University Hospitals of North Midlands NHS
NHS Trust

Achieving Sustainable Quality in Maternity Services

ASQUAM

Guideline for Home Births

(Including the Management of a Delivery in an Unplanned Environment (BBA)

Date of Revision:	March 2016
Date of Minor change:	March 2018
Date for Review:	March 2019
Ratified by:	Labour Ward Forum Sub-Group Obstetric Guideline Group
Reviewed by:	B Hamilton-Cody Outpatient Matron - Maternity
Consultant Lead:	Dr J Chan Consultant Obstetrician and Gynaecologist

VERSION CONTROL SCHEDULE

Version	Date	Author	Comments
1	1995		
2	1996		
3	2008		
4	2011	Elspeth Larkin Community Midwife	
5	2015 – January		
6	2016 – March		Full update to include process at County Hospital
7	2016 – June		Equipment carried in on call bag changed to read: Syntocinon 10 international units x 1 ampoule
8	2017 – January		Guideline title changed to include the management of a delivery in an unplanned environment (BBA) and Appendix 5 added regarding this management Appendix 1 - Checklist for request for planned home confinement/ waterbirh – updated to include postnatal VTE Contact number for MAU incorrect – changed to read 672300. In addition length changed to head circumference
9	2018 - March		Minor change to Appendix 5 – Management of a Delivery in an Unplanned Environment (BBA) to read: In no circumstances must women or babies be transferred to the accident and emergency department - all newly delivered newborns requiring any intervention immediately after birth must be brought to the delivery suite at the royal stoke hospital In addition updated to reflect the changes to midwifery supervision

Contents Page No.

1. PURPOSE OF GUIDELINE

For the majority of women pregnancy and childbirth are normal life events requiring minimal medical intervention. These women may choose to have midwifery led care including a home birth (DOH 2007).The birth outcomes are as good for 'low risk' women with planned home births as for 'low risk' women with planned hospital births (DOH 2007). According to NICE (2017), the evidence now shows midwife-led units to be safer than hospital for women having a straightforward (low risk) pregnancy. Its updated guidance also confirms that home birth is equally as safe as a midwife-led unit and traditional labour ward for the babies of low risk pregnant women who have already had at least 1 child previously.

There is evidence to support a woman's right to choose where to deliver her baby (DOH, 2007). Midwives have a professional duty to provide midwifery care and to ensure that the emotional and physical needs of the woman are the primary focus of his/her practice. This applies even when she/he does not agree professionally with the choices made (NMC, 2015). Women have a right to make their own decisions if they are competent to do so and midwives have a duty of care to respect a women's choice (NMC 2015). It is therefore imperative to work in partnership with the woman and her family.

If the type of care a women is requesting is judged to potentially cause significant risk to her or her baby, discussion with the women of her wishes, providing detailed information relating to her requests, options for care, and outlining any potential risks should take place, so that the woman may make a fully informed decision about her care (NMC 2015).

Each woman has the right to have advice and care tailored to meet her individual needs. Having received all the information and ascertaining that she is fully aware and understands any risks relating to her choice of delivery (RCM 2012). If a woman decides to reject the advice given, the midwife should discuss with her line manager or Professional Midwifery Advocate.

It is essential that community based facilities are fully equipped and that staff have the skills for the initial management and referral of obstetric and neonatal emergencies. When complications arise, clinical response should be quick and in accordance with best clinical practice. Immediate, safe transfer should be available for mother and baby who need transfer to consultant care in labour or after delivery (DOH 2004). (NICE 2006) recommended that there should be written communication about the transfer of care between clinical sectors and health professionals.

The guideline aims to provide clear guidance to midwives in the provision of care to low risk women who choose to give birth at home and ensure all women receive appropriate and timely emergency care as required, in order to promote the best optimal outcome for mother and baby.

2. BACKGROUND

NICE 2017 “Intrapartum Care” state women should be offered the choice of planning a birth at home, in a Midwife Led Unit or in an Obstetric Unit. Women should be informed:-

- That giving birth at home is generally very safe for both the woman and her baby.
- There is a higher likelihood of a normal birth with less intervention amongst women who plan to give birth at home.

The rate of home births within the UK remains low at approximately 2%, but it is believed that if women had their choice the rate would be nearly 10% (RCM-2007). The current homebirth rate at UHNM is around 1%.

3. PROCESS FOR HOME BIRTH

3.1 ANTENATAL

3.1.1 Booking

The Named midwife will:

- Undertake a comprehensive booking history as per UHNM Low Risk Guidelines for booking before 12+6 weeks, allocating to the appropriate care pathway.
- Offer the option of a planned home birth to all women who meet the booking referral criteria for low risk care.
- Record on K2 the name of the named midwife as the lead professional.
- Document and provide the woman with the contact numbers of the named midwife and 24 hour contact numbers via Midwife Assessment Unit (MAU) [redacted] at Royal Stoke or Freestanding Midwifery Birth Unit (FMBU) [redacted] at County.

- Explain the need to assess the progress of the pregnancy and that any deviation from the normal pathway a Consultant appointment will be offered to discuss subsequent management.

3.1.2 Contraindications

If the woman has identified risk factors at booking and is considering home birth as an option or If the woman's "Risk" category changes during the pregnancy appropriate referral must be made.

The Midwife will:

- Explain to the woman and her partner the inclusion criteria for a low risk birth in UHNM, and ascertain whether the woman and her partner are fully aware of and understand the possible risks and consequences associated with their decision to enable them to make an informed choice.

- Discuss alternatives and options for care maintaining full communication with line manager or Professional Midwifery Advocate with prior agreement of the woman.

- Offer the opportunity to deliver on the Midwife Birth Centre arranging further discussion with the MBC Manager if appropriate, who will formulate detailed plan of care.

- Consider referral to consultant care with woman's consent and inform about her impending discussion with the named Consultant. Ideally, this should be before 36 weeks.

- Provide the woman and her partner, with both verbal and written information regarding the plan of care. This plan will be made in co-operation with the woman's named Consultant Obstetrician, the community midwifery team, and Senior Midwives, which will assist in effective communication within the Obstetric team.

- Record and document contemporaneous, accurate and detailed records of events, discussions, advice and outcomes of advice on K2.

The named/ midwife will:

- Undertake routine antenatal care in accordance with NICE Antenatal Care Guidelines (2017) "Antenatal Care – Routine Care for the healthy pregnant women" and as per local care pathways.

- Offer a Consultant appointment if any deviation from the normal pathway to discuss the impact this will have on her plans for home birth.

- Discuss with any woman choosing to have a waterbirth at home the equipment required and advise that it will be her own responsibility to make enquiries around the ordering and delivery of that equipment ensuring health and safety requirements are met.

- Advise the woman that it would be advantageous that her birthing partner be available for a planned home visit at 36 weeks of pregnancy so that any potential emergency situations are discussed with them both.

The named midwife will arrange to meet the woman and her partner at home at 36 weeks to:

  - Complete the homebirth/waterbirth risk assessment on K2 (see Appendix 1) and birth plan on K2, which should include discussion of: Actions that would be taken in the event of an emergency including paramedic attendance and transfer times.
  - Bags to pack in case of transfer
  - Child care arrangements
  - Access/ parking arrangements
  - Options for pain relief, making her aware that narcotic analgesia and epidurals are not offered as a choice of analgesia at home and would necessitate transfer into delivery suite, RSUH.
  - Situation of waterbirth pool as appropriate and undertake risk assessment.
  - Equipment to be provided ie towels, protective sheets for floor/bed, torch, clear surfaces
  - Arrangements for induction of Labour

- Elicit specific choices/ requests ie. waterbirth, doula present, hypnobirthing

- Discuss with the woman and her partner information around a home birth as a choice for place of birth including:
  - Equipment carried by community midwives including resuscitation equipment for mother and baby
  - Pain relief available at home
  - Medical assistance in the event of deviation from the normal including time limitations and transfer arrangements to **RSUH** by ambulance. Transfer to the nearest alternative hospital will only be instigated in a life threatening situation/BBA (see Appendix 5)

- Reiterate contact details and ensure the woman is aware of the procedure for contacting her midwifery team in the event of a home birth:
    - Contact the Freestanding Midwifery Birth Centre (FMBU) on [redacted]

- Complete a VTE assessment for postnatal prophylactic thromboprophylasis and organise prescription for daltaparin if applicable.

- Organise Induction of Labour as per ASQUAM Induction of Labour guidelines.

It is the responsibility of the named midwife to:

- Inform the community office if booking for a home birth and complete the team home birth record sheet, updating the form as appropriate. The home birth list will be updated and sent out to all community midwives weekly, by the Community Secretary, RSUH.

- Inform all the midwives within the teams of any specific requests/ choices that may impact on the quality of care provided and discuss with line manager if additional support/ advice required.

- Ensure all community midwives are given directions and contact numbers on how to get to the woman's home if the property is difficult to find.

The Team Lead/Deputy will:

- Ensure that the off duty is covered with an on call midwife who is competent in waterbirth/home birth. If necessary liaise with other teams to provide cover.

- Ensure that a 2nd on call midwife is rostered on the off duty from a planned home confinement reaching 37 weeks of pregnancy until delivery.

- Ensure that two skilled and experienced midwives are present during the labour and the birth of any woman requesting care against professional advice. The presence of two midwives during the woman's labour and delivery fulfils a statutory obligation and enables assistance to be given and, if necessary, medical assistance can be sought

- Ensure all midwives are facilitated to attend annual mandatory training in emergency drills and adult and neonatal resuscitation, to ensure clinically competent to manage obstetric emergencies.

- Identify training issues for midwives and ensure fitness to practice, assisting midwives who need to acquire new skills to develop competency in relation to this sphere of practice.

- Liaise with the management team to arrange for any professional updating, additional training/experience, for midwives as required to provide the care requested.

- Provide professional and personal support to help the midwife with any anxiety and distress she may experience.

If unexpected sickness/absence occurs outside normal working hours (Mon-Fri, 9-5), it is expected that the remaining community midwives will liaise with each other to ensure ongoing cross cover for the home birth service. They should also ensure that the Delivery suite co-ordinator at RSUH and Band 7 midwife on the FMBU at County are aware of any impact this may have in relation to the Escalation Policy

3.2 INTRAPARTUM

On receiving the call from a woman booked for a home delivery the MBC/FMBU midwife will:

- Record the woman's details on the telephone record sheet/day book and on the K2 telephone call log. Inform the woman that the community midwife on call will be contacting her.

- Contact the community midwife on call for the relevant area/homebirths.

- Record details on FMBU 'white' board/MBC day book.

- **The On Call Midwife (for any team) will:**

- Ensure the home birth bag, medical gases and equipment have been checked daily and are properly maintained and in date. Complete and sign home birth equipment checklist (Appendix 2).

- Check community drugs in date and ensure stored in a sealed container in accordance with NMC standards. (NMC Standards for Medicines Management 2007).

- Contact the woman to confirm labour, advise and assess the plan of care. She will check the details against the Homebirth sheet and check if any Alert form completed.

- Visit the woman at home to assess onset of labour.

- Adhere to lone worker guidelines.

- Advise the FMBU that she is leaving to attend the home address of the woman.

- Undertake a full assessment taking into consideration the woman's reactions to the dynamic physiological and emotional changes that are occurring. This assessment should also include information obtained from the pregnancy history, previous medical and obstetric history, maternal observations and assessment of fetal wellbeing. A fetal wellbeing assessment should include fetal movements, fundal height, auscultation of fetal heart (which should be taken initially with a pinnard stethoscope). If there is a history of spontaneous rupture of membranes, the colour of the liquor should be assessed and the time of rupture clearly identified and recorded.

- Offer a vaginal examination, if indicated, after discussion and consent with the woman.

<u>If not in established labour:</u>

- Reinforce contact numbers to ring if any concerns, explain latent phase of labour and advise accordingly.

- Update FMBU of the findings and plan made.

- Advise the woman to inform FMBU if intensity and frequency of contractions increases, changes in fetal activity, vaginal loss or any other concerns.

<u>If SROM has occurred, with no contractions</u>

- Arrange for assessment and CTG on MAU and book induction of labour – Refer to ASQUAM Induction of Labour Guideline.

- Document findings, advice and plan of care in pregnancy held records.

Once established labour has been confirmed:

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- Follow Low Risk Intrapartum guidelines

- Commence intrapartum records documenting on K2 all care provided, advice given and plan of care.

- Ensure the room is prepared for delivery once established labour has been confirmed. This will include:
  - Ensuring a warm environment
  - A firm surface with changing mat or towel and ambu bag checked and prepared for use
  - Adequate lighting for assessment of perineal repair.
  - Warm towels and clothing for baby
  - A clock identified for recording times
  - Check home birth pack complete
  - Prepare and check entonox apparatus
  - Discuss delivery environment
  - Ensure community drugs and delivery pack are at hand.
  - Check position of waterbirth pool ensuring adequate space for emergency evacuation if required and all equipment needed present and in working order.

- Endeavour to provide the care discussed in the birth plan.

- Call the 2nd Midwife when labour is well established taking into consideration travelling distance. It is expected that an experienced community midwife will support an inexperienced midwife when she/he attends a woman at home during labour and delivery. Two midwives will be present from the beginning of established labour in the case of a home birth against professional advice.

- Request the 2nd midwife to bring further equipment e.g. entonox as required

In the event of the named midwife wishing to attend the home birth, this should be documented on K2 and arrangements made for contact agreed between the two parties and the team leader informed. The on call midwife contacting the named midwife when labour is established.

Accountability and Responsibility of midwives present at home birth

- The first on call midwife will be the lead midwife unless negotiated previously at the request of the woman or the midwife. She/he will be accountable for midwifery care provided (NMC 2015) and responsible for the management of the case.

- The second on call midwife will be accountable for midwifery care she/he provides and act without delay if she/he believes that they, a colleague or anyone else may be putting someone at risk (NMC 2015).

- Each midwife is accountable for their practice and ensure they maintain their knowledge and skills for safe and effective practice, attending yearly mandatory emergency skills training. Any midwife who feels they need further training should approach their Supervisor of Midwives.

- You must recognise and work within the limits of your competence (NMC 2015). Except in an emergency, a practising midwife shall not provide any care, or undertake any treatment, which she has not been trained to give (NMC 2015). It is expected that an experienced community midwife will support an inexperienced midwife when she/he attends a woman at home during labour and delivery. No midwife will undertake the lead for a delivery at home until she has been orientated to the principles of midwife led care and received guidance in conducting home births, deeming themselves competent to undertake the care.

3.3 Immediate Care Following Third Stage

The attending Midwife will:

- Assess condition of baby using the apgar score. If resuscitation is required adhere to neonatal resuscitation guidelines.

- Promote skin-to-skin contact and offer assistance with chosen method of feeding.

- Note time placenta and membranes delivered. Examine the placenta and membranes and record total blood loss. Return placenta and membranes in placenta bucket to MBC/FMBU for disposal.

- Check maternal observations, vaginal loss, and inspect perineum. Perform perineal suturing as required (Refer to Perineal Trauma - Management and Repair Guideline).

- Dispose of used instruments and sharps in purple lidded sharps (sharpsguard cyto 5 UN3291) containers to transport sharps from home birth to MBC/FMBU.

- Contact FMBU to inform them of the delivery.

- Undertake initial baby check including weight and head circumference and dress warmly.

- Adhere to principles of care for the newborn and administer Vitamin K if informed consent has been given.

- Encourage the woman to pass urine post birth, and ensure output is measured and documented. Refer to Bladder Care Guideline.

- Complete postpartum VTE assessment. Where woman is intermediate risk, ensure time for initial dose of daltaparin is arranged, sharps disposal box arranged and prescription chart signed. Reiterate how to self-administer daltaparin and to administer 4-6 hours after delivery.

- Take cord and maternal blood for Rh negative women informing the woman to contact FMBU/ MBC after 24 hours to check if anti D required whereby arrangements will be made to attend the hospital for administration.

- Document findings and complete delivery records on K2 and issue of child health record.

- Provide the woman with the opportunity of completing a Friends and Family feedback form.

- Assist to the bath/shower if wishes. Once comfortable and mother and baby's observations are reassuring, arrange next postnatal visit ensuring contact numbers to ring if any concerns.

- Restock home birth bag. The Entonox tubing is re-usable. Entonox cylinders **must** be replaced by contacting the hospital porters on 672000 at Royal or contact the porters via switchboard at County.

- Inform the MBC / FMBU on return home.

- Ensure that Neonatal Physical examination (NIPE) is arranged within 72 hours of birth by suitably qualified midwife.

- Arrangements for Hearing Screening are made using the appropriate request form.

- Inform the woman's General Practitioner of the home birth the next working day.

- Initiate an "on call" audit form during "on call" hours and return to the Community Office, RSUH/FMBU (Appendix 3)

- Advise the Community office/FMBU of the outcome for any planned home birth.

The Community Secretary will:

Ensure that home birth book/spreadsheet is updated for audit (even if woman did not deliver at home).

3.4 Transfer To Hospital

In the event of maternal or neonatal complications, an emergency or a deviation from normal the midwife will commence emergency drills as per relevant guidelines (refer to ASQUAM guidelines) and summon urgent assistance using 999 and alerting delivery suite for emergency transfer into delivery suite, RSUH.

Indications for Transfer

The following is not meant to be a complete list of indications for emergency transfer. It is understood that other situations indicate the need for transfer and will be determined by the community midwife at the time.

- Delay in first or second stage of labour
- Meconium stained liquor
- Abnormality of fetal heart
- Request for stronger analgesia
- Malpresentation
- Maternal hypertension
- Maternal pyrexia
- APH
- Cord prolapse
- Shoulder dystocia/PPH
- Retained placenta
- 3rd/4th degree tear or extensive perineal tear
- Neonatal resuscitation
- Baby weighing below 10th centile
- Maternal request
- Maternal collapse

3.4.1 Process of Transfer

Do not leave the woman/neonate unattended.

The on call midwife will:

- Determine the urgency and clinical need for transfer.

- Inform the woman and her partner of the need for transfer and gain her consent as she may decline transfer or have preferences of an alternative hospital for social reasons. **In the event of the woman declining the recommendation for transfer, inform the delivery suite co-ordinator. Ensure rationale for transfer is clearly documented in the intrapartum records** on K2.

- Give verbal Information to the second midwife who will initiate an **Emergency Ambulance Request by contacting '999'** to initiate the emergency transfer to the Royal Stoke University Hospital Delivery Suite.

- The midwife making the call must relay the level of urgency (**always request time critical ambulance)** and state that they are a midwife calling from patients home address giving clear indications for transfer and where to be transferred to, giving details of any specialised service required. **(Have patient details available as the ambulance service may ask for further details).** In the event of a postpartum transfer, the ambulance service must be informed that a baby may also need to be transported. If the parents are married, the father can transport a well baby in a car seat in his own transport.

- Give verbal Information to the second midwife to contact Delivery Suite Co-Ordinator at the RSUH via telephone [redacted] and arrange transfer, providing reason/details of the impending emergency transfer. In the event of a neonatal transfer the Neonatal Unit at the RSUH can be contacted direct on [redacted] for advice.

- Instruct an individual present to contact ambulance via 999 system and delivery suite in the event that no second midwife present/ does not allow her/him to access the telephone.

Categories for transfer:

DEGREE OF ILLNESS	URGENCY - EMERGENCY	ESCORT
TIME-CRITICAL	10 minutes	Midwife
INTENSIVE	20 minutes, but 8 minutes if immediate intervention required in receiving area	Midwife
ILL UNSTABLE	30 minutes	Midwife
ILL STABLE	60 minutes	Midwife

Taken from: Patient Transport Triage Table West Midlands Ambulance Service

Transfer to hospital must be by paramedic ambulance with the midwife accompanying.

- Continue to provide individualised care in accordance with the clinical need of mother/baby and prepare environment for transfer. The woman's belongings will be packed prior to transfer.

- Apply identification wristbands to the woman and baby as per Trust guidelines.

- Documentation of all records will be kept contemporaneously as is reasonable, and when possible entered onto K2 and an SBAR (see Appendix 4) completed. Continuous and detailed records of observations made and care provided should identify:

    - The name of the healthcare professional transferring the woman
    - The name of the healthcare professional accepting the woman
    - The precise destination of the woman with respect to receiving hospital
    - The reason for transfer, condition of the mother and fetes/baby prior to leaving the home
    - Accurate times of events, including time of call for ambulance, arrival of ambulance and arrival to consultant unit
    - Events during transfer

- Provide the paramedic crew with a brief concise history, equipment necessary and urgency of transfer ensuring that the crew are familiar with the route to the receiving hospital. Entonox, oxygen and facilities for monitoring maternal/ neonatal wellbeing are provided by the paramedic crew. The midwife is the lead professional at this time and instructs the ambulance crew appropriately. If APH/ PPH/ retained placenta IV access will be required. Advise paramedic crew of need

for above. Take bloods for Group and Save/ FBC/ Clotting/ U&E's/ LFT's/ urates if possible.

- Accompany the mother and baby (if delivered) during transfer in ambulance. If undelivered take the following equipment in order to monitor fetal wellbeing and conduct delivery if required:
  - Delivery pack
  - Sterile gloves
  - Towels
  - Sonicaid
  - Cord clamp
  - Syntometrine
  - Neonatal (basic life support) resuscitation equipment

- Secure herself into the seat provided once the woman and/or neonate are safely secured into the ambulance, Midwives should only provide care out of the secure seated position if it is a life threatening situation for either the woman and/or baby.

- Ensure that the woman's birth partner is communicated to throughout and that all belongings are taken with the woman or her birth partner. In most circumstances the birth partners will be expected to make their own way to the Royal Stoke University Hospital.

- Transfer all the woman's records, charts and neonatal records with her. It is the duty of the accompanying midwife to ensure these are complete and up to date, including time of arrival on the Consultant Unit and time of handover. An identity check should be made, confirming that the woman's details and hospital number are correct. If postpartum the baby's details must also be checked.

- Complete SBAR Maternal /Neonatal Transfer Form (see appendix 4)

- Provide a full comprehensive handover of care from the accompanying midwife to the nominated Delivery Suite Midwife which must be made whilst in the presence of the woman to allow her to understand and/or contribute to the transfer information. If delivery is imminent she/he may stay for continuity of care.

- Complete an electronic datix incident reporting form for all transfers.

3.5 Postnatal Care

Subsequent postnatal care will be provided according to the individual needs of mother and baby. Refer to Guidelines for routine postnatal care of women and their babies.

- Arrangements will be made for the completion of the neonatal examination of the newborn by the midwife and neonatal screening.

- **Arrange a home visit for the next day or later that day if required (depending on time of delivery) to the woman and her new baby.**

4. MONITORING AND AUDIT

The need to monitor/audit the standards set out below will be considered alongside other Directorate requirements and prioritised accordingly. The Directorate Clinical Audit programme is drafted by the Directorate Clinical auditor, in liaison with clinical staff, and approved by the Directorate.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and lead(s)	Change in practice and lessons to be shared
Guideline content	Guideline Co-ordinator	Guideline Review	Every three years	Labour Ward Forum Subgroup: Guideline Meeting	Required changes to practice will be identified and actioned with the release of the updated guideline.	Required changes to practice will be identified and actioned with the release of the updated guideline.
Clinical standards within guideline	Directorate Clinical Auditor	Clinical Audit	As required in relation to other Directorate priorities	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.

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APPENDIX 1 - CHECKLIST FOR REQUEST FOR PLANNED HOME CONFINEMENT/WATERBIRH

Surname:

First Name:

D.O.B:
Unit Number:
(or affix Patient Label)

- ❑ Low risk no medical/obstetric complications
- ❑ Must be 37 completed weeks at onset of labour
- ❑ Agrees to go into RSUH if her or the baby's condition causes concern during the Antepartum, Intrapartum or Postpartum period. List examples given.
- ❑ Suitability for ambulance/ emergency access if required
- ❑ Understands it may not be her named midwife who attends but a member of the Team
- ❑ Is she agreeable to the presence of a Student Midwife, either giving direct care or observing
- ❑ Aware that Entonox is the only available pain relief at a Home Birth
- ❑ Explain alternative non-pharmacological methods available for self administration.
- ❑ Discuss individual birth plan and special requests ie doula to be in attendance, hypnobirthing etc
- ❑ Made aware of transfer into unit for delivery if Pethidine is requested prior to or during labour.
- ❑ Explain emergency transfer arrangements and time factors involved if mother or baby needs transfer to hospital
- ❑ Discuss the need for suturing tears or episiotomies and possible need for transfer into hospital.

- ❑ Perform VTE (postnatal) risk assessment.
- ❑ Discuss recommended prophylactic treatment of daltaparin
- ❑ Explain and teach women how to self administer daltaparin and timeframe for first dose following delivery (recommended 4-6 hours after delivery)
- ❑ Arrange a prescription chart for prescribed daltaparin.
- ❑ Collect TTOs from postnatal wards
- ❑ Provide sharp box and advise women to store safely until required.
- ❑ Made aware of limitations of resuscitation equipment if baby is born in a poor condition
- ❑ Explain that in exceptional circumstances a situation may arise which could reduce the level of service in the Community. Discussion would then take place offering hospital delivery with early discharge.
- ❑ Who will perform baby's neonatal examination.
- ❑ Give all relevant contact numbers including how to access a midwife for home confinement

WATERBIRTH CHECKLIST

- Explain responsibility of parents to set up pool and ensure meets health and safety regulations, including not using prefilled and heated pools.
- Check and reiterate, all equipment should be in working order. Ensure have sieve, bucket, water thermometer.
- Discuss sitting of pool.
    - Ensuring access to all sides around pool considering emergency evacuation if necessary.
    - Ensure minimal clutter and obstacles
    - Space for mother to lie on the floor to attend to her needs as necessary.
    - Situation of plug sockets and advise re use of electrical plug covers.
    - Access to water supply including hot water for filling/emptying of pool
    - Safety aspects associated with filling and maintaining water temperature explained ie. Slips, scalds etc
    - Flooring structurally safe, especially if assembling pool upstairs
    - Discuss potential evacuation from the pool
        - Birth partners role in the evacuation
        - Physical ability to participate
        - Understanding midwife lead for coordinating manoeuvres and evacuation
        - Instruction of procedure

Comments

The above issues have been fully discussed with:

Patient's Name: ……. Hospital No: ……

Patient's Signature: …… Date: ……..

Midwife: ……

Midwife's Signature: …… Date: ……..

APPENDIX 2 - EQUIPMENT CARRIED IN ON-CALL BAG

Single use delivery pack
Single use suture pack
Suture material - 2^{o} and 3^{o} vicryl
10 x 10 XRD swabs with ties x 1 pack
Placenta pot and bags
Sharps disposal box
Gloves – sterile/non-sterile, various sizes
Syringes; 4 x 2ml
4 x 10ml
Hypodermic needles; green/orange
Bladder filling: 1L normal saline/16G Foleys catheter/spigot/large bore giving set
Drugs:

Vitamin K	x 1 ampoule
Syntometrine	x 2 ampoule
Syntocinon	x 10 international units x 1 ampoule
Lignacaine 1%	x 2 ampoules (10mls)

Inco pads x 4
Cord clamp x 1
Amnio hook x 1
Catheter in/out x 1
VE packs x 2
Foil bowl
Blood bottles: purple and pink top x2 each plus forms
'Tiger' bag and orange bag

PAPERWORK
Prescription chart, VTE form, SBAR transfer form.

NEONATAL RESUS
500ml resuscitation bag and mask (facemasks 0/1 and 00)
neonatal airways; 00 and 000, single use laryngoscope, mucus extractor

APPENDIX 3 – ON-CALL AUDIT SHEET

Name:	Team

Request made by:	Date: Time:

Reason given for request: e.g. homebirth, escalation, FMBU, BBA

Activity undertaken:

Time back Home:	Total time:

Impact from On Call request (i.e. sleep time, workload etc.)

APPENDIX 4 - SBAR MATERNAL /NEONATAL TRANSFER FORM

PART A (To be completed by the transferring Midwife)

Date: …… Time: …… Name: ……

Unit No: …… GP: ……

Situation:

Location of woman for transfer: ……..

Midwife looking after woman: ……

Consultant Unit Contacted: Date:…….. Time: ……..

Contact Name/Designation: ……...

Time Ambulance Called: ……. Arrived: ……. Left: ……. Arrived at receiving Unit: ……..

Midwife for Transfer: Yes / No …… Emergency (blue light) Yes / No ……

Background (relevant history)

……

……

……

Reason for transfer (circle any that apply)

	Not in Labour	APH, PPH, Meconium in liquor, Non-reassuring or pathological fetal heart rate, Prolonged rupture of membranes (state how long), Other – please specify
	In Labour	APH, PPH, Delay – 1st stage, Delay- 2nd stage, Meconium in liquor, Non-reassuring or pathological fetal heart rate, Prolonged rupture of membranes (state how long), Retained placenta, Other – please specify

Assessment (latest)

BP: …… Pulse: …… Temp: …… Baby temp (if applicable): ……

Fetal Heart Rate (if applicable): ……

Further comments: ……..

……

Recommendation – Medical Review

Management Plan documented in maternal records- Yes……. (please tick)

Care handed over to: …… Date: …… Time: ……..

Sign and print ……..

APPENDIX 5 – MANAGEMENT OF A DELIVERY IN AN UNPLANNED ENVIRONMENT (BBA)

1. BACKGROUND

NICE 2017 “Intrapartum Care” states if something goes unexpectedly seriously wrong at home, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care. Unintended home births or women who received no antenatal care are linked to a higher rate of both maternal and perinatal complications (RCM 2007). If the woman has a pre-existing medical condition or has had a previous complicated birth that makes her at higher risk of developing complications during her next birth, she should be advised to give birth in an obstetric unit.

The On Call service provides a midwife to attend planned births only.

2. KEY ISSUES TO BE ADDRESSED WHEN DEALING WITH A DELIVERY IN AN UNPLANNED ENVIRONMENT

2.1 Communication

For all women anticipating an unplanned home delivery

Ambulance is called by either:-

- Labouring woman dialling **999** direct **or**
- The maternity Unit at Royal Stoke or Free Standing Midwifery Birth Centre, County Hospital dialling **9-999** following a telephone call from the woman/ her relatives,

Community midwives will NOT be dispatched to attend a woman delivering in an unplanned environment (unless already assessed for home birth) as it is recognised that there may be cases where Safeguarding and/or Lone worker issues may present a risk. These women should be attended by the ambulance service and transferred to the Delivery Suite at Royal Stoke**.**

IN NO CIRCUMSTANCES MUST WOMEN OR BABIES BE TRANSFERRED TO THE ACCIDENT AND EMERGENCY DEPARTMENT - ALL NEWLY DELIVERED NEWBORNS REQUIRING ANY INTERVENTION IMMEDIATELY AFTER BIRTH MUST BE BROUGHT TO THE DELIVERY SUITE AT THE ROYAL STOKE HOSPITAL

MANAGEMENT PLAN

The midwife will:
Remain on the telephone until arrival of the paramedics providing advice, support and reassurance to the woman/family. Arrangements for transport to hospital by ambulance should be speedy and constructive

The paramedics will:

- Inform Delivery Suite by telephoning [redacted] of the transfer of the woman (and baby if born) providing details of:
  - Patients name, address, Date of Birth and NHS number
  - Gestation of pregnancy if applicable
  - If delivered time of delivery, condition of mother and baby

If premature birth is anticipated (less than 37 weeks) or baby in poor condition:

The receiving Midwife will:

- Advise the paramedics to bring the woman in to Delivery Suite, UHNM (if nearest unit).
- Inform the neonatal team of impending admission, prepare a room/resuscitaire in readiness to accept the woman, and stabilise the baby, before possible transfer to the neonatal unit.

Arrival at hospital

The receiving midwife will:

- Provide care in accordance with stage of labour, or postnatal care.
- Escalate any clinical concerns to the Obstetric Registrar (Paediatric Registrar as necessary) on call.
- Check the alert files at the maternity unit to ensure that safeguarding plans are not in place for the baby and contact Social Care in order that lateral checks can be undertaken. Safeguarding concerns should be considered as a potential reason for remaining at home.
- Complete the relevant documentation including labour notes and partogram on K2, based on information received from the handover from the ambulance service, post natal notes for mother and baby on K2 and Child health record. Complete the computer records on K2 including generating NHS number for baby.
- Produce a birth notification - the mother and baby are admitted to the “BBA ward” on the Medway computer system.
- Complete a Datix report for every unplanned home birth regardless of the outcome.