liquor
- Fetal heart abnormality
- Neonatal concerns/ Resuscitation of the newborn/low apgars
- Third degree tear
- Retained placenta
- Post partum blood loss of 500mls or more, or less if the mother is symptomatic
- Any case where the midwiife's clinical judgment is such that she recommends an obstetric opinion.

4. How transfer would be achieved

During the home visit at 37 weeks, there needs to be a frank discussion with the woman and her family regarding the practicalities of transfer to hospital, as this may be an important factor in deciding on place of birth. This discussion should include time for an ambulance to reach the home, and estimated transfer time. This discussion should also include the level of expertise and equipment available to the midwife and the ambulance crew.

Refer to the Maternal Transfer guideline.

It is the responsibility of the attending midwife to call for a paramedic ambulance via 999, and this should be clearly communicated as urgent. The midwife should accompany the woman in the ambulance during the transfer. Any decision to transfer care should be clearly documented in the notes, together with the date, time and reason for transfer of care. The times of request and arrival of an ambulance should also be documented in the handheld notes. If the woman is in established labour and ready to push whilst being transferred in the ambulance, the midwife should request that the ambulance should stop, to allow the midwife to safely deliver the baby. The midwife will need to consider if she requires TWO ambulances to attend if she is needing to transfer both mother and baby after the birth.

The woman's details should also be displayed on the 'Home birth board' in the Community Midwives office.

Labour

The woman will be cared for by the most appropriate Team Midwife where possible (at night this is the Community Midwives on call).

Equipment for home birth should be collected from the hospital prior to attending the woman at home (see appendix 4 for equipment list) including a 'Soft Pack' (see appendix 1 for Home birth soft pack contents).
The midwife needs to ensure accurate record keeping, including completion of the partogram. Drugs given such as Syntometrine, lignocaine and vitamin K should be clearly documented in the notes, a drug chart is not required.

Once labour is established, the Midwife must remain in the home and the second Midwife should be called as if felt necessary prior to the second stage of labour. The timing of this will be directed by individual situations. If any deviation from the norm occurs assistance must be called immediately. Two Midwives should be present for delivery.

Consideration needs to be given to the length of time a midwife is with the woman, and that she might need to be relieved particularly if she has been on call.
The Team Leader on Labour Ward should be informed that a woman is in labour at home, and should be updated on any relevant events, e.g. slow progress, need for transfer, time of delivery etc.

Management of women with Spontaneous Rupture of Membranes (SROM) at term with no contractions, who have chosen to labour at home

Rupture of membranes may be confirmed by the obvious presence of liquor without the need for further examination. If the midwife is unsure whether liquor is draining, the woman should be asked to have a lying speculum examination and, if SROM is confirmed, the woman should be referred to Labour Ward for augmentation 24-48 hours after SROM. (Refer to Guideline for the Management of Pre-Labour Spontaneously Ruptured Membranes at Term)

In the case of delivery at home >24 hours after SROM, the midwife should take swabs from the baby for culture and ensure that the baby appears well and has fed before the midwife leaves the house. The midwife should advise the woman regarding signs of infection to look for, and what action she should take if she has any concerns.

Post delivery

The midwife will contact the Labour Ward Team Leader to inform them of a safe delivery. The midwife should stay with the woman after the birth until she is satisfied that all is well with both mother and baby before leaving the home.

The delivery notes should be completed and the mother and baby's postnatal checks documented.

The midwife should encourage skin-to-skin contact between mother and baby, and baby's first feed within the first hour after the birth. The midwife should provide any necessary assistance with feeing and the baby should feed before the midwife leaves.

On leaving the home the midwife will ensure that the mother and her carers know:

- How to contact a midwife for any further advice in the event of any problems occurring.
- When the next home visit from the midwife will be.
- When the Newborn Check will be done (leave message on postnatal visit sheet for the Midwife Examiner of the Newborn (MEON) check to be done within 72 hours).

The midwife will ensure correct transfer of used equipment, sharps, clinical waste (unsoiled packaging etc may be disposed of in the ordinary household waste), and disposal of the placenta.
On returning to the hospital, all equipment should be checked and restocked. A postnatal visit sheet should be completed and filed in the appropriate Team folder.

If the woman is Rh D Negative, cord and maternal bloods should be taken and sent to the lab as usual. If the woman requires Anti-D, this should be collected from the ward by the Community Midwife and given to the woman in her home within 72 hours of delivery.

If oral vitamin K has been given, the Community Midwife will need to arrange for subsequent does to be given.
Datix should be completed if transfer in to hospital was required.

The 'Home Birth Audit' (see appendix 3) form should be completed and forwarded to a Community Team Leader.

Home birth against medical/midwifery advice

Ideally mothers choosing home birth will fulfil criteria for low risk care (see guideline Ante-natal Referral to maternity services, booking appointments and maternity care pathway including antenatal clinical risk assessment and missed antenatal and scan appointments).

Women who fall outside criteria who choose to plan to birth at home

If a woman intends to give birth at home, contrary to professional advice, the named midwife must inform the Team Leader and together they must draw up an appropriate management plan. The woman must be involved in this process. The plan should evidence a comprehensive risk assessment and clear documented identification of any risks should be recorded. The nature of the risk should be made explicit when counselling women and a clear documented plan of care made and agreed by all parties (7).

Midwives should continue to provide care for the woman and they are legally obliged to provide emergency care.

The case should also be discussed with a Consultant Obstetrician who may be able to offer further advice. Any discussion should be documented on the woman's electronic notes.

A written plan must be made. A copy should be 'filed' under archived reports on Badgernet and a hard copy placed on the 'Labour Plan' clipboard on Labour Ward.

When the midwife attends the woman at home and established labour is confirmed, the Labour Ward Shift Leader must be informed. The written plan must then be shared with the Obstetric Team of the day.

Monitoring
Compliance with guideline will be monitored annually by review of maternity records detailed the table below. Where deficiencies are identified action plans will be developed and disseminated as required.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangement	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
All planned home births have a are monitored for: • Outcome • Reason for transfers • Any adverse outcomes	**Standard lead** Theresa Spink Clinical Midwifery Manager for Community and Outpatients	All records of women undertaking homebirth using Homebirth Audit Tool monitoring outcomes and ambulance transfers	Annually	Reported to Labour Ward forum and community midwives meeting	**Criterion lead** Theresa Spink who will disseminate and monitor any action plans required. Community Team Leaders	• Communication bulletin • MDT Quality & Safety half days • staff meetings • any other meeting as appropriate • Individual feedback as appropriate One or all of the above

References

1. Brocklehurst P, Hardy P, Hollowell J et al (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. BMJ, vol. 343, p. d7400, Jan. 2011
2. Ng and Sinclair 2002 Women's Experience of a Planned Homebirth: a phenomenological study. RCM Midwives Journal Feb Vol 5 No 2 pp 56-59
3. Maternity matters: choice, access and continuity of care in a safe service 2007 DOH London
4. Nursing and Midwifery Council. Midwives and Homebirth. NMC circular 8 – 2006. NMC London
5. Standards for competence for registered midwives 2018 NMC London
6. National Institute for Health and Clinical Excellence, Clinical Guideline CG190 February 2017 Intrapartum Carefor healthy women and babies NICE London
7. RCM position paper 25. Home Birth Jan 2002 RCM London

Appendix 1 HOME BIRTH SOFT PACK CONTENTS

Placenta Bucket containing:

- 1 Clear plastic instrument bag
- 2 Aprons
- 6 Inco pads
- 4 Medium sterile gloves
- Non-sterile gloves
- 2 Klini-drapes
- KY Jelly
- Entonox mouthpiece
- 2 Cord clamps
- Cot card
- Tape measure
- 1 Sterile dressing pack
- Vaginal speculum and swab

Appendix 2 HOME BIRTH RISK ASSESSMENT

HOME BIRTH RISK ASSESSMENT

Name:	EDD:
Hospital Number:	Parity:
Address:	Midwifery Team:
	Directions:
Tel. No:	
GP:	Surgery:

Previous obstetric history:		
Relevant medical/surgical history:		
Does woman meet the criteria for midwifery-led care?	Yes	No
If no, what are the contra indications?		
Referral to Obstetrician?	Yes	No
Action plan agreed following discussion with Consultant:		
Leaflet 'Where to have your baby' given	Yes	No
Leaflet 'Preparing for Homebirth' given	Yes	No

Discussion Checklist:	Tick if discussed with woman		Comments:		
Birth plan discussed					
Special requests, e.g. water birth					
Birth partner					
Partner present during discussion	Yes	No	In Agreement:	Yes	No
Arrangements for other children					
Items to get ready (e.g. protection for carpets/furniture, torch, refreshments, hospital bag etc.)					
Midwifery on-call arrangements					
Contact arrangements					
Distance/time to hospital					
When to call the hospital					
	Tick if discussed		Comments:		

	with woman	
Environmental factors:		
Lighting		
Heating		
Access (including for ambulance)		
Phones (landline, mobile signal etc.)		
Safety		
Social issues		
Child protection/social services involvement		
Midwives response time		
Fetal monitoring		
Pain relief		
Availability of medical assistance/GP services		
Management of emergencies		
Equipment available		
Method of transfer into hospital		
Postnatal care (e.g. visits, neonatal check, etc.)		

Possible reasons for transfer to hospital in event of deviation from normal:	Discussed (tick)
Concern re maternal wellbeing, e.g. raised blood pressure	
Slow progress	
Need for further pain relief	
Prolonged rupture of membranes	
Undiagnosed breech presentation	
Malpresentation	
Cord prolapse	
Fetal heart abnormality	
Meconium-stained liquor	
Third degree tear	
Retained placenta	
Postpartum haemorrhage	
Neonatal concerns	
Neonatal resuscitation/low Apgars	
Any other issues of professional concern or doubt on the part of the midwife	

Agreed and understood:

Client's Name:	Signature:	Date:
Midwife's Name	Signature	Date:

Please return this form to the Community Midwives Office

Appendix 3:

Address Label/Name & Hospital No.

Appendix 3 AUDIT FOR WOMEN WHO PLAN TO HAVE A HOME BIRTH

Form to be kept with the handheld notes and completed by the midwife after delivery – Return to Community Midwives Office after delivery

Gestation at delivery		
Previous home birth	Yes	No
Time woman contacted SPH		
Date and Time of arrival 1st midwife		
Date and Time 2nd midwife called		
Date and Time of arrival 2nd midwife		
Type of pain relief used	None	TENS
	Entonox	Pethidine
	Water	Epidural
Date and Time of birth		
Estimated blood loss		
Did the woman deliver in water?	Yes	No
Did the woman deliver at home?	Yes	No
If no, state reason for transfer to hospital:		
Date and Time of decision for transfer		
Date and Time ambulance contacted		
Date and Time ambulance arrived at woman's home		
Date and Time ambulance arrived at hospital		
Type of delivery	SVD	Ventouse
	Forceps	LSCS
Has the woman previously met the attending midwife?	Yes	No
Breast or bottle feeding?	Breast	Bottle
Date and Time of first feed		
Skin-to-skin contact offered	Yes	No
Date and Time of skin-to-skin contact		
Perineum	Intact	1st degree
	2nd degree	3rd degree
	Episiotomy	Labial tear
Date and Time of suturing		
Date and Time left woman's house		
Time midwife arrived back at hospital		
Evolution completed	Yes	No
Incident form completed?	Yes	No

Appendix 4 Homebirth Equipment

HOMEBIRTH EQUIPMENT

DATE									
HOMEBIRTH BAG									
SIDE POCKET									
SWABS									
VITAMIN K PLUS SYRINGES AND NEEDLES									
DRESSING PACK									
SCISSORS									
CORD CLAMP X3									
TOURNIQUET									
RH NEG SET WITH BLOOD FORMS AND BOTTLES AND NEEDLES									
RED BOOK, AUDIT QUESTIONNAIRE									
TOP LAYER									
JACQUES CATHETER									
AMNIHOOK									
DELIVERY PACK									
EPISIOTOMY SCISSORS									
PERINEAL REPAIR PACK									
ENTONOX MOUTHPIECE									
BOTTOM LAYER									
BABY AMBU BAG									
NEONATAL MASKS SIZE 0, 1, & 2									
ADULT AMBU BAG WITH MASK									
LAERDAL MASK									
GOGGLES									
1 LITRE NORMAL SALINE									
ADULT SUCTION DEVICE									
NEONATAL SUCTION DEVICE									
SHARPS BOX									
PERINEAL REPAIR POUCH									
SWABS X2									
10MLS SYRINGES X2									
LIGNOCAINE 10MLS X2									
GREEN NEEDLES X4									

VICRYL 2.0 X3									
VICRYL 3.0 X3									
IV POUCH (KEEP SEALED)									
SCISSORS ON FRONT OF PACK									
TEGADERM DRESSING X2									
GAUZE									
TRANSPORE									
TOURNIQUET									
GIVING SET									
VENFLON X2									
LUERLOK X2									
COTTON WOOL									
2X PURPLE BLOOD BOTTLES									
2X PINK BLOOD BOTTLES									
2X BLUE BLOOD BOTTLES									
3X VACUTAINERS									
3X NEEDLES FOR VACUTAINERS									
1X 1MLS SYRINGE									
5X 2MLS SYRINGE									
3X 5MLS SYRINGE									
ORANGE NEEDLES X2									
GREEN NEEDLES X4									
5 MLS LIGNOCAINE X1									
5 MLS SODIUM CHLORIDE X1									
SPONGES									
PLASTERS									
SPECIMEN BAG WITH BLOOD FORMS									

YOU WILL ALSO NEED TO TAKE OUT WITH YOU:

SYNTOMETRINE
ERGOMETRINE
5X ENTONOX
ENTONOX TUBING AND VALVE

Equality Impact Assessment Tool

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		For each category describe how you have involved stakeholders including service users and employees
	Race and Ethnic origin (include gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	NO	Homebirth offered to women at the time of booking as a choice
	Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	NO	
	Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	YES	This is a maternity policy so regards pregnant women & their families
	Culture (consider dietary requirements and individual care needs)	NO	
	Religion or belief (include dress, individual care needs and spiritual needs for consideration)	NO	
	Sexual orientation including lesbian, gay and bisexual people (consider whether the policy/service promotes a culture of openness and takes account of individual needs	NO	
	Age (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist)	YES	Applies to pregnant women and their families only
2.	**Is there any evidence that some groups are affected differently?**	YES	Applies to pregnant women & their families only
3.	**If you have identified potential discrimination, for example, less than equal access, are any exceptions valid, legal and/or justifiable, for example a genuine occupational qualification?**	NO	
4.	**Is the impact of the policy/guidance likely to be negative?**	NO	
5.	**If so can the impact be avoided?**	NA	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	NA	
7.	**Can we reduce the impact by taking different action?**	NA	

If you have identified a potential discriminatory impact of this policy, please refer it to the appropriate Action Group, together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact, HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION
OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

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Policy/Guidelines Name:	Guidelines for Management of Homebirth
Name of Person completing form:	Luisa Jbira
Date:	May 2018
Author(s) *(Principle contact)*	Luisa Jbira
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Luisa Jbira
Date of final draft	May 2018
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency? *(delete as necessary)*	**Yes**
By whom:	Luisa Jbira
Is this a new or revised policy/guideline? *(delete as necessary)*	Revised
Describe the development process used to generate this policy/guideline. *Who was involved, which groups met, how often etc.?*	Maternity Guidelines Committee, Labour Ward Forum, Community Midwives, electronic review by all Obstetric Consultant
Who is the policy/guideline primarily for?	Community Midwives/ Women who are considering a homebirth
Is this policy/guideline relevant across the Trust or in limited areas?	Maternity care only
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?	Newsletter attached to all payslips, notice boards in all clinical areas, staff meetings & Trust inductions, educational half day
Describe the process by which adherence to this policy/guideline will be monitored. *(This needs to be explicit and documented for example audit, survey, questionnaire)*	Audit of intention to have homebirth profoma. Audit of women who plan to have a homebirth.
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?	NICE 2017 Intrapartum care for healthy women and babies
What (other) information sources have been used to produce this policy/guideline?	See reference list
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?	Yes
Other than the authors, which other groups or individuals have been given a draft for comment? *(e.g. staff, unions, human resources, finance dept., external stakeholders and service users)*	Staff/midwifery & medical
Which groups or individuals submitted written or verbal comments on earlier drafts?	Labour Ward Forum – consultant advise
Who considered those comments and to what extent have they been incorporated into the final draft?	Considered by authors & incorporated
Have financial implications been considered?	YES – positive effect as increase in normal birth likely