Guideline for the Management of a planned homebirth

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Version	1	
Status	Approved	
Publication date	28/03/2023	
Review date	23/03/2026	
Approval recommended by	Women's Business and Governance Meeting	Date:17/02/2023
Approved by	CBU 3 Overarching Governance Meeting	Date:22/03/2023
Distribution	Barnsley Hospital NHS Foundation Trust – intranet Please note that the intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments	

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1.0 Introduction

The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant.

The Royal College of Midwives (RCM) state “the environment in which a woman labours can have a great effect on the amount of fear and anxiety she experiences”. Women are more likely to have an enjoyable birth experience with better outcomes if they are able to choose a birth environment that feels best suited to them and are supported in this decision-making process (RCM, 2012).

Barnsley NHS Foundation Trust supports women’s choice of place of birth and aims to provide midwifery care in all birthing environments.

Better Births (2016) reviewed maternity services within the UK with the aim of improving outcomes, providing personalised care for all women and reducing inequalities. The review builds on existing principles of choice in maternity services. Women should receive clear, unbiased advice and should be able to choose where their baby is born (DOH 2007). NICE (2014) states that women who are at low risk of complications are suitable for giving birth in community settings.

The Birth place in England Cohort study (Hollowell et.al. 2015) found that for most low risk healthy pregnant women giving birth is very safe and the incidence of adverse perinatal outcomes is low. It found that birth at home is also relatively safe for these women. For multiparous women there are no significant differences in relation to adverse perinatal outcomes and the chances of intrapartum caesarean section, instrumental delivery and episiotomy is significantly less. However, for primiparous women there is a significantly higher chance of intrapartum and immediate postnatal transfer to an obstetric unit and adverse perinatal outcomes increase from 5.3 per 1000 births in obstetric units, to 9.3 per 1000 for planned home births.

Women who choose home birth are thought to do so for a number of reasons including a desire for a positive birth experience, an expectation of continuity of carer, control and empowerment and a reduction in the risk of intervention (Birthrights, 2013; Handelzalts, Zacks & Levy, 2016; Lindgren & Erlandsson, 2010; Sandall et. al., 2016).

2.0 Objective

To outline the processes to be followed when supporting women who choose to give birth at home in the antenatal and intrapartum period.

3.0 Scope

This guideline is for the use of obstetricians and midwives who will be providing care and/or advice to women who choose to birth at home.

4.0 Main body of the document

4.1 Choice of Place of Birth

All women will be given the opportunity to discuss their choice of birth place at the booking appointment. This will then be followed up at antenatal appointments throughout pregnancy as the woman's preference/risk status may change. The woman can choose a particular place of birth at any time during pregnancy. Women's preferences and decisions must be respected, even when this is contrary to the views of the health professional.

Current evidence will be used to explain the benefits and risks of different birth settings and that giving birth is generally very safe for both the woman and the baby (NICE 2014)

Information regarding birth choice is included in the Personalised Care Plan (PCP) which is accessed via the maternity website.

The following advice should be offered to low risk women to aid decision making (NICE 2014):

For low risk nulliparous women:

- Birth in a midwife led unit is suitable because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.
- Planned birth at home is associated with a small increase of an adverse outcome for the baby from 5.3% to 9.3%
- The rate of transfer to an obstetric unit is 36-45%

For low risk multiparous women:

- Birth at home or in a midwife led unit is suitable because the rate of interventions is lower and the outcome for the baby is no different compared to an obstetric unit.
- The rate of transfer to an obstetric unit is 9-13%

Women booking for a planned home birth should ideally fulfil the criteria for a low risk pregnancy. The midwife is responsible for identifying which women are suitable for home birth by performing a risk assessment based on their medical, gynaecological, previous and current obstetric history **See Appendix 1**

Birth in an obstetric unit is recommended for women with risk factors see Antenatal Care.pdf (trent.nhs.uk)

Women who choose Home Birth outside of guidance.

The midwife will discuss the woman's wishes and discuss alternative places of birth. This discussion must include the potential benefits and risks so that the woman can make a fully informed decision. **See appendix 2** for the BRAIN template to aid decision making. See "Guideline for supporting maternal choices in pregnancy."

If the woman has risk factors and chooses a planned home birth the woman will be offered an appointment in the consultant clinic to discuss their options with an obstetrician.

If the woman chooses a planned home birth a risk assessment must be undertaken to support the woman and midwife. This must be completed as early as possible to allow for an MDT approach to developing a management plan. This can be facilitated through team leader/outpatient manager meetings.

All consultations and risk assessments must be thoroughly documented in the woman's EPR and hospital notes.

4.2 Home birth discussion

The named community midwife will complete the Home Birth Discussion proforma **(Appendix 3)**

The named Community Midwife is the lead professional for women choosing to birth at home and has the responsibility for discussing with the women details regarding the process for emergency transfer. This information will include:

- An explanation of the midwifery day and night on call rota including continuity teams.
- Information on how to contact a midwife including emergency contact numbers (Maternity Assessment Unit and the Birthing Centre).
- Discussion that that the midwife will attempt to arrive in a timely manner, however geographical restrictions may influence this. Explain that the midwife will advise the woman of the expected time frame
- The pharmaceutical and non-pharmaceutical options available for coping with birth in the home environment. Discuss which pharmaceutical methods are restricted in the home setting. Entonox will be provided by the community midwife if requested.
- That birth prior to 37 weeks is considered pre-term and hospital birth would be advised.
- That there is a possibility that a midwife may not be able to attend a planned homebirth where birthing centre acuity is high and/or the escalation policy has been implemented. In this instance birth in the hospital will be recommended. Where a woman declines to attend hospital, they will be re-advised of this option and informed that a midwife is unavailable to attend.
- A discussion that the homebirth assessment will be undertaken at around 36 weeks gestation with all who will be present at the birth. This is to discuss birth specifics. If the woman is high risk and choosing to birth at home, a senior midwife/Team Leader or Matron will also attend.

4.3 Booking a home birth

Refer to **Appendix 4** "Booking a Home Birth Flow Chart."

If low risk, complete the notification of home birth form and include any relevant information. This should be completed by the named Community Midwife and circulated to all Community Midwives, the Birthing Centre, Matrons and the Head of Midwifery, as early as possible, ideally by 37 weeks gestation. **See Home Birth Notification Form (Appendix 5).**

4.4 Home visit at 36 Weeks Gestation

The midwife will complete the "Environmental Risk Assessment for Home Birth" see **Appendix 6.**

The risk assessment will include;

- Review of the home environment, social circumstances and support

network.
- An assessment of the area where the woman intends to birth. The areas should be of sufficient size and clutter free to allow the midwife access to the woman from 3 sides in case of an emergency situation arising.
- Identifying any hazards and make suggestions on how these hazards should be dealt with prior to the home birth. If appropriate, arrange to re-visit the home to ensure care can be safely given and hazards have been removed. Document both the hazards and suggestions made.
- Advice for women requesting a pool birth. A risk assessment will be undertaken of the area to be used for the pool birth and documentation must include:
    - Whether there is access on 3 sides
    - The Location of the pool (consider 'weight' if not on ground floor)
    - Any Hazards – electric plug sockets, route of hoses
    - Information regarding evacuation from the pool
    - Information in the event of flooding

The midwife will arrange a presentation ultrasound scan.

The midwife will Complete the Homebirth Discussion Form and the notification of planned home birth form if not all ready complete.

The midwife will take a blue delivery box to the home containing autoclaved instruments and a locked pouch containing the following drugs to be stored in the woman's fridge;

- Syntocinon 10i/u
- Syntometrine 5i/u
- Ergometrine 500mcg
- Konakion 2mg 1 vial Dosage is 1mg

If the woman requests oral Vitamin K for their baby ensure a prescription is obtained from the GP.

The midwife will Review the Thromboprophylaxis Risk Assessment Form (TRAF) if scores ≥2 following birth prophylaxis treatment will be required. If this is anticipated in the antenatal period, ensure a prescription is arranged by the GP.

4.5 Attendance During Labour and Birth

The woman will be advised to ring the Birthing Centre Maternity Assessment Unit when midwifery support is required.

Between 9am-5pm – The Birthing Centre coordinator will inform the community Team Leaders who will allocate the most appropriate persons to attend the woman.

Between 5pm-9am – The Birthing Centre coordinator will contact the On-call team midwife to attend. A second midwife will be allocated by the coordinator and a decision will be made which team will support dependent upon acuity.

Two midwives will attend the woman. The first midwife will go to the woman's address with their own set of equipment. The equipment must be checked as per Checking and storage of homebirth equipment.pdf (trent.nhs.uk).

The second midwife will attend the woman's address after attending the hospital to collect the baby lifeline homebirth bag, three Entonox cylinders, one oxygen cylinder and portable suction equipment.

NB Entonox and oxygen must be transported in the designated carry bags and the hazardous gases sign displayed in the car. If not, in an accident the insurance policy may be invalidated.

The Community Midwife will inform the Birthing Centre of their arrival at the woman's home.

The coordinator will ensure that a member of staff on the Birthing Centre obtain the woman's notes following the call and record the details. These will be updated accordingly if there are any further developments.

The midwives will keep in contact with the Birthing Centre coordinator at regular intervals during the labour giving details of progress and maternal and fetal wellbeing.

The Community Midwife is accountable for the care in the Community but should inform the Birthing Centre coordinator should any potential problems arise in order to provide a co-ordinated approach to on-going care.

The trust guideline for intrapartum care will be followed.

On attendance, if labour is not established, following discussion with the woman the midwife can leave the woman. The woman must understand when and how to contact the Birthing Centre again when they require the midwife to return.

SROM after 37 weeks of pregnancy and not in established labour

Between **09:00 and 17:00** a Community Midwife will either review the woman at home / hub or local ANC to confirm SROM.

SROM will be confirmed by observing for the presence of amniotic fluid. If the history is uncertain or there is no visual evidence of SROM the midwife can perform a sterile speculum examination to confirm the presence of amniotic fluid. If the midwife cannot confirm SROM the woman will require a review in the maternity assessment where an Actim PROM test can be performed to confirm SROM. A vaginal examination in the absence of contractions should be avoided. Both MOEWS and the Fetal Heart rate will be performed and documented.

Out of hours, between **5pm and 9am** the woman will contact the Maternity Assessment Unit and arrange to have the SROM confirmed.

4.5 Management of low risk women with Prelabour Rupture of Membranes at Term

Please refer to Guideline for the Management of Prelabour Rupture of the membranes at term. Microsoft Word - Guideline for Prelabour rupture of membranes at term ratified at OA Feb 2020 (trent.nhs.uk)

4.6 Management of Labour

Please refer to the guideline for the Management of Normal labour. Microsoft Word - Guideline for the management of normal labour ratified at OA May 2019 (trent.nhs.uk)

Following birth and before leaving the home:

- Inform the Birthing Centre coordinator of the birth outcome.
- If suturing is required but cannot be performed at home arrange for transfer to hospital via ambulance e.g. if a general or spinal anaesthetic is required.
- Perform MOEWS and assess fundal height and lochia.
- Perform VTE assessment. If treatment is required ensure it is administered within 4-6 hours of birth.
- Obtain maternal and cord blood samples if required for antibody screening in women who are Rh Negative.
- Undertake the postnatal mental health assessment and action accordingly.
- Ensure the mother has emptied their bladder and record the time and amount in the postnatal records. See Management of Postpartum Bladder Care guideline. Microsoft Word - Management of Postpartum Bladder Care ratified at OA governance April 2019 (trent.nhs.uk)
- Perform the initial newborn physical check including measuring baby's temperature and weight.
- Offer the administration of Vitamin K.
- Support with feeding and ensure the baby has fed.
- Ensure that the parents are aware of the 'Important Symptoms' of the ill baby and the advice around 'Reducing the risk of cot death' as outlined in the post-natal records.
- Make arrangements for the NIPE examination of the baby. This must be performed within 72 hours of birth.
- Advise that the hearing screen appointment will be at the hospital
- Advise the woman on how to contact a midwife if there are any concerns and provide information on future midwife appointments.
- Provide all relevant contact numbers.
- Complete all appropriate documentation. Postnatal records completed for mother and baby remain at the home.

The Midwives in attendance must remain in attendance for at least one hour and until the mother and baby are stable.

4.7 Transfer to the Obstetric Unit by ambulance

If there are any deviations from normal the midwife must seek medical advice and /or transfer without delay. (NMC Code 2015) Any reason for transfer must be discussed with the woman and birth partners prior to the transfer. Consent must be gained.

If risk factors are identified and the birth is imminent the midwife will assess whether transfer is feasible or whether birth in the current setting is preferable. The need for transfer will be reassessed following birth dependent upon the condition of the mother and baby and the original reason for transfer. The Birthing Centre co-ordinator must be kept informed of the situation and any plans.

The Midwives in attendance will arrange an ambulance transfer by calling 999 stating life threatening emergency and requesting transport with a paramedic in attendance. **Do not contact the Birthing Centre as this can cause delay.** Communication with the Birthing Centre can be made after 999 emergency calls and the appropriate 'stand by' plan to be arranged with the coordinator. The midwife must accompany the mother (and baby if birthed) in the ambulance.

Where possible allow the woman's birth partner to accompany them in the ambulance or ensure they can arrange their own transport.

An SBAR handover will be given to the receiving midwife at the hospital.

Criteria for intrapartum transfer:

- The absence of a fetal heart rate
- Any indications for electronic fetal monitoring (EFM) including abnormalities of the fetal heart rate (FHR) on intermittent auscultation see https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TADDocs/Guideline For Fetal Auscultation (Including Electronic Fetal Monitoring).pdf
- A deceleration in the fetal heart rate heard on auscultation
- Fetal heart rate <110bpm or >160bpm
- Reduced fetal movements in the last 24 hours
- Meconium stained liquor. Consideration should be given to the woman's parity and stage of labour, volume of liquor and type of meconium and the fetal heart rate and transfer time.
- Ante-partum haemorrhage
- Cord prolapse/presentation
- Hypertension/eclampsia:
    - A single diastolic reading of ≥110mmHg or a single systolic reading of ≥160mmHg
    - A diastolic reading of ≥90 mmHg or a systolic reading of ≥140 mmHg on two occasions taken 30 minutes apart
    - 2^{+} protein with a single diastolic reading of ≥90mmhg or a single systolic reading of ≥140mmhg
- Pyrexia:
    - A single reading of ≥ 38.0°C
    - Two readings of ≥ 37.5°C taken one hour apart
- Maternal tachycardia (>120bpm on two occasions 20 minutes apart)
- Delay in the 1st or 2nd stage of labour
- Malpresentation
- High head (4/5 – 5/5ths) or free floating in a nulliparous woman
- SROM for more than 24 hours at the onset of established labour
- Suspected fetal growth restriction or macrosomia
- Suspected oligohydramnios/polyhydramnios
- Pain that differs from the pain experienced during contractions
- Maternal request

Criteria for Postpartum transfer

- Retained placenta
- Postpartum haemorrhage
- Extensive perineal trauma
- Hypertension/eclampsia

Criteria for neonatal transfer

- Low Apgar / advanced resuscitation
- Hypothermia

- Hypoglycaemia
- Congenital abnormalities which necessitate urgent review
- Any baby born through meconium stained liquor
- Birth trauma

All action taken must have a clearly identified rationale recorded in the records

4.8 On Return to the Birthing Centre

The community Midwife will:

- Transport the placenta to the Birthing Centre for disposal. If the woman requests to keep the placenta they must be made aware of safe methods of disposal.
- Return cleaned equipment and clinical waste to the hospital for appropriate and safe disposal.
- Return and restock all equipment.
- Return any unused drugs to the hospital. Any unused drugs obtained via a community prescription (woman's GP) must be returned by the woman or their partner to the Community Pharmacy.
- Complete data input on the Electronic patient record (EPR) which will generate the birth notification, NHS number and notify the GP.
- Inform the Community Midwifery admin team of the birth who will then record the outcome of the delivery on the appropriate spreadsheet, inform all community teams and arrange the next postnatal visit and NIPE.
- Arrange any reviews required e.g. Anti-D, MMR and BCG if appropriate

5.0 Roles and responsibilities

5.1 Midwives

Midwives have a responsibility to follow local and professional guidance in the planning and management of a home birth.
All midwives attending home birth must ensure they have all the equipment required in the Community Midwives equipment list.
When attending home birth midwives must provide regular updates to the Birthing Centre coordinator.

5.2 Obstetricians

Obstetricians have a responsibility to counsel the women on the risks and benefits with the choice to birth at home.

6.0 Associated documents and references

- Hollowell J, Rowe R, Townend J, Knight M, Li Y, Linsell L, *et al.* The Birthplace in England national prospective cohort study: further analyses to enhance policy and service delivery decision-making for planned place of birth. *Health Serv Deliv Res* 2015;3(36)
- National Institute for Health and Care Excellence. Clinical Guideline 190. Intrapartum care: care of healthy women and their babies during childbirth (2014) [online] www.guidnce.nice.og.uk/cg190
- National Institute for Health and Clinical Excellence Intrapartum care section 1.10 Prelabour Rupture of the Membranes at term. Page 39. Sept 2007
- National Institute for health and Clinical Excellence (2012) Clinical guideline 149 Antibiotics for early onset neonatal infection
- Nursing and Midwifery Council (2015) the Code for Nurses and Midwives

- Nursing and Midwifery Council (2015) The Code, Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates.
- Nursing and Midwifery Council (2006) Midwives and Home Birth NMC Circular 8-2006. 13 March 2006
- The transport and carriage of dangerous goods and the Use of transportable pressure equipment regulations (2004) DGSA

7.0 Training and resources

Midwives attending planned homebirths must ensure competence at managing obstetric emergencies and have attended the Trust Mandatory Training and Obstetric skills and drills (PROMPT) within the last 12 months.

8.0 Monitoring and audit

Any adverse incidents relating to the guideline for the Management of the planned home birth will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for the Management of the planned home birth will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

9.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1

Inclusion and Exclusion Criteria for Home Birth

The following criteria have been agreed to guide practice within the Trust:

Inclusion Criteria:
Full term (37 to 40+12 days pregnant)
Singleton pregnancy
Cephalic presentation
Spontaneous onset of labour
An uncomplicated pregnancy, medical and obstetric history (see exclusion criteria)
Women who are having their 1st, 2nd, 3rd, 4th or 5th baby without previous complications or where recurrence of a complication would not be anticipated.
Age – 16 to 40 years
Weight – Body mass index 18 – 35

Exclusion criteria:
Women with the following conditions require booking for consultant-led care and delivery in a consultant unit. Please note this is not an exhaustive list and if you have concerns liaise with consultant obstetrician.
Not all women who require booking under Obstetrician led care need to give birth at the obstetric unit. Conditions in parenthesis e.g. [Fibroids] may be suitable for a community birth and this should be assessed, discussed and documented at an obstetric clinic appointment

Exclusion- Medical History		
Respiratory: • Asthma: severe attack requiring nebuliser/steroids in previous 12 months • Cystic Fibrosis Haematological: • Haemoglobinopathies • Previous P.E. or DVT	Neurological: • Epilepsy • Neurological disease • Myasthenia gravis • Previous CVA Endocrine: • Thyroid disease • Diabetes	Cardiovascular: • Known cardiac disease/congenital heart abnormality • Hypersensitive disorders • Anaesthetic Risk: • Known airway problem • Current Infective:

• Von Willebrands disease/other thrombotic disorders • ITP (current or previous pregnancy) or other platelet disorders <u>Gastro-intestinal:</u> • Liver disease • Crohn's disease/ulcerative colitis • Severe Hyperemesis • Coeliac Disease • Major surgery <u>Immune:</u> • Rheumatoid arthritis • Systemic lupus erythematous • Connective tissue disease e.g., Marfan's syndrome	• Other significant disorders e.g., Cushing's disease <u>Renal</u>: • Renal disease/renal abnormality • Recurrent UTI infections needing prophylactic antibiotics <u>Psychiatric history:</u> • Previous puerperal psychosis • Severe and enduring mental health problems • History of attempted suicide • Current history of substance and alcohol misuse • Child protection concerns or vulnerable adult	• TB • HIV positive • Toxoplasmosis • Chickenpox • Genital Herpes • Hepatitis C and B • Group B streptococcus
Exclusions – Gynaecological History		
• Previous major gynaecological i.e., Myomectomy, • Hysterotomy • Uterine/vaginal abnormality • Recurrent TOP's (3 or more) • Fibroids • Cervical loop excision		
Exclusions – Obstetric History		
Complications in Previous Pregnancy • Uterine rupture • Previous CS • Previous abruption • Stillbirth/neonatal death • Previous pre-term labour • Previous obstetric cholestasis • Previous acute fatty liver disease • Severe early onset pre-eclampsia • Complicated instrumental delivery • Primary PPH > 500ml • Retained placenta		

- Previous 3rd/4th degree tear
- Previous should dystocia
- Previous baby of <2.5kg/>4.5kg
- 3 or more previous, consecutive, spontaneous abortions and no subsequent NVD

Complications in Current pregnancy

- Atypical antibodies that risk haemolytic disease of newborn
- Haemoglobin of less than 90g/l at term
- APH/placental abruption
- Placenta praevia
- Unstable lie
- Multiple pregnancy
- SGA (<10th customised centile)
- Ultrasound diagnosed oligo- or polyhydramnios
- Treatment with low molecular weight heparin
- Suspected thrombo-embolism
- Hypertension >140/90
- Pre-eclampsia
- Gestational diabetes
- Obstetric cholestasis
- Current history of drug/alcohol misuse
- BMI of less than 18 or greater than 35
- History of domestic violence with current partner or current safeguarding concerns
- Induction of labour
- Post maturity (40 + 12 days)
- Prolonged rupture of membranes (greater than 48 hours

Appendix 2- BRAIN template

PROCEDURE/ INTERVENTION	
B **What are the benefits of making this decision?**	
R **What are the risks involved?**	
A **Are there any alternatives?**	
I **What does your intuition say?**	
N **What happens if we do nothing?**	

Outcome	**Accepted**		**Declined**	

Print Name / Signature:

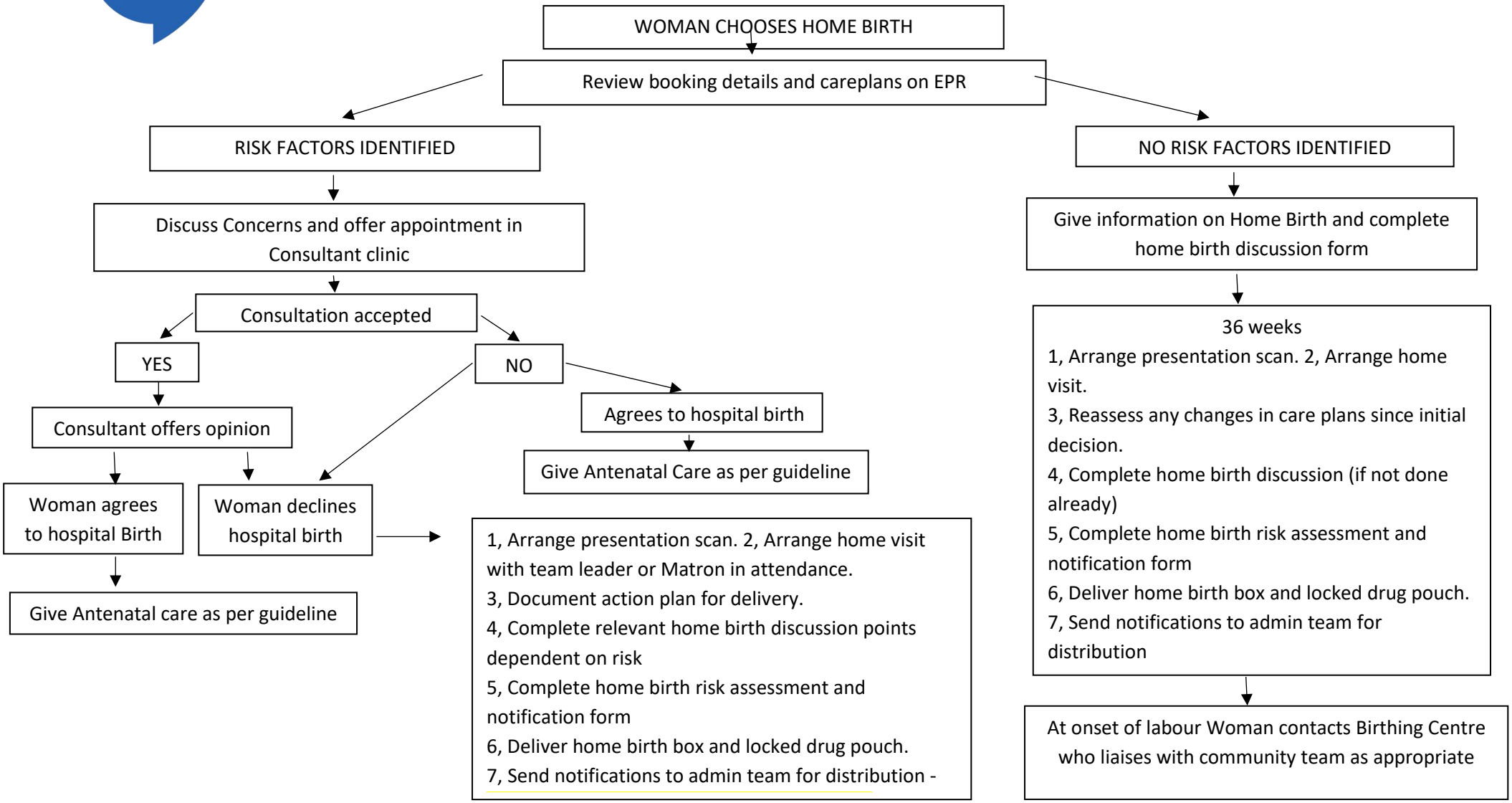
Position:

Date:

Barnsley Hospital
NHS Foundation Trust

Appendix 3

BOOKING A HOME BIRTH FLOWCHART



Appendix 4

Home birth Discussion

Please complete the discussion with the woman and family as soon as the decision for home birth has been made.

Meeting Date/Time		
Name of midwife		Team
Current Gestation	EDD	Gravida/Parity
Other people present at meeting		
Low Risk? Y ☐ N ☐ Risk Factors? Y ☐ N ☐		Comments

Reason for choosing a homebirth (Use BRAIN to aid decision making)	
Preparation and discussion points	**Tick if discussed**
On call rota both day and night	
Suspension of home birth service due to high acuity and escalation. If midwives are out at another home birth this may necessitate hospital delivery	
How to and when to contact the midwife	
Home birth assessment and environment check at 36 weeks	
Are students welcome?	
Generic benefits of home birth	
Being in familiar surroundings where you may feel more relaxed and able to cope	
You don't have to interrupt your labour to go into hospital	
You will not need to leave your other children, if you have any, although you must arrange care for them separately	

You will not have to be separated from your partner after the birth	
You are more likely to be looked after by a midwife you have got to know during your pregnancy	
You are less likely to have intervention such as forceps or ventouse than women giving birth in hospital	
Risks to consider	
Only basic pain relief can be offered at home. Entonox will be brought to the address for active labour. Alternative methods will need to be supplied and administered by the woman e.g. TENS, aromatherapy	
Neonatal resuscitation and equipment are basic compared to a hospital setting	
APH complicates between 2 and 5% of all pregnancies (RCOG)	
Studies quote an incidence of PPH of around 5-10% of all pregnancies (this will be lower in low risk women) (Source: Patient On-line)	
Shoulder dystocia - Shoulder dystocia occurs in about one in 150 (0.7%) vaginal births. (RCOG)	
Transfer times to hospital could potentially result in a delay in treatment	
Delay in midwife arrival due to geographical/traffic restrictions	
Labour prior to 37 weeks is considered preterm and hospital birth is advised	
Limitations of perineal repair in a home setting	
If anyone in the household tests positive for COVID-19. Hospital birth is advised	
Reasons for Transfer into Hospital at any time during homebirth	
Fetal distress	
Shoulder Dystocia	
Cord prolapse	
Prolonged labour/ failure to progress	
Maternal haemorrhage (ante/post natal)	
PROM	
Maternal observations (MEOWS) outside normal limits e.g. Raised BP	
Retained placenta	
Post-natal problems including suturing	
Neonatal concerns post delivery	
I confirm the points above have been discussed with me and I wish to proceed with a home birth. I agree/disagree to transfer to hospital should the need arise (please circle)	

Signature Mother	**Signature Midwife**	**Date**

Appendix 5

Notification of Booking for Home Delivery

Team:	Named Community midwife:	
Woman's Name: DOB: Unit number:	Address:	
Telephone number(s):	Gravida/Parity:	EDD:
Previous obstetric history		
Blood group:	Last Hb result:	
Any other relevant information:		
Directions to house		
Fits Criteria for home birth?		
Yes: continue as planned	Date equipment left in the woman's home:	
No: Attach care plan agreed after MDT meeting		
Midwives name: Signature:		Date:

Distribution list: Matrons; CMWs; Birthing Centre

Appendix 6

Barnsley Hospital NHS Foundation Trust

Name: ……

D.O.B: ……

Unit No. ……..

:…..……

Environmental Risk Assessment for Home Birth

We would like to support your choice of home birth but there may be adjustments that need to be made in the home environment to make it more suitable

Location	Rationale	Tick if suitable or note recommended changes
Access to property suitable for emergency vehicle and has phone signal?	We should not plan a home birth without access to emergency services.	
House clearly signposted or identifiable?	May require an identifiable feature on the gatepost i.e. balloons, fluorescent jacket if hard to find	
Parking nearby?	The midwife will need to deliver her home birth kit and should not be walking alone at night	
If an apartment, is there safe access for the midwife?	Does the lone midwife at night run the risk of contact that may compromise her safety? I.e. outside a bar, groups of youths in the lobby.	
Birth Room		
Spacious enough room to accommodate staff and birth partners?	Need to consider birth partners, 2 midwives and possible ambulance crew at any one time. May need to move furniture to another room.	
Room for resuscitation equipment?	Flat surface on floor or table top required	
Suitable planned birth space?	Bed, couch, floor pads, pool suitable A bath is not suitable due to the midwife position required may lead to back injury.	
Access to sides/ foot of the bed/pool?	To prevent the MW leaning over and risking a strain	

	injury; to allow easy access to get in and out of the bed/pool with ease.	
If upstairs, are the stairs suitable for emergency evacuation on a chair?	No sharp bends, not too narrow or steep. May need to move obstructing furniture	
Adequate lighting?	Angle poise for suturing. Adequate wattage bulb in overhead light.	
If birthing pool, is the floor strong enough to take the weight?	The homeowner/tenant should ensure that the pool is on a solid ground floor or that the floorboards will take the weight of the filled pool and all attendants	
If birthing pool, is the position away from nearby electrical sockets?	To prevent electrocution	
If birthing pool, can this be easily filled, emptied?	The parents will take responsibility for filling, maintaining the temp of the pool and emptying. Position of the taps may need to be considered and advice given.	

Once the risk assessment is complete, the midwife will discuss any changes required with you and you will both agree your place of birth.
Safety for you and your baby are very important to us and we expect you will support us and accept any recommendations made.

I have undertaken a home birth risk assessment on _____ (date) and deemed the premises **suitable/not suitable** (delete as appropriate) for a home birth.

Signature Mother

Signature Midwife

Date

Appendix 7
Glossary of terms

EDD- Estimated date of delivery
EFM – Electronic fetal monitoring
EPR – Electronic patient record
FHR – Fetal heart rate
MDT – Multi disciplinary team
MOEWS – Modified obstetric early warning score
PCP – Personalised care plan
SROM – Spontaneous rupture of membranes
TENS- Transcutaneous electrical nerve stimulation
TRAF - Thromboprophylaxis Risk Assessment Form

Appendix 8 (must always be the last appendix)
Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author
2.	21/07/2014		
3.	10/08/2015		
4.	19/06/2017		

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	N/A
Reviewed at Women's Business and Governance meeting	17/03/2023
Approved by CBU 3 Overarching Governance Meeting	22/03/2023
Approved at Trust Clinical Guidelines Group	N/A
Approved at Medicines Management Committee (if document relates to medicines)	N/A

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Guideline
Document title	Guideline for the Management of a planned homebirth
Document author (Job title and team)	Community Lead Midwives Consultant Obstetrician
New or reviewed document	Reviewed. Replaces; Planned home birth
List staff groups/departments consulted with during document development	Midwives Obstetricians
Approval recommended by (meeting and dates):	WB&G 17/03/2023 CBU3 Governance 22/03/2023
Date of next review (maximum 3 years)	23/03/2026
Key words for search criteria on intranet (max 10 words)	
Key messages for staff (consider changes from previous versions and any impact on patient safety)	Maternal choice
I confirm that this is the FINAL version of this document	Name: Jade Carritt Designation: Governance Midwife

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): **CBU3 Governance**

Date approved: 22/03/2023

Date Clinical Governance Administrator informed of approval: 23/03/2023

Date uploaded to Trust Approved Documents page: 28/03/2023