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| **Approved by:** | Maternity Governance Meeting | |
| **Date of Approval:** | 21st August 2020 | |
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**Key Amendments**

| Date | Amendments | Approved by |
|---|---|---|
| 21st August 2020 | New form added to document – Homebirth Information for Team – Update to Appendix B | Maternity Governance Meeting |

**Introduction**

Maternity Matters (DOH 2007) sets out a national choice guarantee. Within this is a guarantee that by the end of 2009 all women depending on their circumstances should have a choice of where to give birth. One of these options is birth supported by a midwife at home.

Women should be offered the choice of planning birth at home, in a midwifery led unit or in an obstetric unit. Women should be assured that intrapartum-related perinatal mortality is low in all settings (NICE 2007).

Pregnant women should be offered evidence based information and support to enable them to make informed decisions regarding their care. Addressing women's choices should be recognised as being integral to the decision making process. (Antenatal Care Guidelines. NICE Oct 2003)

The results of a study of perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies in 2011 support a policy of offering healthy women with low risk pregnancies a choice of birth setting. Women planning birth in a midwifery unit and multiparous women planning birth at home experience fewer interventions than those planning birth in an obstetric unit with no impact on perinatal outcomes. For nulliparous women, planned home births also have fewer interventions but have poorer perinatal outcomes.

**Booking**

- Ideally women requesting Home Birth should fall within the low risk criteria, if not discuss with Supervisor of Midwives. Women who are recognised as high risk from the risk assessment tool (see Antenatal Risk Assessment) should all have been referred to an obstetrician who should also discuss place of birth using evidence based information.
- The advantages and risks associated with birth at home should be discussed with the woman and her partner. Evidence relating to homebirth is included within the homebirth checklist. Details of this discussion along with the completed "checklist" (Appendix A) by 37 weeks by the named midwife if possible should be documented in her handheld records.
- Give homebirth leaflet (Appendix C).
- The woman and her partner's co-operation should be sought in case of a need to transfer care either antenatally or during birth. Inform Supervisor of Midwives if co-operation not obtained.
- Complete Home Birth Notification Form (Appendix B) and send this to the appropriate Supervisor of Midwives/Community Manager.

**Antenatal Care**

- Antenatal care is followed as midwifery led care (see guideline)
- If any deviation from normal occurs reassess using assessment tool. If now high risk, refer to Consultant and Supervisor of Midwives if appropriate. Discuss place of birth in case of delivery prior to seeing the Consultant. Give evidence based information relating to the deviation, ensuring women and partners are fully informed.

- At 36-37 weeks of pregnancy refer to checklist (Appendix A) again ensuring the woman and her partner are still happy with place of birth and that any recommendations made at booking have been resolved. Homebirth proforma to be completed and sent to Sarah Cooper (Maternity Secretary KGH) for distribution to all community teams.
- Choice of analgesia to be discussed. (Appendix A).
- Entonox cylinders may be left at the woman's home prior to delivery, but she must be given the Entonox information sheet (Appendix C). Note: Entonox heads and flow gauges are not to be left in the woman's home.

**Labour**

- Once established labour has been confirmed the midwife in charge should inform as necessary:
  a) Delivery Suite
  b) The second midwife. The timing for contacting the second Midwife is at the discretion of the attending midwife. Two practising midwives should be in attendance for the birth.
- At a planned home delivery, neonatal and adult resuscitation equipment must be ready for use in close proximity to the woman. IVI equipment should be available and easily accessible.
- Mother and Baby – Identification bands to be completed prior to delivery if time allows. Therefore if transfer needed bands are ready for use, if not for transfer, parents may keep in baby book.
- If women wish to have Pethidine or Meptazinol for pain relief during planned labour at home, this should be prescribed by the GP and is the responsibility of the woman to follow storage instructions given by the GP or pharmacy. Community Midwives can carry Meptazinol as this is the drug of choice, obtained through Pharmacy at hospital, without a prescription.
- Care in labour should be in accordance with:

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| Normal labour including care pathways for midwife led intrapartum care | L2 |
| Waterbirth | L13 |
| Aromatherapy | L18 |

- The Delivery Suite Co-ordinator is to be informed if there is any deviation from normal.
- Any deviation from normal will necessitate transfer to hospital consultant unit**.** The midwife should dial 999 (or ask partner/relative) to request an ambulance with paramedic support and check with the nearest delivery suite that a bed is available. Read in conjunction with relevant guideline. If the woman refuses transfer, document and inform Delivery suite Co-ordinator after discussion with woman and inform on call Supervisor of Midwives.
- Information regarding the reason for transfer and any care provided, interventions and actions should be documented within the handheld notes. This information should be relayed to the receiving health care professional to allow them to continue with contemporaneous records. A copy of the Ambulance record should be filed in the woman's hospital notes.

**Second Midwife's responsibilities**

- Record times and provide support to midwife in charge (documentation to be completed by first midwife).
- If second midwife not present for any reason, ask partner to write times on piece of paper as an "aide memoire".
- Paramedics may be summoned for delivery of baby if second midwife has not arrived.

**Third stage labour**

- Physiological, or expectant management, of the third stage of labour involves the placenta and membranes delivering spontaneously. Active management involves administration of an oxytocic drug, clamping and cutting of the cord (after 2 minutes, as per delayed cord clamping guideline), and controlled cord traction.
- The woman should be offered all information regarding each method in order to make a choice regarding management of the third stage of labour. This discussion should preferably take place in the antenatal period and the woman's wishes recorded on the birth plan in her hand-held notes and documented in her records.
- Active management is suitable for woman with complicated pregnancies/ labours or those at higher risk of postpartum haemorrhage (PPH). It has been found to reduce the incidence of PPH.

**Physiological management of third stage of labour**

- An oxytocic drug is **not** given.
- The cord is **not** clamped and cut, thus enabling the baby to receive its full quota of blood and prevent counter-resistance of placental blood flow. It is clamped and cut either once it has stopped pulsating or after the placenta is expelled, depending on the woman's wishes.
- The baby can be encouraged to breastfeed if the woman wishes in order to stimulate the production of oxytocin, thereby further supporting the physiological processes. The average length of time for a physiological third stage is 15 minutes.
- The woman will experience a contraction and the birth attendant can be guided by the woman's urge to push. The placenta and membranes are then expelled by maternal effort. The woman can be encouraged into an upright position to assist this process. The cord is then clamped and cut. Offer the woman and her partner the opportunity to observe the placenta and membranes.
- N. B. The midwife should not undertake controlled cord traction at any stage.
- If haemorrhage does occur, proceed as for active management of the third stage having previously discussed this with the woman and obtained her consent.

**Active management of third stage of labour**

- An oxytocic drug is given intramuscularly following the birth of the baby.
- Wait two minutes and then the cord is clamped and cut. Place the non-dominant hand over the fundus and await a contraction, keeping the hand still. Mismanagement of the third stage can disrupt myometrial activity and result in only partial separation of the placenta and subsequent excessive bleeding.
- Once well contracted, the uterus is "guarded" with one hand whilst controlled cord traction is applied with the other hand, and the placenta and membranes are gently delivered. In the event of the cord breaking, traction should cease and maternal effort encouraged to complete delivery of the placenta.

**Following expulsion of placenta and membranes by either method:**

- The time is noted and documented.
- The uterus is checked to ensure that it is well contracted.
- The blood loss is estimated.
- The genital tract is checked for trauma.
- The woman is made comfortable.

Offensive waste should be placed in a Tiger Bag . The placenta placed in a placental pot for transfer to hospital for disposal unless the woman wishes to keep her placenta. Explain if burying the placenta it must be at least three feet deep. Document in the notes re disposal of placenta if not brought into hospital.

**Post-natal care**

- Inform delivery suite following delivery that all is well.
- Relevant records must be completed. Complete Home Birth Register at earliest opportunity.
- Notify birth, undertake Athena and complete Bluespier MIS.
- The midwife should remain at the home for a minimum of 1 hour following delivery. Ensure on leaving that all relevant contact numbers are given, complete postnatal check including observations
- Check to see if she has passed urine, if not call her in 12 hours time to recheck (see guideline for Intrapartum and postpartum bladder care) measure and document first void.
- GP should be informed of delivery during office hours. Arrange for neonatal examination to be performed, using NIPE trained midwives where possible.
- Further postnatal care will be arranged according to the woman's needs.

**Women requesting home birth against advice**

An individualised action plan should be drawn up in conjunction with the Supervisor of Midwives and relevant medical staff.

If the woman is assessed as being high risk she should be treated appropriately with the support of a Supervisor of Midwives. Each woman is treated as an individual and makes her own choices based on the evidence and information she is given and her own preferences.

- Refer to Consultant in Antenatal Clinic. The consultant should record in the management plan "against advice"
- Inform Supervisor of Midwives – Supervisor to visit woman at home and discuss issues.
- Develop an action plan with the Community Midwifery Team.

**In Labour**

If the woman declines to accept your advice, continue to give care in labour after you have informed the delivery suite co-ordinator and the Supervisor of Midwives on call.

- Record your advice and actions in the notes contemporaneously.
- Inform Ambulance Control of situation.
- Inform the GP as appropriate. The midwife should note, however, that she can call upon any General Practitioner on the Family Practitioner Committee list and practising in the area for help in an obstetric emergency, and he is required to attend whether or not the patient is on his NHS list, and whether or not the doctor is on the obstetric list. Ref: The NHS General Medical Services Regulations 1992 GP Terms of Service Schedule 2:4 (n).

**Babies born before arrival of healthcare professional (BBA) and unplanned homebirth**

- In the event of a BBA or an unplanned homebirth, where the woman is unbooked or unknown to healthcare professionals, transfer to hospital is required. As soon as possible and , importantly, prior to discharge, ensure that there are no safeguarding issues by contacting childrens services.
- The checks should be undertaken in all cases where;

    - There is no record of access by the woman to a programme of routine antenatal care
    - All cases of undisclosed/unknown pregnancy
    - All births that have not been booked by a midwife in Worcestershire
    - All late bookings of 30 weeks and above gestation
    - All cases of no fixed abode
    - All cases of women residing in a refuge
    - All movements into the area

In all BBA cases contact should be made with Delivery Suite to ascertain if there are any safeguarding issues or alerts. If no concerns and mother and baby are well, plan to stay at home.

Appropriate action should be taken where safeguarding concerns are raised, with reference to the Trust's safeguarding children policy.

Telephone handover to the community midwifery team to notify them of the discharge should then take place, advising the outcome of the communication with childrens services.

**APPENDIX A HOME BIRTH CHECKLIST**

*Please attach patient sticker here or record:*

*Name:*……

*NHS No:* ☐☐☐☐☐☐☐☐☐☐

*Unit No:* ☐☐☐☐☐☐☐☐☐☐

*D.O.B:* ……/……/…….. *Female*

*Address:*……

……*Postcode:*……..

Worcestershire NHS
Acute Hospitals NHS Trust

## DISCUSSION FOR PLANNED HOMEBIRTH

| Women should be informed that: | Tick once discussed |
|---|---|
| A planned homebirth in uncomplicated pregnancies is associated with an increased likelihood of spontaneous vaginal birth (NICE 2007). | |
| Women who give birth at home have reduced morbidity compared to those giving birth in an obstetric unit, for example, less likelihood of contracting hospital acquired infections (NICE 2004).<br>Women who give birth at home are less likely to have an episiotomy and more likely to have an intact perineum, compared with low risk women who birth in an obstetric unit (NICE 2007). | |
| Low-risk women, irrespective of parity, have much shorter labours at home. This is due to a combination of factors, such as:<br>• her ability to adopt positions favourable to facilitating normal birth (Albers et al 1997)<br>• control over the birth environment,<br>• more relaxed, which produces higher levels of oxytocin (Anderson 2005)<br>• continuous labour support from her family and her midwife (Midirs 2004) | |
| The evidence relating to place of birth currently lacks quality, especially in relation to perinatal mortality, between planned home birth for low risk women and birth in an obstetric unit (NICE 2007).<br>Studies have suggested that intra-partum perinatal mortality is similar or may be slightly higher in babies born at home.<br>This, however, may be related to women who have developed high risk labours and have been included in the statistics despite appropriate transfer, or high-risk women who have had an unplanned home confinement (NICE 2007)<br>The most recent study undertaken in 2011 provided the following evidence:<br>Perinatal and maternal outcomes by planned place of birth for healthy women with low risk | |

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|---|---|
| pregnancies 2011. The results support a policy of offering healthy women with low risk pregnancies a choice of birth setting. Women planning birth in a midwifery unit and multiparous women planning birth at home experience fewer interventions than those planning birth in an obstetric unit with no impact on perinatal outcomes. For nulliparous women, planned home births also have fewer interventions but have poorer perinatal outcomes. | |
| Evidence shows that between 4% and 20% of labouring women will transfer to an obstetric unit (primips 30-55%; multips 1-15%) (NICE 2007).<br>Local transfer rates are currently 17% | |

| **Women should be informed that:** | **Tick once discussed** |
|---|---|
| When maternal or fetal complications arise at home during labour, emergency medical care may be delayed due to the time needed to transfer to the consultant unit. | |
| Midwives are experts in normal childbirth and trained to an exceptionally high level. The care provided at home is governed by the trusts protocols in exactly the same way as in hospital. Two midwives are always called to attend the birth. Midwives are highly skilled in recognising when labour deviates from normal and transfer should this occur as soon as this is recognised. | |
| There is evidence showing that women who opt for a home confinement report a positive birth experience (NICE 2007), which is likely to contribute to improved psychological well-being in the postpartum period. | |
| Women are less likely to use pharmacological pain relief if having a homebirth. Please document woman's choice of pain relief in her Birth Plan/handheld notes.<br>If the woman declines ultrasound scan; discuss the implications of not knowing placental site and number of fetuses.<br>Make aware that the eligibility criteria for planned homebirth is between 37 weeks and 41+5 weeks gestation (12 days post dates).<br>Discuss reasons for transfer to consultant care:<br>• Raised BP/Pre-eclampsia<br>• Prolonged spontaneous rupture of membranes over 18 hours if not in established labour<br>• Failure to progress during labour - explain more relaxed at home so this is less likely.<br>• APH/PPH - reduced incidence of PPH due to shorter labour at home.<br>• Cord prolapse<br>• Fetal compromise - less intervention that can cause fetal distress at home.<br>• Maternal/Neonatal Resuscitation - babies born at home tend to have higher apgar scores than those born in hospital.<br>• Shoulder Dystocia - associated with semi-recumbent position and lack of mobilisation, which is more common in hospital. | |
| If drugs prescribed by GP, they should be collected in plenty of time (by 37 weeks) | |
| Discussion of what is needed for mum and baby. | |

| | |
|---|---|
| Ensure she is aware of how to contact midwife. | |
| **Other Checks** | **Tick once discussed** |
| Health and Safety and risk assessment carried out<br>Is house easily accessible for ambulance<br>Adequate lighting e.g. torch available, lamp for suturing if necessary.<br>If only mobile phone available, ensure signal at location.<br>Ensure protective covering available for birth.<br>Ensure childcare arrangements are in place in case of having to transfer to hospital in labour. | |
| Signed: Date:<br>Designation: | |

Worcestershire Acute Hospitals NHS Trust

**APPENDIX B**

# HOME BIRTH INFORMATION FOR TEAM

| | | |
|---|---|---|
| **Date Home birth requested:** | | **Date Home Birth booked:** |
| **Name:** | | **Hospital No.:** |
| **Address:** | | **Date of Birth:** |
| | | **EDD:** |
| **Partner's Name:** | | **GP:** |
| **Tel No's: Landline:**<br>**Mobile:** | | **Surgery:** |
| **Blood Group:** | **Parity:** | **Last FBC:** |
| **BMI at booking:** | **Growth Centile (if known):** | **NHS Birth Choices Leaflet: Received & Discussed ☐** |
| **Named Midwife & Team:** | | **Smoking Status:** |
| **Previous History including birth centile of other children:** | | |

# BIRTH PLAN

| |
|---|
| VTE Assessment and action by Community Midwife |
| Water Birth: Yes / No |
| Pain Relief: |
| Third Stage: |
| Vitamin K: Yes / No Oral / IM |
| Students: Yes / No (only 1 present at Birth if yes) |
| Any Comments/Directions to House: |

# IF OUTSIDE OF GUIDELINES:

| | |
|---|---|
| **Reason:** | |
| **Date seen Consultant Midwife/Matron:** | **Date Seen Consultant:** |
| **PLAN:** | |

# OUTCOME

| | | |
|---|---|---|
| Where birthed: | | |
| Type of birth: | | |
| Date of birth: | | |
| If transferred in: | AN – reason | |
| | Labour – reason | |
| | PN - reason | |
| | | |
| **Send copy to Sarah Cooper, Maternity Secretary, KTC Antenatal ☐ Postnatal ☐** | | |

**APPENDIX C**

## 'ENTONOX'

Information about:

**NITROUS OXIDE/OXYGEN ('Entonox')** cylinders that are left at your home prior to your planned home delivery.

At this time, we will assist you in storing it safely. The points you need to bear in mind are:

Check Household Insurance covers you to store 'Entonox' at home.

### Storage

- Store cylinders lying on the side.
- Cylinders should be under cover, preferably inside and not subjected to extremes of heat.
- To be kept dry, clean and well ventilated (both top and bottom).
- Be sited away from any sources of heat or ignition.
- Smoking and naked lights prohibited within the vicinity of the cylinder.
- Entonox cylinders to be stored at above 10$^{o}$C for 24 hours prior to use.

It may be necessary to store 2-3 small cylinders of Oxygen/'Entonox' at your house for a period of about one month. You are advised to inform your house buildings and contents insurers of this situation as it is a material fact which could affect the cover provided under your policies.

Worcestershire Acute Hospitals NHS Trust will cover any legal liability for bodily injury to third parties (or its own staff) or any damage caused by negligence of Trust staff.

### Handling

Precautions

- Cylinders should be handled with care, never knocked violently.
- Cylinders are heavy.
- Do not attempt to use without the supervision of your Midwife.

### In the event of fire

- As soon as a fire is discovered, notify the Fire Service, warning them of the presence of compressed gas cylinders.
- Unless you are trained in the use of fire extinguishers or fire hoses, do not attempt to fight a fire.

**Do not take any undue risks.**
**If you are concerned, contact Maternity Triage and ask for your on-call community Midwife.**