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TRUST CLINICAL GUIDELINE

Homebirth & Freebirth

Overview

The purpose of this guideline is to provide evidence based guidelines for staff supporting pregnant women and birthing people choosing homebirth or freebirth.

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Homebirth & Freebirth

1.0 Introduction

This guideline aims to provide clear guidance for all staff involved in all aspects of homebirth and freebirth.

These guidelines are intended to provide high quality, evidence-based care to pregnant women and birthing people and babies under the care of the maternity units at University Hospitals Sussex.

2.0 Scope

- All staff providing intrapartum care in the home setting.

3.0 Responsibilities and sphere of practice

Midwives:

- To access, read, understand and follow this guidance.
- To use their professional judgement in application of this guideline. This guidance is for midwives working within University Hospitals Sussex maternity services. This guidance is not rigid and should be tailored to the individual circumstances of each pregnant woman or birthing person. If the guidance is not being followed, documentation on the Maternity Information System (MIS) of the reasoning and/or justification is essential, with clear documentation of alternative plans and discussions.
- To understand the midwives role, scope of practise, responsibilities and accountability in relation to providing midwifery care, in accordance with standards as specified by the Council, to a pregnant woman and birthing person and baby during the antenatal, intrapartum and postnatal periods.
- Except in an emergency, a practising midwife shall not provide care, or undertake any treatment which they have not been trained to give.
- In an emergency or where a deviation from the norm which is outside their current scope of practice becomes apparent in a pregnant woman or birthing person or baby during the antenatal, intrapartum or postnatal periods, a practising midwife shall call such qualified health professional as may reasonably be expected to have the necessary skills and experience to assist them in the provision of care.

4.0 Abbreviations used within this guideline

BBA - Born before arrival	**DAU -** Day Assessment Unit
LMWH - Low Molecular Weight Heparin	**MAU -** Maternity Assessment Unit
MIS - Maternity Information System eg Badgernet	**TED -** Thrombo-embolic Deterrent
SBAR - Situation, Background, Assessment, Recommendations	**VTE -** Venous Thromboembolism

5.0 Introduction

5.1 Homebirth: Midwives guiding principles of care

In the event of a pregnant woman or birthing person requesting a homebirth it is essential that the midwife refer to the Trusts Homebirth & Freebirth guideline in providing care during the pregnancy and labour ensuring the safety of both the pregnant woman or birthing person and their baby.

The standard of practice in the delivery of midwifery care shall be that which is acceptable in the context of current knowledge and clinical developments. In all circumstances the safety and welfare of the pregnant woman or birthing person and their baby must be of primary importance.

It is essential that all midwives read and be familiar with their responsibility and accountability in regard to the NMC The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Any midwife who is not competent to provide care in the home setting must raise their concerns with their line manager in order that additional training can be arranged.

Midwives attending home birth must ensure they consider their own safety at all times and inform labour ward of any concerns for their own or any other person's safety. Please see Appendix 1: Lone worker checklist.

A midwife:

- Cannot arrange for anyone to act as a substitute, other than another practising midwife or a registered medical practitioner.
- Must make sure the needs of the pregnant woman or birthing person or baby are the primary focus of their practice.
- Should work in partnership with the pregnant woman or birthing person and their family.
- Should enable the pregnant woman or birthing person to make decisions about their care based on their individual needs, by discussing matters fully with them.
- Should respect the pregnant woman or birthing person's right to refuse any advice given.

- Is responsible for maintaining and developing their own competencies and learning new skills required in their practice.
- Is familiar with their employer's policies and guidelines.

5.2 Role of the Senior Midwifery Manager / Matron

- To support the midwife in the event of a complicated homebirth to provide reflection and advise if further training is required to improve the midwife's competencies both antenatally and in labour.

5.3 Role of the Midwifery Manager On-Call

- To provide support to midwives in the intrapartum period when pregnant women and birthing people birth at home and the midwives need additional support.

6.0 Booking a homebirth

- Take the pregnant woman or birthing person's obstetric history using the Antenatal Risk Assessment on MIS including suitability for homebirth.
- **PRH/RSCH -** A home visit and risk assessment should be performed at 36 weeks.
- **SRH/WH -** A home assessment should be carried out at some point in the pregnancy, this could be at Booking Appointment or later on in the pregnancy. With planned place of birth being amended to home by 36 weeks.
- Ensure the pregnant woman or birthing person is aware of Homebirth information on MIS.
- Complete the Smart homebirth assessment form on MIS and has the Homebirth Advice & Checklist (see appendix 2).
- Midwives should pre-warn all planned homebirths that sometimes the service has to be suspended for safety reasons.

6.1 Risk and pregnant women and birthing people's choice

- Any midwife providing care regardless of setting must identify possible risk factors and plan to mitigate those risks through their approach to care provision.
- For pregnant women and birthing people having a second or subsequent baby there are no significant differences in adverse perinatal outcomes between planned home births and planned births in obstetric units.
- For pregnant women and birthing people having a first baby who plan a home birth there appears to be a slightly increased risk of an adverse outcome for the baby (9.3 adverse perinatal outcomes per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric units (Hollowell, 2011)
- Pregnant women and birthing people who wish to have their baby at home should ideally be in good general health with an uncomplicated obstetric and medical history. They should ideally have a singleton pregnancy with a gestational age between 37 and 42 weeks and a cephalic presentation.

- Pregnant women and birthing people who have a pre-existing medical or obstetric condition or who have had a previous complicated birth should be advised to give birth in an obstetric unit.
- Pregnant women and birthing people advised to give birth in an obstetric unit who wish to continue with their plan for a homebirth should have their wishes respected and an individualised plan of care should be made as per section 7.0 Homebirth outside of guidance below. This can be facilitated and supported by referral to the consultant midwives via the referral on MIS.

7.0 Homebirth outside of guidance

7.1 Role of the Midwife

- Perform risk Assessment and ensure that clear documentation on MIS of the reasons why hospital birth is recommended.
- If a pregnant woman or birthing person is requesting a homebirth with a high-risk pregnancy, the midwife must inform them that they will be referred to the consultant midwife who will offer their support in individualised care planning. This referral should be made as early on in the pregnancy as possible.
- Risk factors need to be reviewed and documented on MIS during every antenatal appointment.
- Where the plan for home birth continues despite recognised risk factors, the midwife providing care should obtain support from their line manager or team leaders. Support can also be obtained from the labour ward coordinator/on-call manager. All discussions, advice and referrals should be documented by the midwife on MIS.
- Throughout the pregnant woman or birthing person's pregnancy, labour and postnatal periods the midwife should continue to provide appropriate midwifery care.

7.2 Role of the Consultant Midwife

- The consultant midwife should make contact with the pregnant woman or birthing person who request a homebirth outside of guidance and offer either a telephone consultation or a face to face appointment with their named midwife to discuss their birth preference.
- They should support the midwife and work with them and the pregnant woman or birthing person giving evidence based information in order to help the pregnant woman or birthing person make an informed choice about the place of birth.
- They should be giving full and unbiased information ensuring the pregnant woman or birthing person's understanding of their discussion and the reason for any concerns.
- This should be fully documented on MIS.
- The pregnant woman or birthing person's details should be added to the high risk homebirth spreadsheet which is forwarded to SECAMB monthly and an alert is added to the address.

7.3 Role of the Team Leader

- **RSCH/PRH:** A list of high risk homebirths is shared monthly to community midwives, labour wards and triage.
- **SRH/WH:** A list of all planned homebirths from 39 weeks is included on daily huddle and high risk information is shared with all community midwives with information on MIS.
- Team leaders must anticipate any training needs and arrange appropriate skills drills with the maternity practise development team.
- Support midwives where the plan for home birth continues despite recognised risk factors.

8.0 Antenatal care

- Routine antenatal care with risk assessments and appropriate referral if any deviation from normal is identified as per associated antenatal care guidelines.
- By 34 - 36 weeks, the midwife will visit the pregnant woman or birthing person to discuss birth at home and to complete the homebirth checklist on MIS. All discussions should be documented MIS. Ideally at least one antenatal appointment should take place in the home.
- The home birth assessment containing full contact and access details and any known risk factors must be completed and clearly documented on MIS.
- Fluid balance and information leaflet on MIS to be discussed. A measuring jug to be supplied by the pregnant woman or birthing person. This is to reduce the risk of hyponatraemia in the mother or birthing parent and baby.
- Pregnant women and birthing people must be informed that emergency transfer will be by ambulance is to the nearest obstetric unit. This discussion must be clearly documented on the home assessment form as well. Pregnant women and birthing people also need to be made aware of potential delays in transfer dependent on category of call and other demands on the ambulance service.
- If a pregnant woman or birthing person chooses to birth at home without a midwife present then the Senior Midwifery Manager / Matron should be informed. (See Freebirth section 16.0).
- If a pregnant woman or birthing person has chosen the support of a Doula at their birth, they should be asked if they wish the Doula to be involved in the birth preferences discussion.
- By the start of labour, the midwife will ensure the pregnant woman or birthing person has the required equipment for the birth as per appendix 2.
- If a waterbirth is planned the pregnant woman or birthing person must be advised that they should not enter the pool prior to the midwife arriving, as it is essential to confirm maternal or birthing parent and fetal wellbeing before hydrotherapy is used for pain relief in childbirth.
- The pregnant woman or birthing person must be informed of how and when to contact the midwife when labour begins and/or in other instances when assistance is required.
- All community midwives should ensure that all their equipment is in good working order and readily available.

- The community midwife should arrange for presentation scan between 36 - 37 weeks for all pregnant women or birthing people planning a homebirth. If this is declined please document on MIS.

9.0 Post dates plan of care

- Induction of labour should be discussed as per associated induction of labour guidelines.
- Where a pregnant woman or birthing person makes and informed decision to decline induction of labour they must be advised that homebirth is not recommended after 42 weeks gestation (NICE 2017).
- Where a pregnant woman or birthing person makes an informed decision to continue with a planned homebirth after 42 weeks gestation their choice should be respected.
- Pregnant women and birthing people should be recommended to discuss their options with an obstetrician or consultant midwife. The midwife should offer a referral to Day Assessment Unit (DAU) for an appointment in order that a plan for birth can be discussed or the consultant midwife contacted. Full documentation of all discussions and advice must be recorded on MIS.

10.0 Thromboprophylaxis

Community Midwife responsibilities:

- The midwife will assess the need for thromboprophylaxis and arrange an Antenatal Clinic appointment for a prescription of Low Molecular Weight Heparin (LMWH) and TED stockings. At this appointment administration will be discussed along with the risks and benefits of treatment. (Refer associated maternity VTE guidelines).
- Check for allergies, interactions and contra-indications.
- Assess bleeding risk.
- Communicate with the pregnant woman or birthing person verbally the indication for anticoagulation medication.
- Communicate with the pregnant woman or birthing person verbally how long the course is for and when to stop LMWH.
- Inform the pregnant woman or birthing person that LMWH is porcine based. This may be an issue for vegetarians/vegans and some religious groups.
- Train the patient on how to administer the injection; as they are self-administering, a sharps bin should be provided. Signpost to online maternity information on reducing the risk of blood clots.
- Inform the pregnant woman or birthing person of side effects of LMWH and the importance of reporting any symptoms of bleeding to their GP or A&E if severe.

Antenatal Clinic responsibilities:

- Arrange for Obstetrician to review and prescribe the LMWH after receiving request from the Midwife.

- Discuss risks and benefits of treatment
- Discuss administration of LMWH.
- Arrange prescription and collection by the pregnant woman or birthing person.
- Ensure advice is given re disposal of sharps and sharps box given.

Patient/carer responsibilities:

- To be responsible for administering LMWH as prescribed.
- To understand the potential for adverse events and report these to the GP, Triage or Community midwife.
- To check with the community pharmacist that there are no interactions with LMWH, when buying any over the counter medicines or herbal/homoeopathic products.
- To check with dentists or other specialists who may prescribe medicines that there are no interactions with LMWH.
- To inform healthcare professionals that they are prescribed LMWH.

10.0 Organising care in labour

10.1 SRH/WH

- When a pregnant woman or birthing person who is having a planned homebirth calls Maternity Triage, the triage midwife will contact the labour ward coordinator. The community team leader (during the day) or the Labour Ward Coordinator (during the day or night) will contact the on-call community midwife to attend to assess if the pregnant woman or birthing person is in established labour and provide appropriate midwifery care.
- It is the responsibility of the attending midwife to request a 2nd midwife to attend the birth or earlier should they require professional support.

10.2 PRH/RSCH

- Cover for homebirths is provided by the community midwives who carry all the required equipment in the designated homebirth pool cars.
- The triage midwife will contact the community midwife and inform the labour ward coordinator.
- If Telephone Triage is not manned, the calls are diverted to MAU and they will contact the community midwife and inform labour ward coordinator.
- Homebirth equipment, including neonatal resuscitation equipment, in homebirth pool cars must be checked daily and after each use by the community midwife using the vehicle and documented in the homebirth checking log in the vehicle. Homebirth equipment on labour wards must be checked daily and documented in the labour ward equipment checking log.
- Homebirth midwives attending from the labour ward must collect the homebirth equipment (unless using homebirth car where kit is already in situ) ensuring all drugs are available. These must include syntometrine, oxytocin, ergometrine, lidocaine 1% for maternal and vitamin K for neonatal administration.

- Portable entonox cylinders for pain relief must be carried in the appropriate transport bags and dealt with in accordance with the dangerous goods transport policy at all times (see RM30 Transport of Dangerous goods policy)

11.0 Intrapartum Care

- Midwives should follow associated care in labour and waterbirth guidelines.
- Midwives should follow Maternity fluid management guidance.
- Following initial assessment the attending midwife must contact the labour ward coordinator and update with an individualised care plan. For **PRH/RSCH:** Where no reply is received from the labour ward the midwife must call the hotphone on 01273 664422 for RSCH and 014444 48666 for PRH.
- The midwife should communicate with Labour Ward at least every 4 hours to provide an update and as soon as is indicated should a deviation from normal arise.
- If advice is required, the attending midwife should refer to the Coordinator on labour ward, the community team leader or the On-Call Midwifery Manager.
- Two midwives should be present for the birth. The attending midwife must request attendance of the second midwife by telephoning the labour ward and speaking to the labour ward coordinator unless the second midwife has been informed in advance and is contacted directly by the midwife in attendance at the birth. Pregnant women and birthing people in the second stage of labour must not be discouraged from pushing on the basis of waiting for the second midwife to arrive.
- It is the responsibility of the 2nd midwife to support the attending midwife and assist in maintaining contemporaneous record keeping on MIS.
- If a midwife is attending a pregnant woman or birthing person at a homebirth, the maternity service must send a second midwife at the request of the first midwife for support. If there are difficulties in providing a second midwife due to other clinical activity or staffing issues this must be escalated to the maternity manager on call.
- Where an attending midwife requires support in organising a second or relief midwife they must contact the community coordinator (or labour ward coordinator out of hours) who must deal with the request enabling the midwife to provide ongoing care.
- In circumstances where the home birth service is anticipated to be or is compromised due to staffing levels or the homebirth midwives are attending other homebirths, then early escalation is required by
  - The homebirth midwife and labour ward coordinator (**PRH/RSCH**)
  - Community Team Leaders, on-call community midwives and labour ward coordinator (**SRH/WH**) and see appendix 5.

12.0 Intrapartum transfer of pregnant women and birthing people from community to hospital

The following guidance has been developed to ensure that appropriate communication occurs between the community midwife and the Labour ward and that care is maintained when any pregnant woman or birthing person has been transferred in labour or postpartum for emergency reasons.

12.1 Indications for Transfer to Labour Ward

Any indication for transfer into the obstetric unit must be discussed with the pregnant woman or birthing person and their partner and consent for transfer obtained. All transfers must be by ambulance.

Transfer should be considered in discussion with the Coordinator for the following indications (this list is not exhaustive):

Maternal and birthing parent indicators
• Maternal or birthing parent request. • Maternal or birthing parent request for epidural in labour. • Concern regarding maternal or birthing parent observations. • Antepartum haemorrhage. • Positive fluid balance >1500mls. • Rupture of membranes more than 24 hours before the onset of established labour.
Intrapartum indicators
• Delay in the first or second stage of labour. • Intrapartum haemorrhage. • Fetal heart rate below 110 or above 160 beats/minute. • A deceleration in fetal heart rate heard on intermittent auscultation (unless birth is imminent). • Need for continuous electronic fetal heart rate monitoring due to non-reassuring fetal heart rate. • Need for continuous electronic fetal heart rate monitoring due to hypertonic uterus. • Inability to locate or monitor fetal heart rate. • Pain reported by the woman or birthing person that differs from the pain normally associated with contractions. • Any abnormal presentation, including cord presentation. • Significant meconium stained liquor (taking into consideration stage of labour and imminence of birth). • Suspected anhydramnios or polyhydramnios. • Suspected chorioamnionitis. • Retained placenta. • Obstetric emergency such as postpartum haemorrhage. • Third / fourth degree tear or other complicated perineal trauma.
Neonatal indicators
• Neonatal resuscitation. • Baby with suspected infection or unwell. • Suspected birth trauma.

- Suspected congenital abnormalities.
- Baby who requires transitional care.
- Jaundice at birth.

12.2 Process for transfer

- Any call for ambulance attendance and support must not be delayed if resuscitation is required. Organising appropriate additional support is the priority, with emergency resuscitation commenced immediately by the second midwife, if present, or after arranging assistance if only one midwife is in attendance.
- The lead midwife is to dial 999 and state **'obstetric emergency'** if there is risk to the mother or baby eg major APH, intrapartum haemorrhage or PPH, compromise of the neonate / fetus, FH amomaly, thick meconium, maternal or birthing parent compromise, undiagnosed breech, cord prolapse.
- If not an immediate risk to mother or baby, to state not an obstetric emergency but still require ambulance support and answer call handlers questions to determine speed of response indicated.
- If the clinical situation dictates the midwife should request the birth partner telephone 999 giving guidance by using the birth supporter prompt card (See appendix 6) from the home birth equipment or giving verbal instructions. Consider having the phone on loudspeaker.
- The midwife must contact the labour ward and inform the labour ward coordinator that a transfer is being arranged. The midwife must ensure when speaking to the labour ward coordinator that relevant, clear information is given using SBAR:
  - Name and address of the pregnant woman or birthing person
  - Gestation and parity
  - Reason for transfer
  - Length of time in labour
  - Membranes intact or ruptured - colour of liquor
  - Cervical dilatation
  - Contractions- rate and strength
  - Fetal heart rate
  - Maternal or birthing parent condition
  - Length of time with the pregnant woman or birthing person
  - Blood loss where appropriate
- The pregnant woman or birthing person and their relatives must be kept informed at all stages of the arrangements and transfer.

12.3 Care during transit

- On arrival of the ambulance the midwife remains the lead professional assisted by the ambulance crew who will work collaboratively to ensure the safe transfer to hospital.
- The midwife must use professional judgement as to re-assessment of cervical dilatation immediately prior to transfer. In some emergency situations birth of the baby at home with support may be the safer option.

- The midwife will need to be seated safely in the ambulance. The only mitigation to be out of your seat in a moving ambulance is if the patient requires lifesaving/time critical care/intervention.
- Inform labour ward of any changes in the situation on route via ambulance control.
- If the transfer is following the birth, and the baby is well, the baby can be put in the car seat and transferred by car with a relative. The baby will be secured on the stretcher using the ambulance child restraint straps. If mother or birthing parent is well/stable they can travel with baby on a chair. A baby is never able to be free and lose in mother or birthing parent's arms.
- In absence of a second midwife, babies should be transferred under the sole care of the ambulance crew. The midwife's responsibility is to remain with the mother or birthing parent until a minimum of one hour post-birth of the placenta and their condition is stable. See Appendix 7: Ambulance transfer flowchart. For a birth where both the mother or birthing parent, and the baby require intervention, two ambulance vehicles will be sent.
- The midwife must assess the need for intravenous cannulation at the start of the emergency situation and in consultation with the ambulance crew prior to transfer if not already done.
- The midwife must accompany the pregnant woman or birthing person in the ambulance for all intrapartum transfers. In no circumstances should an emergency transfer be by car. Should a pregnant woman or birthing person or their birth partner suggest independent transfer they should be counselled against this and full documentation must be made on MIS. The Manager on call will need to be informed.

12.3.1 Birth en-route to obstetric unit

- Request the ambulance to pull over enabling ambulance crew to give full support and work collaboratively to attend to the birth.
- The midwife must ensure stabilisation of the mother or birthing parent and the ambulance crew will assist with stabilisation of the baby to ensure the best possible care is provided for both mother or birthing parent and baby.
- Following birth the ambulance crew will notify the nearest maternity unit of impending arrival. This may not be the unit of original intention. If diverting to a secondary unit they will inform original unit of change of plan.

12.4 Hospital preparation

The Senior Midwife on the labour ward will alert the Registrar on duty in readiness for the pregnant woman or birthing person's arrival.

- The labour ward coordinator must ensure a room is prepared and consider the need for immediate admission to theatre or treatment in accident and emergency on arrival.
- The on-call obstetric registrar or consultant obstetrician, neonatologist and anaesthetist must be informed as appropriate. It may also be necessary to ensure lifts are available and doors open to ensure the earliest access to emergency treatment.

12.5 Handover

- The community midwife accompanying the pregnant woman or birthing person, should complete an SBAR and use this to hand over relevant information about the case to the Registrar and the hospital midwife providing care. The community midwife may wish or be required to continue care until cover organised. Transfer must be reported on Datix.

12.6 Decline to be transferred into the obstetric unit

- If the pregnant woman or birthing person declines transfer they cannot be transferred against their wishes. The attending midwife must ensure the pregnant woman or birthing person has made a fully informed decision, and continue to provide care to the best of their ability, seeking the support of labour ward coordinator and/or the manager on call.
- Where the indication for transfer gives increased concern for the health of the baby the potential delay in accessing full neonatal services must form part of the discussion with parents. This should include possible recommendation for ex-utero transfer following birth.
- All discussion, advice and decisions must be clearly documented on MIS.
- Out of hours the On-call Midwifery Manager should be informed. An ambulance should be called, however it may be that the crew advise transfer but due to their capacity they may not stay.

13.0 Transportation of specimens & equipment

Transportation method	
Transportation of Entonox	Entonox cylinders need to be transported in the custom Entonox transportation bags. It is vital that you display the green and yellow diamond signs in your car window when transporting Entonox to and from homebirths.
Sharps	You should use sharps boxes with a purple lid at homebirths. This is because oxytocin in all forms is cytostatic.
Placenta	Placentas should be double bagged and transported in a yellow box with a red lid. (Yellow boxes with orange lid are for non-anatomical waste only).
Waste from Homebirth	Non-soiled waste can be disposed of in the house. Blood stained (but not infectious) waste needs to be transported in a UN3291 approved box for clinical waste. Offensive waste should be transported in a yellow bag with black stripes (tiger bag). Should there be an infectious case eg Hepatitis B then a Bio Hazard box will need to be collected from the hospital to transport the waste.
Instruments	Instruments/disposable instruments need to be put in a Tupperware box or the red bloods transporter box to bring them back to the hospital. Please check that the clips on red blood transporter boxes are secured firmly.

14.0 Postnatal Care

14.1 Before leaving the home after a homebirth

- Both midwives must stay at the home until placenta is safely delivered. Following assessment of the health of the mother or birthing parent and baby and need for support with any suturing the second midwife can leave the home.
- The primary midwife must remain in the home until satisfied the mother or birthing parent and baby are in a stable condition with all observations within normal limit. (refer to associated care in labour guidelines).
- Support with feeding must be given in accordance guidance on infant feeding. (refer to associated infant feeding guidelines).
- **SRH/WH -** Breastfeeding support from a Maternity Support Worker should be offered and Feeding Helpline details given.
- **RSCH/PRH -** Signpost the parents to Telephone Triage for feeding support overnight. Further support can be provided by community midwives and maternity support workers.
- The first void of urine must be documented and advice given (see maternity bladder care guidelines). If not voided before midwife leaves a member of the homebirth team will follow up and contact the pregnant woman or birthing person.
- The midwife to undertake oxygen saturation measurements on newborn prior to leaving the home. If readings suboptimal and in the absence of any risk factors/other concerns then the reading can be repeated in one hour. If the second reading remains suboptimal then transfer in should be advised. If the reading is normal then the midwife can leave the home. The reading must be repeated within the first 24hours of life.
- A full postnatal examination of the pregnant woman or birthing person and baby should be carried out before the midwife leaves to return to the hospital, and documented on MIS.
- Any deviations from normal regarding either the pregnant woman or birthing person or the baby should be discussed with the labour ward coordinator or community team leader.
- Before leaving, ensure the pregnant woman or birthing person is aware of the information page 'Potential Serious Conditions and Who to Contact' on the Postnatal Booklet on BadgerNotes. The pregnant woman or birthing person should be aware if any of these occur, they should be aware seek medical advice without delay by calling either 999 or Maternity Triage 01903 285269.
- Pregnant women and birthing people should be signposted to www.lullabytrust.org.uk baby check pages to help them assess whether their baby is unwell and safer sleeping advice. With 'red flags' for serious illness in young babies discussed. (Refer to postnatal care guidleines)
- The midwife must assess when the next home visit will be required, and organise this with the community midwives office. **SRH/WH -** this is done via the spreadsheet for community visits.
- The midwife must ensure that arrangements are made for an examination of the newborn to be carried out within 72 hours of birth. (Refer to neonatal examination guidelines)

- For those pregnant women and birthing people who choose to keep their placenta, give them the information sheet and ask them to sign the release form and scan into MIS. See appendix 8a and appendix 8b.
- If the pregnant woman or birthing person's blood group is Rhesus Negative it is the attending midwife's responsibility to ensure cord and maternal or birthing parent blood samples are taken and sent promptly to the laboratory. Within 24hrs (except at weekends) the results should be obtained. If Anti-D is required then arrangements must be made for administration within 72hrs of the birth within the hospital setting.

14.2 On-going postnatal care

- Selective home visits must be planned according to the pregnant woman or birthing person's individual needs.
- Appropriate care plans must be completed to ensure continuity of care during this period.
- Handover to health visitor care appropriately timed from 10 days onwards with any relevant information passed on.
- Please see postnatal guidelines for full recommendations on postnatal care.

15.0 Outpatient induction of labour

Should a pregnant woman or birthing person who has planned a homebirth require induction of labour then the choice of place of birth should be reviewed and a hospital birth should be recommended.

16.0 Freebirth and unattended homebirth (BBA)

16.1 Definition freebirth

Freebirthing is characterised as an active decision to birth without trained health professionals present, but where maternity care is readily available (Feeley and Thomson, 2016). Pregnant women and birthing people who choose to freebirth may engage in full or partial antenatal and postnatal care, or they may opt out altogether and prefer to carry out their own wellbeing checks (Feeley and Thomson, 2016).

16.2 Freebirthing and the law

Freebirthing is not against the law. Pregnant women and birthing people are not obliged to accept any medical or midwifery care or treatment during childbirth and cannot be compelled to accept care unless they lack mental capacity. (Birthrights 2017) No one can enforce their attendance at a birth.

It is not appropriate for healthcare professionals to refer a pregnant woman or birthing person to social services with concerns about the unborn baby, solely on the basis that they have declined medical support, as they are legally entitled to do this (Birthrights, 2017).

It is illegal for anyone present during the labour or birth, to be undertaking the roles of a midwife or doctor. According to Article 45 of the Nursing and Midwifery Order (2001), it is a criminal offence for anyone other than a midwife or registered doctor to 'attend' a woman or person during childbirth, except in an emergency. Birth partners, including doulas and family members, may be present during childbirth, but must not assume responsibility, assist or assume the role of a midwife or registered medical practitioner or give midwifery or medical care in childbirth.

16.3 Freebirthing Choice

All health professionals should understand that there are many reasons why pregnant women and birthing people make the decision to have a 'freebirth'.

- Some pregnant women and birthing people choosing to have an unassisted birth have had a previous negative personal or traumatic experience of maternity services; they perceive the risks of attending a hospital to give birth as being greater than giving birth unassisted at home and they see 'interference' in the birth process as a risk.
- Pregnant women and birthing people may feel that freebirth is the only way that they can retain choice, control and autonomy over their bodies during the birth process (Feeley and Thomson, 2016; Holten and de Miranda, 2016; Plested, 2014; Jackson, Dahlen and Schmied, 2012).
- During the COVID-19 pandemic there may be additional reasons why pregnant women and birthing people do not wish to attend hospital to give birth; these relate to concerns about them or their baby contracting the virus; or because they fear their partner may not be able to be with them during labour and birth (particularly if their partner has symptoms of COVID-19).

A number of key sections of the NMC Code set out the responsibilities of midwives, that can be related to caring for pregnant women and birthing people who identify that they wish to give birth without assistance or choosing to give birth at home outside of recommendations for homebirth. (NMC 2018)

16.4 Professional's communication with the pregnant woman or birthing person and their partner

When a pregnant woman or birthing person indicates that they plan to give birth without assistance, the community midwife should reach out to the pregnant woman or birthing person to build a relationship and professional dialogue.

- Acknowledge the pregnant woman or birthing person's choice as belonging to them.
- Arrange for an extended appointment to spend time talking with the pregnant woman or birthing person (and their partner, if appropriate) to understand more fully their concerns and reasons.
- During the conversation(s) give time for the pregnant woman or birthing person to share what is important to them in relation to their psychological and physical safety.

- Consider any underlying history such as previous birth trauma that may impact on decision making. Consider potential benefits of offering psychological support via Perinatal mental health Midwife/team or Consultant Midwife.
- Ensure that there is an opportunity to have a one to one conversation with the pregnant woman or birthing person about their wishes and plans, without the presence of a partner or other family members. Consideration should be given to the possibility of coercion or pressure being placed on the woman or person to have an unassisted birth. (See safeguarding section 16.7)
- Spend time explaining and providing the evidence about any particular individualised risk factors for them and their baby of their intended birth plan.
- Identify any misconceptions or misunderstanding about current practice or service provision in the area and provide the pregnant woman or birthing person with accurate information.
- Indicate the need for the pregnant woman or birthing person to take full responsibility for any outcome if a trained professional is not in attendance at the birth.
- Avoid comments that imply a judgemental approach about choices made, as labelling pregnant women and birthing people as deviant or bad may reinforce their decision to disengage with services (Nolan 2011).
- Avoid revisiting the information and discussions at every visit, this may be perceived as bullying or coercive and is likely to alienate the pregnant woman or birthing person (Nolan 2011).
- If possible, provide continuity of midwifery carer during the antenatal period to enable a relationship of trust to build and support on-going dialogue.
- Work towards a plan of care, including how to seek help should any emergency situation arise.
- Reassure the pregnant woman or birthing person that they will continue to be offered usual antenatal and postnatal care even if they decide to have an unassisted birth.
- Reiterate that they can access care at any point should they need or want to and offer referral to an obstetrician if any clinical assessments fall outside the norm.
- Ensure that the pregnant woman or birthing person has contact numbers for the midwives, maternity and emergency services should they change their mind or need assistance in an emergency.
- Advise the pregnant woman or birthing person how to notify and register the baby's birth (see section below).
- Inform the pregnant woman or birthing person about the role of the health visitor and GP in relation to their child and advise that it is in the best interest of the child's health and wellbeing to engage with these professionals.

16.5 Referral and escalation

- Inform Community Team leader/Matrons of all pregnant women and birthing people that plan to free birth.
- Pregnant women and birthing people to be offered a referral for additional birth planning support with the teamleader or matron ideally < 36/40.
- Birth plan to be completed by community midwife or community team leader / matron and ensure it is uploaded / evident on the maternity information system.

16.6 Notification of birth:

As there are legally defined time limitations for notification of birth which must be adhered to if the midwife was not present at the birth (36 hours in the Notification of Births Act 1907), Parents must be given information about the process for notification and registration of the birth.

16.7 Safeguarding

If midwives have worries about safeguarding or the mother or birthing parent's psychological or mental health they should be encouraged to consider the mother or birthing parent's 'capacity to Act' in line with the 'Mental capacity Act' 2018 (England and Wales)and have a low threshold for advice/referral to appropriate professional.

Planning or having a freebirth in itself is not a reason to refer to social services. A holistic assessment must be done, including if possible examining the pregnant woman or birthing person's reasons and motivations towards freebirth and eliminating the possibility of coercion from any other person. However should there be concerns other than just the decision to freebirth then a referral should be made.

If there are concerns that the pregnancy is concealed then refer to the Safeguarding guidance.

16.8 Documentation

All meetings and discussions with the pregnant woman or birthing person to be documented on MIS in the relevant sections.

When completing and registering the birth on MIS, the birth currently will need to be declared as a BBA. Please add in a clinical note if the birth was a freebirth for audit reasons.

16.9 Baby born before arrival (BBA) of medical or midwifery aid

On receiving information that a baby is being born without the presence of midwifery or medical aid the midwife must:

- Contact ambulance control and request attendance at the home address of an ambulance clearly stating all known details.
- Arrange for two homebirth midwives (unless ambulance crew present and baby and placenta have been delivered) with appropriate equipment to attend the home without delay ensuring they are aware of all known risk factors. The labour ward coordinator should arrange for these two midwives to attend the address together. MIS should be checked by the midwife taking the call to check for any issues.
- In the event of suspected freebirth and assistance by community midwives is declined, midwives still have a duty of care. There will be guidance from the Local Maternity and Neonatal System (LMNS) surrounding this in the future. The coordinator and on-call obstetric registrar should offer to speak to the pregnant woman or birthing person. This should be documented on MIS even if declined.

- **PRH/RSCH -** If there is a delay in contacting a homebirth midwife, a midwife from the labour ward should attend taking the appropriate home birth equipment. If unable to facilitate sending a midwife from labour ward then escalate to manager on call / community team leaders.
- On arrival the midwife must assess the safest course of action as to remaining in the home or transferring to the nearest maternity unit.
- If both mother or birthing parent and baby are low risk, and all is well, the midwife can suggest for them to remain at home. The midwife must ensure the pregnant woman or birthing person has sufficient support and consents to remaining at home.
- If transfer to the maternity unit is indicated the process for transfer as above must be followed.
- All equipment and clinical waste must be dealt with as for planned home birth as above.
- All BBAs should be reported via Datix.

17.0 Suspension of Homebirth Service

The maternity service aims to provide a home birth service 24hrs a day, 7 days a week. The suspension of the service should only be in extreme circumstances.

All decisions to suspend the home birth service should be taken in collaboration with the Senior Midwifery Manager and the manager on call. See *UHSC022 Maternity Escalation Policy*.

18.0 Monitoring

- All BBAs (Born before Arrival) are reviewed as part of by the Patient Safety Team as part of the DATIX system.
- Any planned homebirths that are transferred into hospital are reviewed by the Patient Safety Team as part of the DATIX system.

SRH/WH - A spreadsheet of equipment checks is completed weekly by all community midwives and compliance is audited.

PRH/RSCH - Equipment checks is completed daily by all community midwives and compliance is audited.

Appendix 1: Lone worker checklist

Before undertaking any home visits	Tick when complete/read
All community staff members to have completed mandatory training on conflict resolution.	
Ensure contact details for staff members are up to date and accessible.	
Planning for a homebirth/home visit	**Tick when complete/read**
Staff to highlight any concerns about client / partner / family to Team Leader / Community Manager.	
Check MIS for alerts.	
Check with GP surgery for alerts and update Team Leaders / Community Manager.	
Ensure homebirth risk assessment has been undertaken and documented on MIS.	
PRH&RSCH - Ensure community office aware of time of visit and communicate with community office when visit is complete. **SRH&WH -** Liaise with labour ward.	
PRH&RSCH - Ensure that all visits are brought in or phoned into office at end of shift.	
Do not do lone visits if client / partner / family are known to be aggressive / violent. Make clients aware that two health professionals will visit.	
Document any concerns and escalate to Team Leader / Community Manager.	
PRH&RSCH - Check that first aid kit is available either in pool car of homebirth bag.	
During visit	**Tick when complete/read**
All community staff to keep mobiles with them switched on during home visits at all times.	
Keep ID badge visible.	
Be alert to warning signs of aggressive behavior: All staff to have completed conflict management (every 3 years).	

If community staff feels that there is any risk, to leave appointment as quickly and as safely as possible. If unable to leave then to call colleague for help: • **Say on phone "I am at *patients name* at *address.* Can you check the red homebirth folder and let Sally O'Sullivan know that I'm going to be late to see her please."** Colleague then should be prompted to say "do you need the police?" and call for relevant help and escalate to managers.	
When parking: • Ensure that no personal possessions are visible • Look out for street lamps and junctions and park nearby, so that the car can be seen easily. • Park car facing towards direction of exit.	
When in client's home always be aware of entrances and exits, to enable quick escape if required.	
Be aware of positioning of equipment that potentially could cause harm.	
Be aware of your position in room in case of needing to escape, i.e. avoid corners of rooms.	
Use appropriate security measures e.g. mobile phones/trackers on cars.	
If no contact from community staff member at agreed time with community office / buddy / labour ward coordinator: • Call community staff member. • Check wellbeing by using passwords. • **If problem community staff member to say on phone "I am at *patients name* at *address.* Can you check the red homebirth folder and let Sally O'Sullivan know that I'm going to be late to see her please."** • Colleague then should be prompted to say "do you need the police?" and call for relevant help and escalate to managers. If unable to contact community staff member within reasonable time limit (30 minutes) or if they have any concerns to call police on 999.	

Appendix 2: Homebirth advice & checklist

HOMEBIRTH ADVICE

The aim of this leaflet is to provide you with information about having your baby at home.

If you are healthy and have had a normal pregnancy, home birth can be a safe option. Your midwife will be happy to discuss this with you.

In exceptional circumstances if a midwife is not available to come to your home for the birth of your baby you will be asked to come into the maternity unit.

Who will attend my baby's birth?

During the day a midwife from your community team will attend your homebirth and at night there is an on call system from the whole community midwifery team. Normally two midwives will be present for the birth and (with your permission) a student midwife may also attend. Note: There may be occasions when your team are unavailable during the day in which case another midwife will attend.

How do I contact the midwife?

Contact the midwife via:

Telephone Triage	**01903 285269**

The midwife taking your call will take your details and discuss your stage of labour with you, please ensure you advise the midwife the hospital you attended for scans. The midwife will arrange for the community midwife to telephone or visit you depending on how quickly labour seems to be progressing.

When should I phone?

You should contact the labour ward at any time of day or night if you have any worries or concerns. If labour begins during the day it is helpful to inform us early in case the midwife needs to reorganise her workload. If labour begins at night, contact the triage line when the contractions are five minutes apart or whenever you feel the need for advice. If your waters break please inform us as soon as possible. When your labour is confirmed, a midwife will stay with you.

How can I help the midwife get to my home?

It is helpful to use the ***'what3wordsapp'*** especially if your home is not easy to find. If the midwife is attending you at night please put on your house lights until she has arrived. Please advise where to park if access is difficult.

Who can be with me during the birth?

You can have whoever you would like to be with you in labour. Most women choose to have a birth partner (or support person) present for support in labour. This may be your baby's father, a relative, friend or doula.

What about my children?

You may want your children to be with you or you may wish to arrange for them to stay with family or friends. If your children stay, it is sensible to have someone to look after them especially should you require to be transferred into the hospital. Feel free to discuss this with your midwife.

What do I need to arrange/supply?

- A good portable light with an adequate extension lead or a good torch with batteries in and a willing hand to hold it!
- A handheld mirror for the midwife to visualise external progress if you are in certain positions or in the pool.
- Adequate heating in the room you plan to give birth in Hot water bottle or radiator to warm the baby's clothes
- A clean/hot water supply
- A measuring jug (to measure urine)
- Plastic sheet / shower curtain to protect bed and floor
- Old clean sheets and towels (a good supply)
- Packet of incontinence pads or bed / change mats
- Two packets of maternity sanitary towels and old or disposable underwear
- Overnight bag for you and baby in case transfer to hospital is needed
- Refreshments for the midwife would be appreciated.
- Please ensure that there is a good mobile phone signal or landline

For the baby:

- Two soft towels (old but clean)
- A vest
- A baby grow or night-dress
- A cardigan and hat
- Nappies Cotton wool Cot sheets and blankets

What equipment is carried by the midwives?

Your midwife will provide:

- Equipment for the birth Entonox (gas and air)
- Resuscitation equipment
- Paperwork

Pain Relief

You might like to hire an obstetric TENS machine to help with pain relief at home. Your midwife can advise you where to hire one from and how to use it.

You may also like to use a pool for pain relief which you can either hire or buy.

Please do not get into the water until the midwife is with you. If you do hire a pool then please discuss with your midwife how you would leave the pool in case of an emergency.

How will the midwife monitor my wellbeing during labour?

Throughout your labour the midwife will take your temperature, pulse and blood pressure.

She will encourage you to empty your bladder at regular intervals for your comfort and to ensure that the bladder does not become over full.

The midwife will ask you if she can listen to your baby's heartbeat and rate at regular intervals. She will use a handheld Sonicaid to do this (the same used by your community midwife at your antenatal appointments). Every 15 minutes is recommended throughout the first stage of labour (before you are fully dilated) for at least one minute following a contraction. In the second stage of labour (when you are fully dilated and want to start pushing), the midwife will listen every five minutes.

Transfer to Hospital

You may decide you want to transfer to hospital or the midwife may advise you that transfer is necessary. If transfer is required, the journey will be made by ambulance so that traffic can be easily negotiated and good communication links with the hospital team can be maintained in the event of difficulty. The midwife will accompany you, and your partner will be asked to follow in their vehicle. Any transfer is always discussed with you and your wishes taken into consideration. In the unlikely event of you being unwilling to accept the advice of the midwife and you decline hospital transfer, the midwife will inform the most senior midwife on shift or the midwifery manager on call out of hours, and continue your care at home.

It must be appreciated that the midwife does not have access to the more sophisticated equipment and medical expertise that is available in hospital.

Reasons to transfer:

- There is concern over the baby's heart rate
- Abnormal bleeding
- Labour is not progressing
- The midwife has concerns about your wellbeing this will include urinary output
- There is significant meconium in your waters
- You have raised blood pressure
- You request stronger pain relief
- You need stitches and the tear is too complex to repair at home
- The placenta does not deliver
- There is concern about your baby after the birth

What happens after the birth?

The midwives will stay with you for at least one hour after the birth of your baby. They will check you and your baby, write the notes, help with feeding and with your permission, administer Vitamin K to your baby. When they are happy that all is satisfactory, they will leave you but will ensure that you have telephone numbers which you can call if you have any worries or concerns at any time (24 hour service).

Your midwife will discuss your postnatal care and make a plan of care with you.

She will advise you when to expect your next visit.

A newborn check is arranged to take place within 24 hours of the birth, the newborn check will be carried out in your home if possible but if this is not possible, you will be asked to take your baby to the postnatal ward.

If you have a rhesus negative blood group and require postnatal Anti D, it will be necessary to attend the hospital to have this administered as we do not give this injection at home.

What are the risks and benefits associated with a homebirth?

There are risks and benefits wherever you decide to have your baby, but giving birth is generally very safe. Research shows that a planned homebirth is at least as safe as a hospital birth for healthy women with normal pregnancies. It is associated with good outcomes for both mothers and babies. Women who choose a homebirth are less likely to have a Caesarean section, less likely to have an instrumental delivery and have a lower risk of haemorrhage. Babies who are born at home are less likely to have birth injuries and are less likely to need resuscitation. However, if a transfer to hospital during labour is necessary, there could be some delay while an ambulance is organised and this may affect the outcome for you or your baby.

Research shows that 1 in 3 of first time mothers will require transfer from home to hospital. This is often because a first labour can be longer. The transfer rate for women having their second / subsequent baby is approximately 1 in 8. Induction of labour If you do not go into labour and an induction of labour is arranged then your care will be transferred to the hospital team.

Appendix 3: Equipment and preparation for homebirth

Equipment checking

- Each midwife is responsible for checking their equipment is clean and working and in date.
- **SRH/WH -** A spreadsheet of equipment checks is completed weekly by all community midwives.
- **PRH/RSCH -** Equipment checks is completed daily by all community midwives.
- Midwives bag and homebirth equipment to be checked weekly and complete safety standard spreadsheet.
- Observe the storage instructions for the following drugs: Konakion, Syntocinon, Syntometrine and ergometrine (See Appendix 2).
- By 36 weeks - complete birth plan.
- Complete home birth checklist embed into MIS.
- Arrange for presentation scan between 36 - 37 weeks for all planned homebirths.
- **SRH&WH -** By 38 weeks for SRH midwives, or at time of labour for WH midwives, ensure availability of Entonox (if required) and sheet of patient stickers, path forms if rhesus negative.

- ☐ Antiseptic hand gel
- ☐ Gloves – sterile & non-sterile
- ☐ Long gauntlet glover for pool births
- ☐ Aprons
- ☐ Mirror
- ☐ Amnihook
- ☐ Speculum
- ☐ Incopads
- ☐ Delivery pack
- ☐ Cord Clamps
- ☐ Lubricant gel sachets
- ☐ Instilagel
- ☐ Catheter in-dwelling
- ☐ Sterile water
- ☐ Catheter bag hanger
- ☐ Placenta bag & bin
- ☐ Tiger waste bag

Drugs:

- ☐ Vitamin K & oral syinges
- ☐ Lignocaine 1%
- ☐ Syntometrine
- ☐ Syntocinon 10 units
- ☐ Ergometrine

Vaginal suture pack:

- ☐ Sterile swabs – variety of sizes
- ☐ Variety of needles and syringes
- ☐ Vicryl rapide
- ☐ Sharps box

IV cannulation kit:

- ☐ Venepuncture equipment
- ☐ Variety of venflons including grey
- ☐ Chloraprep
- ☐ Tegaderm dressing
- ☐ Disposable tourniques
- ☐ Non-sterile swabs
- ☐ Flush
- ☐ IV bungs / swan locks
- ☐ IV giving set

Resuscitation Kit:

- ☐ Adult pocket mask
- ☐ Neonatal ambi bag and size 1 and 00 masks
- ☐ I-gel airway
- ☐ Suction

Diamorphine at homebirth – if a patient requests diamorphine, it is their responsibility to obtain a prescription from the GP and return to pharmacy if unused.

Appendix 4: Storage of drugs carried by Community Midwives

Konakion MM Paediatric (Vitamin K- phytomenadione)

- Manufacturer: Cheplapharm Arzneimittel GmbH
- Ampoule solution should be stored below 25°C and be protected from light. The solution should not be frozen. Do not use if the solution is turbid.

Syntocinon (Oxytocin)

- Manufacturer: Mylan/Novartis.
- Recommended storage conditions are between 2°C and 8°C.
- Can be stored at up to 30°C for up to 3 months, but must then be discarded. This product should not be returned to the fridge.

Syntometrine (ergometrine with Oxytocin)

- Manufacturer: Alliance.
- Recommended storage conditions are between 2° and 8°C. Protect from light.
- According to Specialist Pharmacy Service, when protected from light, the product is stable for up to 6 months at 25°C. Prolonged exposure to light may result in a loss of active substance.

Ergometrine

- Manufacturer: Hameln.
- Recommended storage conditions are between 2°C and 8°C. Protect from light.
- Accelerated stability testing by the manufacturer found that a sample of 1000 ampoules of ergometrine were within licensed specification after 3 months at 25°C. This testing was conducted under controlled conditions and may not be representative of general practice, for example when stored in a healthcare professional's bag or exposed to light or fluctuations in temperature.

If different a manufacturer used please refer to:
https://www.sps.nhs.uk/home/tools/refrigerated-medicines-stability-tool/

Appendix 5: Provision of homebirth service (SRH/WH only)

When the home birth rota is affected either by sickness, community midwives being called into the unit or community midwives at another homebirth the following options should be considered before the homebirth service is suspended.

- Community midwife from opposite site (see below)
- Consider any assistance from the core midwives.
- Midwifery manager on call.

When the community midwife has worked for in excess of 12 hours without more than one hour break then recognition must be given for their continued fitness to practise.

Consideration should be given to them being replaced by the second on call midwife if birth is not imminent. Arrangements should then be made for a substitute second on call. This may be from the list as described as above.

If there is no midwife to fall back upon then the last resort would be for the labouring woman to be transferred into the unit. The Birth Centre should be her first option.

Homebirth Staffing arrangements for SRH/WH

- If both sites have 2 midwives the homebirth service runs independently on each site.
- If one site has 1 midwife and the other has 2 midwives - homebirth service can continue with support from other site - this needs to be checked on case by case basis - if 2 midwives already out then the single midwife can only attend a BBA.
- If both sites have 1 midwife - suspend on both sites unless the core midwives are able to support.

Please note:

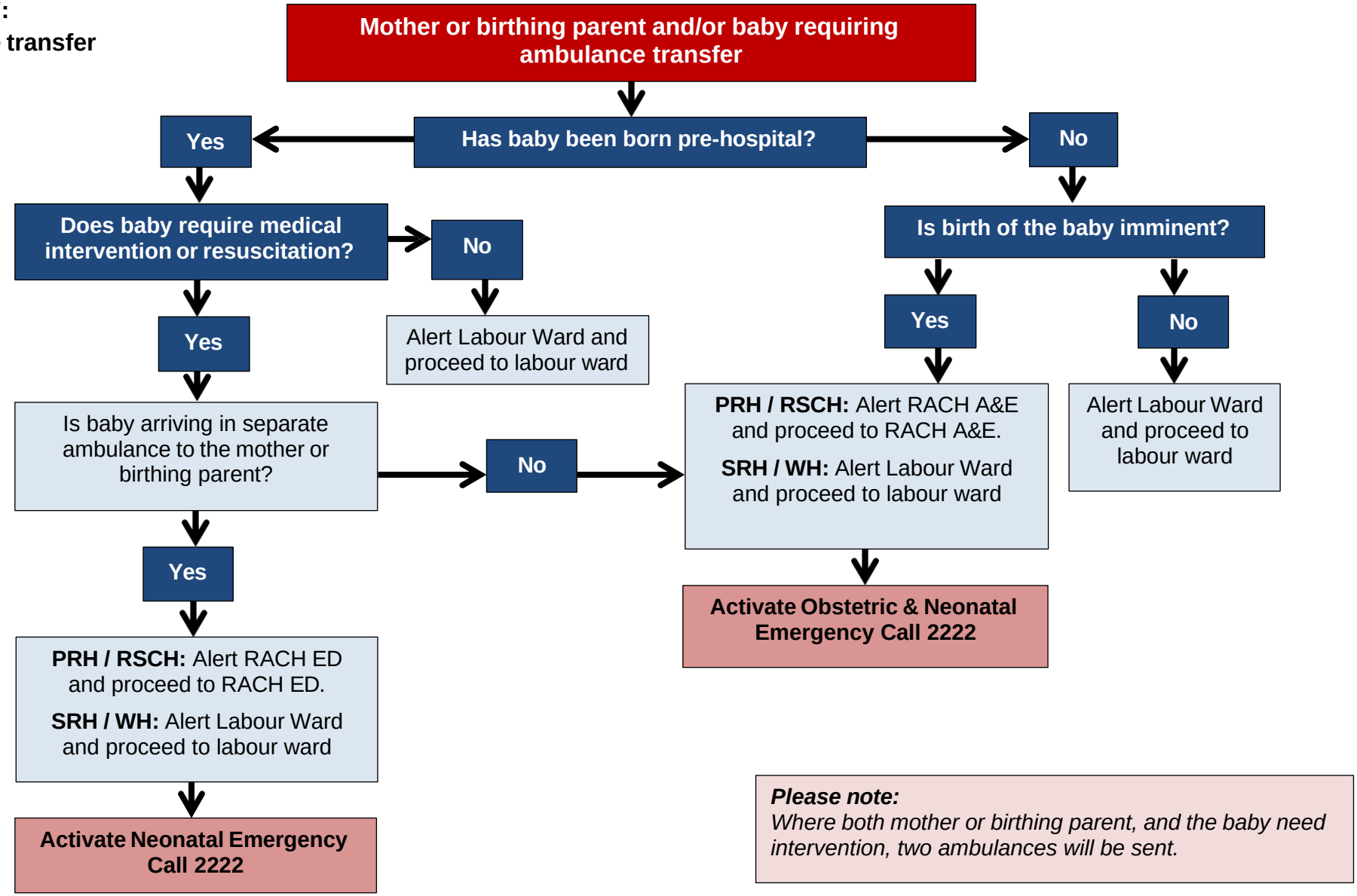
- Under no circumstances can a midwife be sent to a homebirth without confirmation that the second midwife can attend.
- Need to take geography of where the midwives live and address of homebirth - safety of travel time especially for the return journey into consideration.
- Consideration should be given to closing the homebirth service should there be 4 or less midwives working in the units.
- If the community midwife is called in to work in the unit the agreement is that this is for 4 hours.
- Consideration of the impact of calling in the community midwives especially at the weekend - this severely depletes the capacity for covering community work the following day.
- Community midwives are pre-warning all planned homebirths that sometimes the service has to be suspended for safety reasons.

- if a homebirth labours and is asked to come into the unit please consider the option of calling in the community midwife so that they can provide care on the birth centre at SRH or the low risk area in WH.

Appendix 6: Prompt card for partner to call 999

Call 999 (first call)	
Ask for	An ambulance
Give	Information required - name, address & contact number
Tell them	Emergency at homebirth & the midwife is in attendance
Tell them	The emergency is (the midwife will tell you which to say): • Severe fetal distress (baby still inside) • Shoulder dystocia (baby Is stuck) • Unexpected breech birth (baby bottom/feet/foot coming down first) • Cord prolapse (cord coming down first) • Antenatal haemorrhage or postpartum haemorrhage (maternal bleeding) • Baby requiring resuscitation • Mother or birthing parent requiring resuscitation
Inform your hospital (second call)	
PRH	01444 448666 (Labour ward hotline)
RSCH	01273 664422 (Labour ward hotline)
SRH	01243 788122 ext 32961
WH	01903 205262
Ask for	Midwife in charge
Tell them	• Home birth. • Describe emergency as told by the midwife. • Name of woman or birthing person, address and contact number. • Midwife in attendance. • Ambulance called and on way.

Appendix 7: Ambulance transfer flowchart



Please note:
Where both mother or birthing parent, and the baby need intervention, two ambulances will be sent.

Appendix 8a: Releasing placentas to parents – Information sheet for parents

This information is intended to guide you through how to safely transport and dispose of your placenta if you decide to take it home with you (or to keep it at home following a home birth).

A placenta provides a perfect environment for micro-organisms to grow. There are some standard precautions you should be aware of for your health and safety and that of others in your household. In order to reduce the risk of spreading infections, the following steps should be followed:

1. The placenta should be put in 2 bags, each sealed separately and then placed into a leak-proof, sealed container to transport it home in. Once sealed, the container should not be re-opened until you arrive home.

2. A placenta will deteriorate quickly and should be stored in a fridge that does not contain any food for no more than 48-72 hours before it is disposed of.

3. While the risk of getting an infection from a healthy placenta is low, standard hygiene precautions should be followed, including handling it as little as possible, avoiding contact with food and drink, wearing protective gloves and always washing your hands thoroughly after any contact with it.

4. Avoid contact between blood from the placenta and breaks in the skin such as cuts, burns or sores. If blood does contaminate any of these areas, wash the area immediately with soap and water.

5. As a placenta is not considered ‘bodily remains’ there is no law to prevent you from burying it at home. If you decide to do so, it is your responsibility to ask your local council if there are any applicable guidelines and to follow them.

6. It is suggested that you bury the placenta at a depth of no less than 1 metre to prevent it being dug up by animals and becoming a potential source of infection.

7. The placenta should be free of any plastic cord clamps and not be buried in a plastic bag or container, due to not being biodegradable.

8. The placenta should not be buried in a location likely to contaminate a domestic water supply, near a river or on public land.

9. If you decide that you do not want to bury the placenta, it cannot be disposed of in a domestic waste bin. You may return it in a sealed container to the hospital for disposal.

Appendix 8b: Release of Placenta form

- I have received the information sheet 'Releasing placentas to parents' and have had the opportunity ask any questions.
- I understand that placental tissue is clinical waste and must be disposed of correctly.
- I take responsibility for the safe storage and disposal of the placenta. If not disposed of by myself, I understand it can be returned to the hospital for disposal.

Recipient's signature:

Print name:

Date:

_____

Staff signature:

Print name:

Date:

<u>Scan this form into MIS</u>

Patient label here

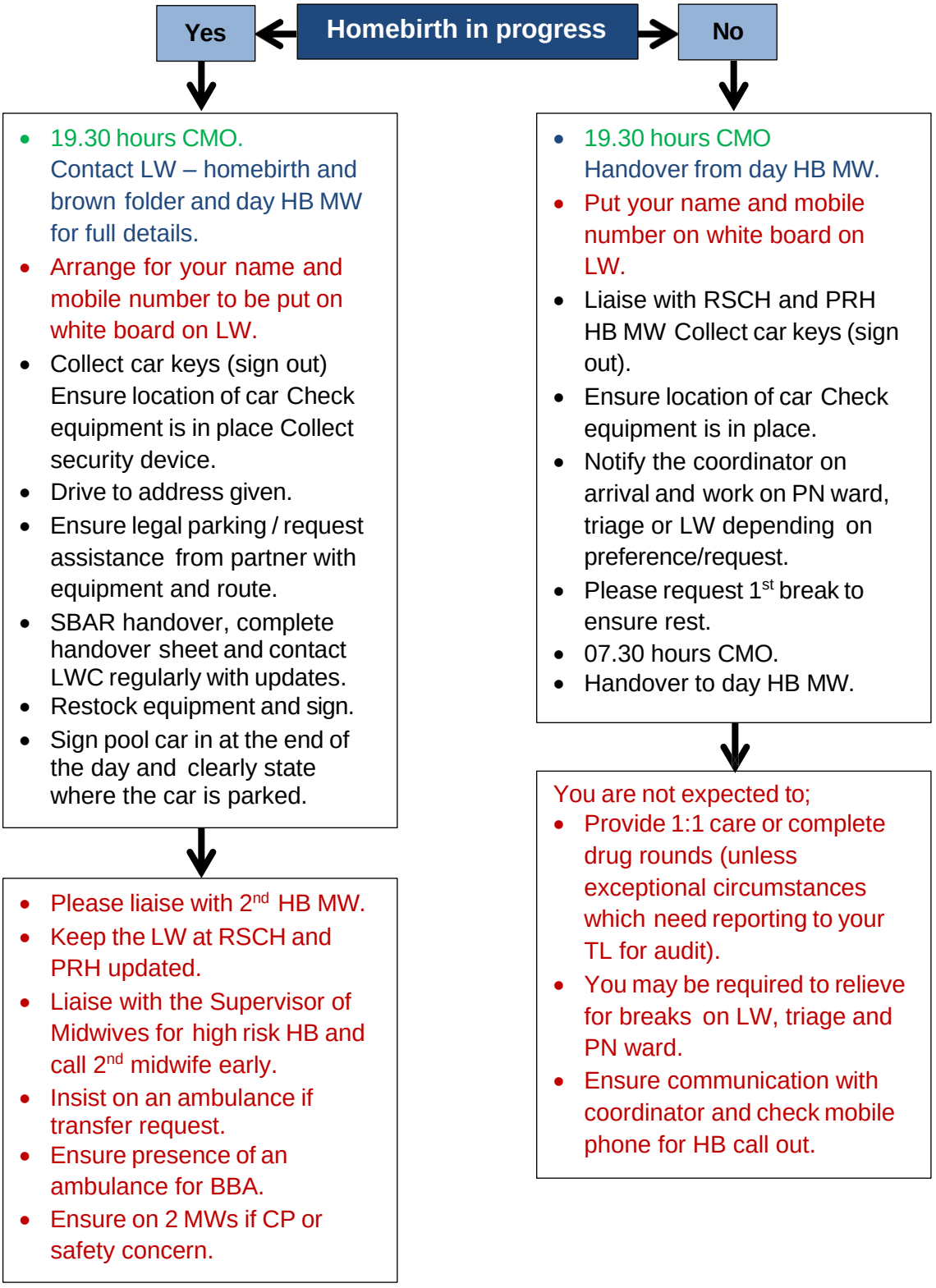
Appendix 9: Use of waterbirth pool at home

The use of pools at home for labour and birth is considered a low risk option for pregnant women and birthing people with uncomplicated pregnancies. Pools are recommended rather than baths, as they are deeper, wider and more accessible.

The following is suggested advice for those parents considering this as an option:

- Pools for use in labour and birth can be hired and bought. It is advised that this is done through reputable companies.
- It is the responsibility of the parents to ensure the equipment they use is safe and appropriate.
- It is recommended that the pool be disinfected with the appropriate cleaning solution to reduce the risk of infection. If the pool is hired or a reusable inflatable pool, a liner should be used.
- The pool should be used in an appropriate room, this should include consideration for:
    - The weight of a full pool the floor joists (ground floor is recommended where possible), a surveyors report may be necessary if the pool is not situated on a ground floor dues to its heavy weight. As a rough guide a fully filled birth pool has the equivalent weight of 10-13 adults.
    - The pool needs to be accessible from all sides, to ensure access for midwives in an emergency.
    - Topping up with hot water to maintain recommended temperature and keeping the water clean is the responsibility of the partner or doula.
    - The room needs to be draught free but with ventilation.
    - Consideration should be given for close access to a hot water supply and also drainage for the pool.
    - Consider how the pool will be topped up and emptied, during use.
    - A heat supply in the room, but this needs to be away from the pool.
    - Electrical sockets should not be near the pool.
    - A step should be provided for ease of entrance, but also for exit from the pool.
    - Have an area for pre and post birth care, outside of the pool area.
    -
- You should check with your home insurance company and where applicable landlord, that cover will be provided for use of the birthing pool at home.
- Waterproof covering of the area around the pool and /or material to ensure a slip free surface.
- A supply of large bath towels for mum and smaller towels for baby.
- It is useful to have a disposable sieve and a bath thermometer.
- You should have access to a constant supply of hot water, to ensure the correct temperature at all times. Along with this you should always check the temperature of the pool before entering it.

Appendix 10: Homebirth Shift Night Time 19.30-08.00 (PRH/RSCH only)



Remember you are working on the unit in a supernumerary agreement unless specific request by team leader, community manager or labour ward coordinator.

Appendix 11: Guideline Version Control Log

This should be included for all updated guidelines, summarising the changes between the current and previous version. (Earlier changes should be deleted from the list when the guideline is updated.)

Do not list minor and stylistic changes or changes which do not alter the processes described.

If the update includes a significant reorganisation of the material, indicate this and list the main areas where the process itself has changed.

Change Log – Homebirth & Freebirth

Version	Date	Author	Status	Comment
1.0	December 2023	G. Addison, HoM (SRH&WH) B. Elms, HoM (PRH&RSCH) J. Bell, Community Team Leader CE Team	LIVE	New Trust wide guideline replacing: • CG12032 Homebirth & Freebirth Guideline (legacy West) • MP060 Homebirth (legacy East) • MP063 Free Birthing (legacy East)

Appendix 12: Due Regard Assessment Tool

To be completed and attached to any guideline when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	Age	*No*	
	· Disability	*No*	
	· Gender (Sex)	*No*	
	· Gender Identity	*No*	
	· Marriage and civil partnership	*No*	
	· Pregnancy and maternity	*No*	
	· Race (ethnicity, nationality, colour)	*No*	
	· Religion or Belief	*No*	
	· Sexual orientation, including lesbian, gay and bisexual people	*No*	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	*No*	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	*NA*	
4.	**Is the impact of the document likely to be negative?**	*No*	
5.	**If so, can the impact be avoided?**	*NA*	
6.	**What alternative is there to achieving the intent of the document without the impact?**	*NA*	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the guideline should continue in its current form?**	*NA*	
8.	**Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?**	*Yes*	

If you have identified a potential discriminatory impact of this guideline, please refer it to [Insert Name], together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact uhsussex.equality@nhs.net 01273 664685).

Appendix 13: Template Dissemination, Implementation and Access Plan

To be completed and attached to any guideline when submitted to Corporate Governance for consideration and TMB approval.

	Dissemination Plan	**Comments**
1.	Identify:	
	Which members of staff or staff groups will be affected by this guideline?	Midwives and obstetricians
	How will you confirm that they have received the guideline and understood its implications?	Dissemination through the usual Communication channels and highlighted at Safety Huddles.
	How have you linked the dissemination of the guideline with induction training, continuous professional development, and clinical supervision as appropriate?	All new members of staff are shown where to access Clinical documents that are relevant to their area of practice.
2.	How and where will staff access the document (at operational level)?	Accessed by staff via Sharepoint

		Yes/No	**Comments**
3.	Have you made any plans to remove old versions of the guideline or related documents from circulation?	Yes	Previous versions will be archived as part of the uploading onto sharepoint process.
4.	Have you ensured staff are aware the document is logged on the organisation's register?	Yes	Dissemination plan includes notifying staff via email, safety noticeboards, departmental newsletter and social media.

Appendix 14: Additional guidance and information

Birthrights (April 2017) Information about consenting to treatment and assessment of mental capacity: https://www.birthrights.org.uk/factsheets/consenting-to-treatment/

Birthrights (April 2017) Unassisted Birth Factsheet. Available at: https://www.birthrights.org.uk/factsheets/unassisted-birth/

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Feeley C & Thomson G (2016) Why do some women choose to freebirth in the UK? An interpretative phenomenological study. BMC Pregnancy and Childbirth. Available at: http://bmcpregnancychildbirth.biomedcentral.com/track/pdf/10.1186/s12884-016-0847-6?site=bmcpregnancychildbirth.biomedcentral.com

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Holten L and de Miranda E 2016 Women's motivations for having an unassisted childbirth or high-risk homebirth: An exploration of the literature on 'birthing outside the system', Midwifery, vol 38, pp 55-62. https://www.ncbi.nlm.nih.gov/pubmed/?term=Women%D7%B3s+motivations+for+having+unassisted+childbirth+or+high-risk+homebirth%3A+An+exploration+of+the+literature+on+%E2%80%98birthing+outside+the+system

Jackson et al (2020) Birthing outside the system: the motivation behind the choice to freebirth or have a homebirth with risk factors in Australia, BMC Pregnancy and Childbirth, https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-020-02944-6

Mental capacity Act (2005) www.legislation.gov.uk

National Institute for Health and Clinical Excellence (2021) Antenatal Care – Routine Care for the Healthy Pregnant Women. Available at https://www.nice.org.uk/guidance/ng201

National Institute for Health and Clinical Excellence.2021. *Intrapartum care: Care of healthy women and their babies* NICE: London available at https://www.nice.org.uk/guidance/cg190

National Institute for Health and Clinical Excellence. 2021. *Postnatal Care*NICE:London available athttps://www.nice.org.uk/guidance/ng194

Nolan, M. L., (2011) Home birth: The politics of difficult choices Routledge Oxon

Nursing and Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses and midwives. https://www.nmc.org.uk/standards/code/

Nursing and Midwifery Council (2010) *Supporting women in their choice for home birth* London: NMC. Annexe 2 M/10/15.

The Nursing and Midwifery Order (2001)
http://www.legislation.gov.uk/uksi/2002/253/contents/made

Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort studyBMJ 2011; 343 doi: https://doi.org/10.1136/bmj.d7400 (Published 25 November 2011) Cite this as: BMJ 2011;343:d7400

Plested M and Kirkham M (2016) Risk and fear in the lived experience of birth without a midwife, Midwifery, vol 38, pp 29- 34 https://www.ncbi.nlm.nih.gov/pubmed/26948871

RCM (2020) Guidance for provision of midwife-led settings and home birth in the evolving coronavirus pandemic, version 1.1, 17 April 2020
https://www.rcm.org.uk/media/3893/2020-04-17-guidance-for-provision-of-midwife-led-settings.pdf

RCM Clinical Briefing Sheet: 'freebirth' or 'unassisted childbirth' during the COVID-19 pandemic
freebirth_draft_30-april-v2.pdf (rcm.org.uk)

Royal College of Obstetricians and Gynaecologists and Royal College of Midwives (2007) Home Births – RCOG and RCM joint statement number 2.

Royal College of Obstetricians and Gynaecologists (2015) Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium, Green-top Guideline No. 37a.