Homebirth Guideline	
☑ Business Group	☑ Guideline
APPROVAL / VALIDATION	Labour Ward Forum Quality and Governance Committee
DATE OF APPROVAL / VALIDATION	November 2016
INTRODUCTION DATE	December 2016
DISTRIBUTION	Intranet
REVIEW	**Original Issue Date** 2004 **Review Date** December 2019
CONSULTATION	Child and Family Business Group
EQUALITY IMPACT ASSESSMENT	☑ Screening
RELATED APPROVED TRUST DOCUMENTS	Retained Placenta in the Community
AUTHOR/FURTHER INFORMATION	Janet Cotton Jane Ingleby
THIS DOCUMENT REPLACES	Homebirth Guideline v6

Document Change History:

Issue No	**Page**	**Changes made** (include rationale and impact on practice)	**Date**
V7	**6**	Guidance regarding Syntocinon/Syntometrine added	October 2016
5		Format changed. PPH in Community Guideline added as Appendix 1	January 2016

1. INTRODUCTION/PURPOSE OF THE DOCUMENT

All women may choose any birth setting and should be supported in their choice (NICE 2014). The guideline that follows details the process to be followed throughout the pregnancy continuum to facilitate birth within the home setting.

2. STATEMENT OF INTENT / SCOPE OF THE DOCUMENT

A failure to follow the requirements of the policy may result in investigation and management action being taken as considered appropriate. This may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees; and other action in relation to other workers, which may result in the termination of an assignment, placement, secondment or honorary arrangement.

3. SUMMARY OF THE DOCUMENT

This guideline was written to ensure a consistent approach is adopted to homebirth within Stockport NHS Foundation Trust. All guidance provided within this document is based on the Intrapartum care: care of healthy women and their babies during childbirth guideline (NICE 2014).

4. DEFINITIONS

Homebirth refers to the birth of a baby within the home setting.

5. ROLES & RESPONSIBILITIES

Head of Midwifery

The Head of Midwifery has overall responsibility for ensuring safe homebirth procedures are in place.

Supervisor of Midwives

The Supervisor of Midwives will provide advice and support to her Midwifery colleagues and the woman at the centre of the care delivery when identified risks or concerns are expressed and professional guidance is required.

Midwifery Staff

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

6. THE POLICY

The guidance that follows details the process, equipment and procedures to be followed for home birth:

THE PROCESS

At Booking

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

Women at low risk of complications

The Midwife should explain to both multiparous and nulliparous women who are at low risk of complications that giving birth is generally very safe for both the woman and her baby and that that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth.

The Midwife should:

- Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) 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 a midwifery-led unit (freestanding or alongside) 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. (NICE 2014)

Medical conditions and other factors that may affect planned place of birth

Referral to a Consultant Obstetrician is indicated when the following medical risk factors that indicate an increased risk are present and home birth is requested.

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

Other Factors

Certain factors require referral to a Consultant Obstetrician and a detailed consideration of place birth to be undertaken with the woman so that an informed discussion can take place and an individualised assessment of risk is required.

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

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

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

WOMEN REQUESTING HOME BIRTH AGAINST ADVICE

In this instance:

- The midwife should seek the support of her Manager/ Team Leader and a Supervisor of Midwives if the known risks are of concern, while continuing to support the woman's choice. The Midwife must at all times ensure that the woman remains central to the delivery of care and that her informed choice is respected at all times.

- A referral to the Supervisor of Midwives should be undertaken so an individualised action plan can be drawn up in conjunction with relevant Medical staff.

- A referral to an Obstetric Consultant should be undertaken so the risks can be discussed fully and an informed choice can be made. The Obstetrician should ensure that all advice given should be clearly recorded within the maternity notes and if indicated the consultant should record in the management plan "against advice"

- The Community Team Leader should be informed so an action plan can be devised for the Community Midwifery Team.

Antenatal visit - 36 weeks

At 36 weeks gestation the Midwife should:

- Undertake a home visit at 36 weeks gestation to discuss the plan of care with the woman ideally with her birthing partner present. The Midwife will undertake a risk assessment if required of the home and ambulance access to the property (NICE 2014) and clearly document her findings in the hand held notes.
- Inform the woman what equipment she will need to provide ie sheets, mirror, and that which the service will provide and complete the checklist.

- Inform the woman how/when to contact the 24 hour midwifery service when labour is suspected.
- Ensure that the haemoglobin result from the 28 week sample or later is available within the handheld notes.
- Discuss with the woman alternative methods of analgesia and coping strategies.
- Discuss the reasons for potential transfer to the maternity unit prior to labour, Ie meconium liquor, cord prolapse, abnormal fetal heart rate, retained placenta, pph (Appendix 1)
- Complete the homebirth proforma (Appendix 3) and send a copy to Triage.
- Place a copy of the homebirth proforma in the hand held notes and the clinical file.

Labour

When the woman is in established labour the Midwife should ensure that:

- One midwife and another appropriate person who is proficient in NNR e.g. assistant practitioner or second midwife, attends the home birth, the latter being called towards the end of the first stage. If another person cannot attend then the Midwife should contact the Supervisor on call.
- The relevant equipment is collected from the hospital where appropriate
- Triage are informed on arrival at the woman's home and provided with regular updates regarding progress in labour.
- Care is given according to normal care in labour guidelines and record keeping standards.
- The placenta is transported to the hospital in a placenta bag and disposed of in the usual manner or may be kept by the family, if requested.
- Suturing is undertaken at home where possible unless transport to hospital is indicated due to the nature of the wound
- The decision to transfer in labour is made it should be timely and efficient, minimising potential for delay to influence outcome (CESDI, 2005).
- Transfer to hospital if required is arranged with the ambulance service.

Postnatal

During the early postnatal period the Midwife should:

- Ensure comfort, cleanliness and warmth of mother and baby.
- Undertake the initial maternal / infant observations to ensure stability of their condition, including oxygen saturations on the baby after 2hrs if clinically appropriate.
- Undertake the initial examination of the baby as per policy, followed by arrangements for the neonatal examination of the new-born within 72 hours of birth.
- Remain in the home for as long as necessary (at least one hour post birth) until both mother and baby are in a stable condition and make sure the parents have contact phone numbers for the midwifery services.
- If the mother is breast feeding, this will be initiated prior to the midwife leaving.
- Ensure woman has passed urine. First void to be measured; time and volume to be documented in the records.

EQUIPMENT

See (Appendix 2) for equipment required for homebirth.

MEDICATION

It is the responsibility of each Community Midwife to ensure that when Syntocinon 10iu and Syntometrine 1ml ampoules are removed from the fridge and placed in their homebirth bag, they are replaced every two months. The date that the medication is taken out of the fridge should also be noted on the ampoule box.

Transfer to the hospital

In the case of an emergency a 999 ambulance should be called and transfer should be undertaken to the nearest maternity unit. Wherever possible the Midwife should ring ahead to the receiving unit in advance and notify of the impending transfer. If delivery occurs in transit then the ambulance should be asked to pull over at the roadside then the paramedic can assist the Midwife as appropriate. On arrival at the receiving unit a full verbal handover should be given by the Lead Midwife to the receiving carer. All records throughout should be maintained in accordance with professional standards.

7. IMPLEMENTATION

This guideline will be introduced following the approval and dissemination of the guideline to Midwifery staff within the Child and Family Business Group.

8. MONITORING

Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Audit	O&G Audit lead	3 yearly	O&G Audit meeting	O&G Audit Lead/Auditor	Quality Governance Committee 6 monthly

Stockport NHS
NHS Foundation Trust

POSTPARTUM HAEMORRHAGE IN THE COMMUNITY

Get Help – Don't delay

1. Dial 999: request paramedic ambulance
2. Inform Stepping Hill Delivery suite

Assess cause of bleeding: 'the 4 Ts'

- Tone – Uterine atony
- Tissue – Retained placenta
- Trauma - Tear, haematoma, uterine rupture, inversion
- Thrombin - Coagulopathies

Give Syntometrine – I ampoule IM if not already given

- Stimulate uterine contraction by abdominal massage.
- Catheterise.
- Attempt to deliver placenta if still in situ with CCT/check placenta complete.

No response, give 5 units syntocinon IV

ASSESS

- **A** – Airway
- **B** – Breathing
- **C** – Cardiac Circulation

Maintain observations of pulse, respirations and BP

- Cannulate with **Two 16 g (grey) venflons** (by midwife or paramedic)
- Take blood for **FBC, crossmatch x 4 Units & clotting screen.**

No Response ⇒ Apply bi-manual compression

Transfer via ambulance.
Woman must be accompanied by the midwife
Ensure contemporaneous documentation of all events / management

Appendix 2

Homebirth Disposables Box (check seal)

Urinary catheters x2
Sterile gloves (assorted size)
Assorted gloves
Plastic aprons (3)
Cord clamps
Vomit bowl (4)
Sterile swabs
Placenta bag / tub
Sharp's box
Clinical waste bags
Goggles
Tape measure
Lubricating gel
Amni Hook
Inco pads
Sterile Jug

Homebirth Bag

Sphygmomanometer
Stethoscope
Sonicaid
Thermometer
Urine sticks
Cannulation / blood collection
Grey venflon
3-way tap
Cannulae dressing
Tourniquet
Skin preparation
Blood bottles:
FBC (2xlilac), GRP (2xpink), Ochre x2, Greyx1, blue x1
Request forms
Syringes; 2ml, 5ml, 10ml (3 of each)
Needles; orange 2, green 4 x3
Vacutainers

Neonatal ambu-bag
Neonatal face mask
Airways 000, 00, 0
Torch
Oxygen
Sterets
Suture pack
Spare swabs
Suture material
Weighing scales
Entonox + tubing
Tampon
VE pack
Delivery pack

Drugs

Syntocinon (2 amps)
Syntometrine (2 amps)
Lidocaine 1% 10mls (2 amps)
Vitamin K 1mg
0.9% Sodium chloride 10mls (2 amps)
Cord prolapse:
500mls normal saline, Foley size 16 catheter, spiggot

Notes

Baby notes
Continuation sheets
Partogram
Labour notes
Shoulder dystocia proforma
Drug Kardex (Maternal / baby)
Palpation / VE stickers
SBAR form
Child Health Record

Appendix 3

Stockport NHS
NHS Foundation Trust

HOMEBIRTH PROFORMA

NAME: **D.O.B.** **MAT.NO**

ADDRESS:

NHS.NO:

OBSTETRIC HISTORY: **EDD:**

MEDICAL HISTORY:

DATE OF CONSULT:

COUNSELLED BY:

OPTIONS /RISKS DISCUSSED

MANAGEMENT PLAN:

REFERRED TO SUPERVISOR OF MIDWIVES : ☐

COPY:-PATIENT ☐

CENTRAL FILE ☐

TRIAGE ☐

SIGNATURE **PRINTED NAME:**

....