Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 125/08

Title:	Guideline for the management of home birth			
Author(s)	Mary McCormack, Team Leader Community Midwives Margaret Rogan, Consultant Midwife Gillian Morrow, Practice Educator Seana Talbot, Chair BHSCT MSLC			
Ownership:	Aidan Dawson, Director, Specialist Hospitals and Women's Health			
Approval by:	Specialist Hospitals Women's Health Standards and Guidelines Committee Policy Committee Executive Team Meeting		**Approval date:**	18/07/2017 27/09/2017 04/10/2017 11/10/2017
Operational Date:	October 2017		**Next Review:**	October 2022
Version No.	2.0	**Supersedes**	1.0 December 2008-2011	
Key words:	Home Birth			
Links to other policies	BHSCT (2016) *Management of the third stage of labour following vaginal birth, Guideline for Obstetricians and Midwives.* Ref No. SG191/12 BHSCT (2015) *Breastfeeding Policy for the Maternity and Neonatal Services of BHSCT.* Ref No. SG126/09 BHSCT (2016) *Effective Communication and Handover using SBAR within Maternity Services.* Ref No. SG23/16 BHSCT (2013) *Procedure for Perineal Repair by medical and midwifery staff.* Ref No. SG138/09 BHSCT (2015) *Policy on Lone Working.* Ref No. TP021/08			

Date	Version	Author	Comments
27/05/2016	1.1	Mary McCormack Gillian Morrow Margaret Rogan	Shared with Midwife Manager, Community Midwives and User Group. Comments made
02/06/2016	1.2	Mary McCormack Gillian Morrow Margaret Rogan	Changes made and circulated for comment
24/06/2016	1.3	Mary McCormack Gillian Morrow Margaret Rogan	Home birth guideline advisory group met and guideline updated, recirculated to group for further comments
08/08/2016	1.4	Mary McCormack Gillian Morrow Margaret Rogan	Changes made and circulated for comments
19/09/2016	1.5	Mary McCormack Gillian Morrow Margaret Rogan	Circulated to all clinicians and members of MLSC for comment
06/01/2017	1.6	Mary McCormack Gillian Morrow	Formulation of risk assessment check list

		Margaret Rogan	
18/07/2017	1.7	Seana Talbot	Comments and modification of risk assessment checklist

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Belfast Health and Social Care Trust will support women to make an informed decision about their place of birth by providing a balanced description of the benefits and risks of the different types of maternity settings

The Trust seeks to actively support women in their decision making process and to ensure safe birth of mother and baby within the home environment.

This guideline provides direction for all midwives involved in the care of women who have requested home births

When a woman has chosen a home birth, midwives have a key role to play in completing timely and accurate risk assessments (Appendix 1) in partnership with women to meet their needs and safety. The most important factor is that the woman must remain central in care delivery and the birth option must be chosen by her.

Women requesting home birth will often fall within the low risk criteria. If not, discussion with community midwife, team leader, supervisor of midwives (SOM) and senior midwife will take place at an early stage to support the woman's decision making and develop a care plan. Women who are recognised as high risk from the risk assessment tool will be offered referral to an obstetrician who will discuss place of birth using evidence based information.

BHSCT accepts that women may have different views from healthcare professionals about the balance of risks, benefits and consequences of treatments. The Trust accepts that women have the right to decide not to have a treatment, including deciding not to birth in hospital, even if Trust staff do not agree with their decision, as long as they have the capacity to make an informed decision and have been given and understand the information needed to do this.

The Birthplace study (2011) and Maternity Strategy (NI, 2012) indicate that;

- For women having a second or subsequent baby, home births and midwifery unit births are safe for the baby and offer benefits for the mother
- For women having a first baby, a planned home birth increases the chance of adverse perinatal outcomes for the baby from 5:1000 – 9:1000
- For women having a first baby, there is a 45% chance of transferring to an obstetric unit during labour or immediately after birth
- For women having a second or subsequent baby, the transfer rate is around 10%.

1.2 Purpose

This guideline provides direction for all midwives/maternity support workers involved in the care of women who have requested a home birth.

1.3 Objectives

- Aid midwives to provide evidence-based information so that women can make choices for care including home birth
- To facilitate women to give birth in their chosen environment
- To achieve a healthy outcome for mother and baby

2.0 SCOPE OF THE POLICY

This guideline is to be used by all midwives and maternity support workers caring for women in the home setting.

3.0 ROLES/RESPONSIBILITIES

3.1 Community Midwife Team Leader

- Management duties as per job description including; audit, appraisals and facilitation of identified learning needs
- Daily coordination of team
- Promote a community model of care in keeping with NI Maternity Strategy, amongst women and staff
- Facilitate team meetings to discuss risk and environmental issues, caseloads and communication
- Coordinate assessment and delegation of referrals for home birth.
- Communicate activity to senior midwife team and SOM on call.
- Off duty planning and implementation
- Continually monitor hours worked within the team and adjust accordingly to fulfil monthly contractual hours

3.2 Community Midwives

- Promote a community model of care in keeping with NI Maternity Strategy, amongst women and staff
- Attend homebirths as required in accordance with the Midwives Rules & Standards
- Participate in off duty planning
- Daily coordination of team in absence of team leader
- Minimum clinical skills must include IV Cannulation, Administration of Medicines; Midwives Exemption/PGD/Prescription only, Neonatal Life Support, PROMPT, Perineal Repair, Waterbirth and Examination of the Newborn
- Attend team meetings to discuss risk issues, caseloads and communication.
- Continually monitor hours worked and adjust accordingly to meet monthly Contracted hours

3.3 Maternity Support Workers

- Responsibility to support midwives in the community, including home birth
- Preparation, provision and collection of equipment
- Re-stock and reorder equipment
- Management of blood spillage
- Assist in cleaning birthing environment during and/or following birth
- Support women with general personal hygiene
- Parenting skills such as; bathing and infant feeding support

- Input and retrieve data into and from computer systems, for example test results, contact details and discharge information
- Organise and set up antenatal and postnatal classes and clinics, for example booking rooms, ensuring leaflets and other written information is available and arrangement of the room
- Assist midwives with opening packs, gathering equipment, disposal of equipment e.g. perineal repair

3.4 Delivery Suite Co-ordinator, RJMS

- To support and advise community midwives who are with a woman in labour on the management of labour, as requested.

4.0 KEY POLICY PRINCIPLES

4.1 Booking Process

- A request for home birth may come from; the woman directly (self-referral form), midwife booking appointment, GP or individual request at any time during pregnancy.
- The midwife who books the woman for a home birth is responsible for informing the community team leader and the rest of the community midwifery team (Appendix 2).
- The community midwife will inform the woman's GP.
- A booking appointment will be arranged between the community midwife and the woman at an agreed venue. A dating scan may also be arranged.
- At the booking appointment advantages and disadvantages associated with birth at home and hospital will be discussed by the midwife with the woman and her partner, using the Tables from NICE Guideline CG190 (Appendix 3)
- It is at this point that the midwife will assess risks, make appropriate referrals and ensure that all decisions are made by the woman.
- This booking assessment shapes the care pathway and care plan.
- An anomaly scan will be offered and arranged if accepted.
- Community midwifery contact details will be entered in the Maternity Hand Held Record (MHHR).

4.2 Antenatal Care Pathway

- Antenatal visits may take place in the woman's home or health care facility (whichever is mutually convenient). The structure of antenatal visits will be in accordance with NICE/NI Maternity Antenatal Core Pathway
- If any deviation from normal occurs, in discussion with the woman a referral will be offered to a consultant obstetrician using the HART Tool (Appendix 4). If declined the midwife will record this and inform the community midwife team leader and supervisor of midwives on call.
- The midwife is responsible to ensure the woman is fully aware of all local options for antenatal education. Information will be offered to suit the woman's requirements e.g. hospital antenatal education classes, Getting Ready for Baby Programme (GRFB), local National Childbirth Trust (NCT) and Sure Start projects.
- Community midwives and maternity support workers will provide all necessary practical preparation for the birth.

4.2.1 Antenatal Care Pathway for women outside low risk criteria

During the antenatal period it is the midwife's responsibility to identify any factors which may indicate the woman may have a higher chance of adverse birth outcomes. These should be discussed with the woman fully so the information can be considered in her decision making regarding place of birth. Midwives should also consult and offer appropriate referral to other services. Where women are competent to make decisions and have adequate information their decisions should be respected (NICE CG 138).

Patient views and preferences (NICE CG 138)

1.3.4 Hold discussions in a way that encourages the patient to express their personal needs and preferences for care, treatment, management and self-management. Allow adequate time so that discussions do not feel rushed.

1.3.5 Review with the patient at intervals agreed with them:

- their knowledge, understanding and concerns about their condition and treatments
- their view of their need for treatment.

1.3.6 Accept that the patient may have different views from healthcare professionals about the balance of risks, benefits and consequences of treatments.

1.3.7 Accept that the patient has the right to decide not to have a treatment, even if you do not agree with their decision, as long as they have the capacity to make an informed decision (see recommendation 1.2.13) and have been given and understand the information needed to do this. [QS]

1.3.8 Respect and support the patient in their choice of treatment, or if they decide to decline treatment. [QS]

1.3.9 Ensure that the patient knows that they can ask for a second opinion from a different healthcare professional, and if necessary how they would go about this. [QS]

During the antenatal period midwives will:

- Provide information to the woman about the risks, benefits and potential outcomes **specific to her** (Appendix 1). Involve a Supervisor of Midwives (SOM) in planning care. Inform the woman that she can contact a SOM directly for support/advice.
- Clearly document any discussions with the woman and record these in the MHHR, share with community midwifery team to enable effective communication.
- Agree and document an appropriate plan for care with the woman in the MHHR, including strategies for managing any complications which may arise.
- Continue to work in partnership with the women and provide appropriate care.
- **Once individual risk factors have been identified and a care plan agreed midwives will only revisit these if there is an added complication**.
- Involve other relevant health care professionals in planning care.
- Ensure that the risk assessment and care planning is a continuous process and that all discussions and revisions of the plan for care are recorded, dated and signed in the MHHR by the woman and the midwife and communicated to the rest of the midwifery team. (Appendix 8)

4.3 Discussions about safety

- It is national and local policy that all women should be able to choose their place of birth.
- For all women planning a home birth, the midwife will assess the home

environment and discuss with the woman any issues or changes she may wish to make to ensure the safety of mother, baby and staff.
- In developing the care plan with the woman, the midwife will complete a full individualised assessment and document appropriately.
- **Midwives will avoid discussions about complications that are not pertinent to the woman**.

4.4 From 34 Weeks Gestation

- Arrangements will be made for the woman and her partner to meet the community midwifery team.
- The midwife will facilitate an individual discussion with the woman about her birth preferences.
- If opiate drugs are requested this needs to be arranged on an individual basis with the woman and her GP.
- Entonox and Oxygen cylinders will be ordered from pharmacy as appropriate.
- 4xCD size Entonox cylinders and 2xD size Oxygen cylinders are required per home birth.
- Midwives assisted by maternity support worker will prepare the home birth box and equipment.
- Arrangements will be made with the BHSCT transport to deliver all equipment to the woman's home, by 37 weeks gestation.
- Midwife will call to the woman's home to ensure that it has arrived complete and that the suction machine is being electrically charged. Any problems with equipment will be amended before on-call begins.
- The midwife will give advice on how the equipment will be stored and about safe storage of medicines. See hand-out ‘Guidance for the Storage of Home Birth Equipment, in the home’ (Appendix5)

4.5 Equipment

- Appendix 6 (Home birth equipment List)

4.6 On Call Arrangements:

- On-call will commence at the beginning of the 37th week of pregnancy.
- The woman will be made aware that for the duration of the ‘on call period’ all members of the community midwifery team will provide cover.
- Written and verbal information will be given to the woman and her birth partner about how to contact the first and second on call midwife.
- In the unlikely event of being unable to contact either midwife, the woman will be advised to contact the delivery suite coordinator who will be able to contact members of the community midwifery team.
- Copies of the on call rota will be given to the mother, the community midwife team leader, delivery suite, admissions and the hospital bleep holder.

  Where a student midwife is on placement in the community, the woman's permission for her to attend the birth will be sought.

4.7 On arrival at the home during labour the midwife will:

- Review the care plan and woman’s birth preferences with the woman and her birth partner.
- Follow the normal labour and birth care pathway (GAIN, 2016).

4.8 Labour and Birth

When the mother feels that she is in labour, she will be advised to contact the first on call midwife who will:

- Respond to the expectant mother with a phone call
- Inform the second on call midwife
- Go to the home to assess the progress of labour
- Inform the delivery suite coordinator
- Inform 'on call' supervisor of midwives, if any concerns have been identified
- The second 'on call' midwife will go to the mother's home when labour is established or when requested by first 'on call' midwife
- Two midwives will remain present for active labour and birth and will remain with the mother and baby for a minimum of 2 hours after the birth.
- The partogram will be used to document labour progress and maternal and fetal conditions.
- Normal vaginal birth will be conducted in accordance with local procedure. The woman will be supported to achieve a normal birth and every effort will be made to fulfil the woman's birth preferences. The management and documentation of the third stage will be in accordance with BHSCT Management of the Third stage of Labour Guideline Ref No. SG191/12.
- Each midwife is responsible for her own health, safety, and fitness to practise. If a midwife considers that she is unfit to continue, then care must be handed over to another community midwife and the community team leader should be informed.
- If the midwife recognises a deviation from normal and a risk is identified the woman and her partner will be given an explanation and advice and in collaboration with the delivery suite coordinator the situation and urgency will be determined and transfer to hospital may be necessary.
- All communication / escalation will be documented utilising SBAR Communication as per BHSCT Guideline SG23/16.

4.9 Emergency Transfer

- Initiate emergency treatment until help arrives.
- The midwife will call 999 and ask for paramedic assistance and an ambulance to be dispatched simultaneously to the woman's home.
- Use a systematic communication process (SBAR) and have clear and concise information ready about address details, contact telephone numbers and history of particular situation.
- **Be clear about the urgency of request.**
- Inform the delivery suite Coordinator, RJMS.
- Keep mother and her family members calm and informed about events.
- The midwife will maintain accountability, travelling in the ambulance with the woman and aid paramedics with her safe transfer to hospital.
- The community midwife will relinquish her role as lead carer when a handover report has been given to the delivery suite team and all records have been completed.

- The community midwife has the option to continue to provide the midwifery care.

4.10 Non urgent transfers to hospital

Not in established labour

- Discuss with delivery suite coordinator for advice.
- Arrange suitable transport, i.e. the woman may transfer to hospital in her own car with her partner or another adult driving.
- The community midwife will follow in his / her own car to the hospital for handover report.
- The woman will not be transferred to hospital in the community midwife's car

In established labour

- If the woman is in established labour, but the transfer is non-urgent, then the mode of transportation to hospital should be agreed with woman.

4.11 Postpartum

- Midwives will remain with the mother for a minimum of two hours post birth and carry out maternal and baby observations in accordance with local procedure.
- Inform delivery suite that the birth has taken place.
- Inform Team leader and colleagues, if overnight, the next morning.
- All midwifery documentation will be completed**.**
- The mother will be supported with her chosen method of infant feeding.
- If the attending midwife is skilled to carry out an examination of the newborn, then she will do this and the findings will be documented in the paediatric notes and in the parent held child health record
- The Parent hand held Child Health Record (PCHR) will be issued to the parents.
- All clinical waste will be double bagged and brought back to the hospital for incineration.
- The placenta will be brought back to the hospital for disposal unless the mother requests otherwise.
- Before leaving the mother's home the midwife will ensure that:

1. Mother and baby appear to be in satisfactory condition.

2. Mother has contact numbers for the Community Midwife.

3. The mother (and her partner) are clear about the circumstances in which she/they should call 999

- On return to BHSCT office, the NIMATS labour ward summary, CHS 3a and 3b and CHS1 Notification of Birth will be completed electronically by the midwife who attended the birth, and copies will be printed and inserted in the MHHR. The baby's weight will be entered

onto the GROW system.

- Notification of birth forms will be completed and forwarded to the Registrar of Births and the Child Health Office
- The midwife will inform the mother's G.P at next available opportunity.
- If birth occurs after 4.30 pm, a midwife will remain on call until 8.30 am the next day to provide advice and support.
- The delivery suite coordinator will be informed about the outcome before the midwife leaves the mother's home.
- The community midwife team leader will be informed about the birth the beginning of the next working day.
- The frequency of post-partum visits will be tailored depending on individual need and in agreement with the mother.
- As soon as possible, arrangements will be made for the mother to take her baby for audiology screening.
- If required an appointment will be made for TB vaccination.
- Arrangements will be made to remove all equipment from the mother's home within 24-48 hours of birth.
- Empty Entonox and Oxygen cylinders will be returned to pharmacy for refill.
- Where the mother has obtained Diamorphine from her local pharmacy the mother will be advised to return any unused ampoules to the dispensing pharmacy.

4.12 Documentation:

- All records will be made in the Maternity Hand Held Record (MHHR)
- The woman will be encouraged to complete a Birth Plan; the midwife will record any discussion of this in MHHR
- The partogram will be used to record observations during labour
- Guidelines and Audit Implementation Network (GAIN) Normal Labour and Birth Care Pathway NI
- SBAR
- HART

Post Due Dates:

If the birth has not occurred by $40+^{7}$ weeks gestation, a full antenatal assessment will be offered at the hospital with an Obstetric Consultant. A 'HART' tool will be completed for this referral.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Guideline will be disseminated to all maternity wards and departments throughout the Belfast Trust. It will be implemented by replacing the existing Guideline. There will be sessions of awareness raising via team meetings and safety briefings for all midwifery staff regarding the implementation of this guideline.

5.2 Resources

None

5.3 Exceptions

None

6.0 MONITORING

Provide detail of any inherent key performance indicators (KPI) relevant to the successful implementation of this policy.
Describe the process for monitoring the effectiveness of all of the above and who and how this will be done. This monitoring should include any section 75 implications of implementing the policy.

7.0 EVIDENCE BASE / REFERENCES

A Strategy for Maternity Care in Northern Ireland (2012-2018) Intrapartum Care 6:13 Choice of Place of Birth D.H.S.S.P.S. N.I

Carlisle R. (2012) Ante-natal Screening and Management of Results. Belfast Health and Social Care Trust.

De Jonge A, Van der Goes B, Ravelli A, et al (2009) Perinatal Mortality and Morbidity in a Nationwide Cohort of 529,688 Low Risk Planned Home and Hospital Births; British Journal of Obstetrics and Gynaecology 116: 177-1184.

Department of Health (2010) Midwifery 2020 Delivering Expectations. D.H.S.S.P.S. N.I.

Guidelines and Audit Implementation Network (GAIN, 2016) Guideline for Admission to Midwife-Led Units in Northern Ireland and Northern Ireland Normal Labour and Birth Care Pathway. GAIN: Belfast.

National Institute for Clinical Excellence (2006) Routine Post-Natal Care of Women and Babies, N.I.C.E. Guideline 37.

National Institute for Clinical Excellence (2008) Ante Natal Care: Routine Care of Healthy Pregnant Women. Nice Clinical Guideline 62.

National Institute for Health and Clinical Excellence, *NICE guidelines [CG190] Published date: December 2014*. Intra-partum care: Care of Healthy Women and their babies during childbirth.

National Prescribing Centre Feb. 2007 www.npc.nhs.uk.pg19,21,58.

Nursing Midwifery Council (2006) Midwives and Home Birth N.M.C. Circular 8-2006

Nursing Midwifery Council (2009) Record Keeping, Guidance for Nurses and Midwives. HMSO London.

Nursing Midwifery Council (2012) Midwives Rules & Standards: Responsibility and Sphere of Practice, HMSO London.

Nursing Midwifery Council Annex 2 M/10/15 Supporting Women in their Choice for Home Birth.

RCM (2012) Evidence based Guidelines for Midwifery Led Care in Labour. RCM; London.

The misuse of drugs regulations 2001. SI 2001 No. 3998 .11.21.

www.bocmedical.co.uk/safety/image/storage and handling of cylinders.asp

8.0 CONSULTATION PROCESS

A homebirth advisory group of service users and the Chair of BHSCT MLSC collaborated with community midwives and authors to co-produce this guideline.

This guideline was widely circulated amongst Excellence and Clinical Governance Committee, Supervisors of Midwives and all key workers prior to ratification.

9.0 APPENDICES / ATTACHMENTS

Appendix 1: NICE antenatal assessment guidelines.
Appendix 2: Home Birth Notification Form
Appendix 3: NICE Guideline CG190 Tables for Place of Birth
Appendix 4: HART Tool
Appendix 5: Mother's Guidelines for the Storage of Equipment for Home Birth. (Or Preparing for a Homebirth-Mother's Guide)
Appendix 6: Home Birth Equipment list.
Appendix 7: Telephone Numbers
Appendix 8: Risk Assessment Check List

10.0 EQUALITY STATEMENT

The Trust is committed to ensuring equality of opportunity for all service users and staff in terms of disability and complies with the Disability Discrimination Act 1995, the United Nations Convention on the Rights of people with disabilities. The Human Rights Act 1998 and Section 75 of the Northern Ireland act 1998. The Trust has a number of policies/strategies in place including the Disability Action Plan, aimed at encouraging disabled people to participate in public life and promote positive attitudes towards disabled people. All staff has access to Disability awareness training.

If support is required in terms of the communication of this policy regarding interpreting or translated information this will be provided

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. X

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ **Date: ____October 2017____**

Author

_____ **Date: ____October 2017____**

Director

Appendix 1

Intrapartum care: care of healthy women and their babies during childbirth

NICE guidelines [CG190] Published date: December 2014

Table 6 Medical conditions indicating increased risk suggesting planned birth at an obstetric unit

Disease area	Medical condition
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 100×10^9/litre 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 Diabetes
Infective	Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended Hepatitis B/C with abnormal liver function tests Carrier of/infected with HIV Toxoplasmosis – women receiving treatment Current active infection of chicken pox/rubella/genital herpes in the woman or baby Tuberculosis under treatment
Immune	Systemic lupus erythematosus Scleroderma
Renal	Abnormal renal function Renal disease requiring supervision by a renal specialist
Neurological	Epilepsy Myasthenia gravis Previous cerebrovascular accident
Gastrointestinal	Liver disease associated with current abnormal liver function tests
Psychiatric	Psychiatric disorder requiring current inpatient care

Table 7 Other factors indicating increased risk suggesting planned birth at an obstetric unit

Factor	Additional information
Previous complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty Previous baby with neonatal encephalopathy Pre-eclampsia requiring preterm birth Placental abruption with adverse outcome Eclampsia Uterine rupture Primary postpartum haemorrhage requiring additional treatment or blood transfusion Retained placenta requiring manual removal in theatre Caesarean section Shoulder dystocia
Current pregnancy	Multiple birth Placenta praevia Pre-eclampsia or pregnancy-induced hypertension Preterm labour or preterm prelabour rupture of membranes Placental abruption Anaemia – haemoglobin less than 85 g/litre at onset of labour Confirmed intrauterine death Induction of labour Substance misuse Alcohol dependency requiring assessment or treatment Onset of gestational diabetes Malpresentation – breech or transverse lie BMI at booking of greater than 35 kg/m^2 Recurrent antepartum haemorrhage Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound) Abnormal fetal heart rate/Doppler studies Ultrasound diagnosis of oligo-/polyhydramnios
Previous gynaecological history	Myomectomy Hysterotomy

Table 8 Medical conditions indicating individual assessment when planning place of birth

Disease area	Medical condition
Cardiovascular	Cardiac disease without intrapartum implications
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease Sickle-cell trait Thalassaemia trait Anaemia – haemoglobin 85–105 g/litre at onset of labour
Infective	Hepatitis B/C with normal liver function tests
Immune	Non-specific connective tissue disorders
Endocrine	Unstable hypothyroidism such that a change in treatment is required
Skeletal/neurological	Spinal abnormalities Previous fractured pelvis Neurological deficits
Gastrointestinal	Liver disease without current abnormal liver function Crohn's disease Ulcerative colitis

Table 9 Other factors indicating individual assessment when planning place of birth

Factor	Additional information
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause Pre-eclampsia developing at term Placental abruption with good outcome History of previous baby more than 4.5 kg Extensive vaginal, cervical, or third- or fourth-degree perineal trauma Previous term baby with jaundice requiring exchange transfusion
Current pregnancy	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation) BMI at booking of 30–35 kg/m^2 Blood pressure of 140 mmHg systolic or 90 mmHg diastolic or more on two occasions Clinical or ultrasound suspicion of macrosomia Para 4 or more Recreational drug use Under current outpatient psychiatric care Age over 35 at booking
Fetal indications	Fetal abnormality
Previous gynaecological history	Major gynaecological surgery Cone biopsy or large loop excision of the transformation zone Fibroids

Appendix 2

Home Birth Notification Form

Name: _____
Address: _____
_____
BT_____
Phone Numbers: _____
_____
Date Booked: _____

EDD: ___/__/____
Hospital Number: _____
G.P:_____
GP Address: _____
Parity: _____

Named Midwife: _____

Details:

_____
_____
_____
_____
_____
_____
_____

PLEASE SEND TO: MARY MCCORMACK Team Leader RJMH.

For Office use:

Rota Commenced On: _____

Delivery: _____

Comments:

Signed: _____

Date:_____

Appendix 3

NICE Guideline CG190

Table 24: Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: low-risk nulliparous women (sources: Birthplace 2011; Blix et al. 2012)

	Number of incidences per 1000 nulliparous women giving birth			
	Home	Freestanding midwifery unit	Alongside midwifery unit	Obstetric unit
Spontaneous vaginal birth*	792	810	765	686
Transfer to an obstetric unit*	440	363	402	10**
Epidural*	218	200	240	349
Episiotomy*	165	165	216	242
Caesarean birth*	80	69	76	121
Forceps birth	70	61	81	106
Ventouse birth	62	57	78	113
Blood transfusion	12	8	11	16

** Figures from Birthplace 2011 and Blix et al. 2012 (all other figures from Birthplace 2011).*
***Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.*

Table 25: Outcomes for the baby for each planned place of birth: low-risk nulliparous women (source: Birthplace 2011)

	Number of babies per 1000 births			
	Home	Freestanding midwifery unit	Alongside midwifery unit	Obstetric unit
Babies without serious medical problems	991	995	995	995
Babies with serious medical problems*	9	5	5	5

** Neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for 75% of the total. Stillbirths after the start of care in labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon outcomes – less than 4% of adverse events. For the frequency of these events (how often any of them actually occurred), see appendix K*

Recommendations

1. Explain to women who are at low risk of complications that giving birth is generally very safe for both the woman and her baby.
2. Explain to the woman that she may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support her in her choice of setting wherever she chooses to give birth.
3. Advise low-risk multiparous women to plan to give birth at home or in a midwifery led unit (freestanding or alongside). Explain that this is because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.
4. Advise low-risk nulliparous women to plan to give birth in a midwifery-led unit (freestanding or alongside). Explain that this is because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit, but if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby.
6. Using tables 24 and 25, explain to low-risk nulliparous women that:
planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit

planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings

there are no differences in outcomes for the baby associated with planning birth in an alongside midwifery unit, a freestanding midwifery unit or an obstetric unit

planning birth at home is associated with an overall small increase (about 4 more per 1000 births) in the risk of a baby having a serious medical problem compared with planning birth in other settings.

Table 1 Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: low-risk multiparous women (sources: Birthplace 2011; Blix et al. 2012)

	Number of incidences per 1000 multiparous women giving birth			
	Home	Freestanding midwifery unit	Alongside midwifery unit	Obstetric unit
Spontaneous vaginal birth	980	975	965	925
Transfer to an obstetric unit	86	94	125	10*
Epidural	28	40	60	121
Episiotomy	15	23	35	56
Caesarean birth	7	8	10	35
Forceps birth	4	8	11	20
Ventouse birth	5	4	12	37
Blood transfusion	4	4	5	8
* Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.				

Table 2 Outcomes for the baby for each planned place of birth: low-risk multiparous women (source: Birthplace 2011)

	Number of babies per 1000 births			
	Home	Freestanding midwifery unit	Alongside midwifery unit	Obstetric unit
Babies without serious medical problems	997	997	998	997
Babies with serious medical problems*	3	3	2	3
Neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for 75% of the total. Stillbirths after the start of care in labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon outcomes (less than 4% of adverse events). For the frequency of these events (how often any of them actually occurred), see appendix B.				

Advise low-risk multiparous women to plan to give birth at home or in a midwifery-led unit (freestanding or alongside). Explain that this is 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 to plan to give birth in a midwifery-led unit (freestanding or alongside). Explain that this is because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit, but if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby.

Commissioners and providers should ensure that all 4 birth settings are available to all women (in the local area or in a neighbouring area).

Ensure that there are robust protocols in place for transfer of care between settings. Providers, senior staff and all healthcare professionals should ensure that in all birth settings there is a culture of respect for each woman as an individual undergoing a significant and emotionally intense life experience, so that the woman is in control, is listened to and is cared for with compassion.

Senior staff should demonstrate, through their own words and behaviour, appropriate ways of relating to and talking about women and their birth partner(s), and of talking about birth and the choices to be made when giving birth.

Appendix 4

HART Tool

Belfast Health and Social Care Trust
caring supporting improving together

AFFIX ADDRESSOGRAPH LABEL HERE

HART Referral and / or Transfer Report

Between Midwifery Led Care and
Obstetric Led Care Regarding On-going Management

H

History

Antenatal ☐ Intrapartum ☐ Postnatal ☐ Parity _____ Gestation (if applicable) _____

A/N / Intrapartum / P/N History (as applicable)

_____

_____

_____

_____

_____

A

Assessment of Current Situation

Temp____ Pulse ____ Blood Pressure (BP) ____/____ OEWS score _____ FH_____ (as applicable)

Assessment of current situation and reason for referral/transfer

_____

_____

_____

_____

_____

R

If Obstetric Emergency proceed directly to **T**ransfer

Referral

Referred to Dr _____ (name) on _____ (date) at _____ (time)

Reviewed by Dr _____ Date _____ Time _____

Suitable to remain Midwifery Led Care Yes ☐ No ☐ (if **no** please complete transfer section below)

Arrangements for next review (if applicable)

Date _____ Time _____ Department _____

T

Transfer

Is transfer agreed Yes ☐ No ☐

Obstetric Consultant informed of transfer Yes ☐ No ☐ Date _____ Time _____

Consultant Dr _____ (name) **agrees** / **disagrees** to assume on-going responsibility for the care of this woman

Obstetric Consultant name inserted as Lead Professional on inside front cover of Maternity Handheld Record ☐

Arrangements for next review (if applicable)

Date _____ Time _____ Department _____

Plan for on-going management should be documented in Maternity Hand Held Record

Midwife Name (Printed) _____ Signature _____ Date _____ Time _____

Doctor Name (Printed) _____ Signature _____ Date _____ Time _____

Belfast Health and Social Care Trust
caring supporting improving together

The HART report should be used to report all referrals/transfers of low risk women from midwifery led care to an obstetrician

- There should be explicit criteria for referral or transfer of care from midwife-led to consultant-led care.
- HART report must be completed **in full** for all referrals/transfers to ensure accurate, informative documentation.
- On transfer of care Obstetric Consultants name must be documented on the inside cover of the Maternity Hand Held Record as the Lead Professional.
- If care being transferred direct to RJMS Delivery Suite the Coordinating Sister must be informed.
- Plan for on-going management should be documented in Maternity Hand Held Record.
- On referral/transfer the HART report should be filed at the front of the Maternity Hand Held Record and on completion of documentation re-filed in the relevant section of the Record dependant on the episode of care.

GAIN

GAIN Guideline 'Admission to and Transfer from MLUs in N. Ireland'

This guideline predominately relates to women with a straightforward pregnancy[1] at the point of labour[6]. It is important to note that at each point of maternity care, all women should be assessed to ensure that they are receiving care from the most appropriate professional, i.e. continue with midwife-led care (MLC), transfer to consultant-led care or transfer back to MLC[2]; in particular, women who have been referred for investigation(s) or treatment which has resolved.
If there is any uncertainty, multidisciplinary discussion is necessary, with appropriate documentation.

Planned Birth in any MLU (FMU & AMU) for women with the following:

1. Maternal Age ≥16 years and ≤40 years
2. BMI **at booking** ≥18 kg/m² and ≤35 kg/m² [5]
3. Last recorded Hb≥100g/L
4. No more than 4 previous births
5. Assisted conception with Clomifene or similar
6. SROM ≤ 24hrs and no sign of infection
7. Women on Tier 1 of the SEHSCT Integrated Perinatal Mental Health Care Pathway[6a]
8. Threatened miscarriage, now resolved
9. Threatened preterm labour, now resolved
10. Suspected low lying placenta, now resolved
11. Medical condition that is not impacting on the pregnancy or the woman's health
12. Women who have required social services input and there is no related impact on the pregnancy or the woman's health
13. Previous congenital abnormality, with no evidence of reoccurrence
14. Non-significant (light) meconium in the absence of any other risk [6b]
15. Uncomplicated third degree tear
16. Serum antibodies of no clinical significance
17. Women who have had previous cervical treatment, now term

Planned Birth in AMU only for women with the following:

1. Maternal age <16 years or >40 years[6c]
2. BMI **at booking** ≥35 kg/m2 and ≤40 kg/m² with good mobility
3. Last recorded Hb >85g/L [6d]
4. No more than 5 previous births [6e]
5. IVF Pregnancy at term (excluding ovum donation and maternal age >40 years)
6. SROM >24hrs, in established labour and no sign of infection
7. Women on Tier 2 of the SEHSCT Integrated Perinatal Mental Health Care Pathway, following individual assessment [6f]
8. Previous PPH, not requiring blood transfusion or surgical intervention
9. Previous extensive vaginal, cervical, or third degree perineal trauma following individual assessment
10. Prostaglandin induction resulting in the onset of labour [6g]
11. Group B Streptococcus positive in this pregnancy with no signs of infection [6h]

*FMU Freestanding Midwife - Led Unit

*AMU Alongside Midwife - Led Unit

Appendix 5

Guidance for the Storage of Home Birth Equipment, in the home

- Towards the end of the 36th week of your pregnancy, the necessary equipment for your home birth will be delivered.
- In order to protect carpets and furniture, you will require a supply of towels, plastic protection covers, and linen.
- The room where you decide to have your baby needs to be big enough to enable a safe birth. Remember that usually two midwives, your partner and the equipment will be with you. If you are hiring a pool take account of the size and potential weight of the pool when filled. It is advisable to have a trial run with filling the pool and emptying it to ensure the connections fit and work and that you water can be kept at a sustained temperature.

- It is your responsibility to ensure that the equipment is safely stored and these guidelines should be followed:
  - If possible, all equipment should be stored in the room where you plan to deliver your baby.
  - All equipment should be stored in a cool, dry place away from direct heat − You should ensure that equipment is kept out of children's reach
  - Oxygen and Entonox cylinders should be stored horizontally
  - It is essential that there are no naked flames or smoking in the room where the Entonox cylinders are stored.
  - In the event of a fire, you must inform the fire brigade of the presence of medical gas cylinders.
  - Any medicines supplied for your home birth should be stored in a secure cupboard out of children's reach.
  - Some items are sealed to keep sterility, it is important not to tamper with this equipment.

Appendix 6

Home Birth Equipment List

1. Normal Delivery/ suture Pack
2. 2 x Theatre Towels
3. Sterile Gloves (assorted sizes)
4. Plastic Aprons
5. Hibitane/get for lubrication
6. 1 Torch (suitable for water pool)
7. 1 Placenta box
8. Aquafetal Doppler
9. Pinard stethoscope
10. Non sterile gloves (assorted size)
11. Paper towel pack
12. Inco-pads
13. Sanitary pads
14. Kidney receiver dishes
15. 2 x black disposal bags
16. 2 x yellow clinical waste bags
17. Water thermometer
18. Sieve
19. Entonox masks
20. Entonox mouthpieces
21. AMBU-bag and masks – Adult
22. Hand Torch
23. Suture material vicryl rapide is the only suture we use for perineal repair.
24. O2 tubing (green)
25. Space blanket
26. 1 x catheterisation pack
27. Size 12 urinary catheter
28. 2 x MSU bottles
29. Labstix
30. Adult suction catheters (Yankhauer)
31. Adult airway size assorted sizes
32. Sharps box
33. Alcohol wipes/plasters
34. Needles – green/orange/blue
35. Syringes 2ml/5ml/10ml/20ml
36. Vacutainers and Needles
37. Pink topped blood transfusion bottles
38. 4 ml purple top haemoglobin bottles
39. 4 ml yellow top clinical chemistry bottles
40. Venflons and vecafix
41. Venflon fixing tape
42. I.V. infusion sets
43. Spare 10x10 gauze wipe
44. Equipment for Kleihaur.
45. Bottles and forms for group and hold.

BABY EQUIPMENT

1. Ambu bag and masks (assorted sizes)
2. Laryngoscope
3. Infant airways size 0/.00/
4. O2 tubing
5. Suction catheter size 8cm 10
6. Spare Hollister clamp
7. Scales
8. Tape measure
9. Suction machine

Medicines

- Syntocinon 10 units/1ml (5x1ml amp pack)
- Syntometrine 5 units +500mcgs in 1ml
- Ergometrine 500 micrograms in 1 ml
- Carboprost / Haemabate 250mcgs IM (can be repeated at intervals of NOT <15minutes and total dose should not exceed 2mgs (8doses)
- Phytomenadione 2mg in 0.2ml strength (administer 0.1ml x intramuscular route)
- Naloxone hydrochloride (Neonatal) 400micrograms in 1ml. (administer 0.5ml /200mcgs)
- Lignocaine 1% x 20mls
- Lignocaine 1% x 5 mls
- Water for Injection x lamp x 10 mls
- Hartmann's Sol (l litre)
- Normal saline (500 mls)
- 4 X Entonox cylinders (Closed Cylinders)
- 2 x D size oxygen cylinders (Closed cylinders)

  Diclofenac 100mgs suppository is administered to all women who undergo perineal repair and is covered by PGD

Documentation

- Spare progress/evaluation sheets
- Spare partograph (in maternity handheld record)
- Maternity Medicine Kardex
- M.E.O.W.S. Observation Chart
- Perineal repair proforma(in maternity handheld record)
- H.A.R.T. tool form.
- Proforma for PPH
- Proforma for Shoulder Dystocia
- Proforma for Cord prolapse.

Equipment Prepared and Checked by:

Signature: Date:

Appendix 7

Telephone Numbers

Community Midwives:		
North Belfast Community Midwives		**028 90 636622**
South Belfast Community Midwives		**028 95 042650**
West Belfast Community Midwives		**028 95 040353**
Community Midwives Office in RJMH		**029 90 633802**
Team leader Community Midwives:	Mary McCormack	
		028 90 634992
	Mobile:	**07885238624**
Midwife Manager:	Christina Menage	
		028 90 633693
	Mobile:	**07775790410**
Supervisor of Midwives:	See on call rota and list of supervisors telephone numbers	
Delivery Suite		**028 90 632003/3546**
RJMH Reception		**028 90 632150**
Equipment Technician:	Paul Russell	
		028 90 632491
	Bleep:	**2205**

Appendix 8

1. MOTHER'S DETAILS					
Name:					
Address:			Telephone Number:		
			H&C number:		
			USS EDD:		
			Named CMW:		
2 WHO HAS BEEN INFORMED?					
GP:	Yes ☐	No ☐	Consultant	Yes ☐	No ☐
Supervisor of Midwives	Yes ☐	No ☐	Community Manager	Yes ☐	No ☐
Community Team Members	Yes ☐	No ☐	Labour Ward ☐	Yes ☐	No
3. PREPARATION					
Trust Home Birth Patient Information Leaflet (PIL) received				Yes ☐	No ☐
Student welcome				Yes ☐	No ☐
Birth plan completed				Yes ☐	No ☐
How to contact a midwife and on call rota discussed				Yes ☐	No ☐
Home birth available from (date when will be 37 wks to (date at 40 $^{+12}$ wks):					
3a. DISCUSSION ON HOME ENVIRONMENT					
Heating and good lighting				Yes ☐	No ☐
Child care arrangements				Yes ☐	No ☐
Protective bedding/flooring				Yes ☐	No ☐
Planned room to birth in seen				Yes ☐	No ☐
Access available to woman from 3 sides and clutter free				Yes ☐	No ☐
If pool obtained, water birth check list completed N/A ☐				Yes ☐	No ☐
Any unprotected electric sockets near to pool				Yes ☐	No ☐
Arrangements for pets				Yes ☐	No ☐
Equipment (as stipulated in Trust leaflet) provided				Yes ☐	No ☐
No naked flames (once Entonox) in use				Yes ☐	No ☐
Working telephone				Yes ☐	No ☐
Car parking permits/ access for midwives				Yes ☐	No ☐
3b. HOME Risk Assessment					
Identified hazards (if any):					
Record of recommendations/advice given made to remove any identified hazards (before birth)					

4. RISK FACTORS		
Past & present obstetric history checked?	Yes ☐	No ☐
Past & present medical history checked?	Yes ☐	No ☐
Exclusion List Checked?	Yes ☐	No ☐
Identified Risks (if any):		
Record of discussion re planned management of risk and any advice given.		
5. PLANNED ANALGESIA		
TENS	Yes ☐	No ☐
Water	Yes ☐	No ☐
Entonox	Yes ☐	No ☐
Other (please specify)	Yes ☐	No ☐
7. CONSENT		
Vitamin K	Yes ☐	No ☐
Syntocinon / Syntometrine	Yes ☐	No ☐

I confirm that the above information has been discussed with me:

Signed: _____ (Mother) Print: _____

Signed: _____ (Midwife) Print: _____

Signed: _____ (SOM) Print: _____

Date: _____