Home Birth Operational Guideline including management and risk assessment

University Hospitals of Leicester NHS
NHS Trust

Contents

1. Introduction and who guideline applies to:

The UHL Home Birth Team ensures pregnant women and people and their families are given appropriate information surrounding birthplace choice. They provide a dedicated homebirth service 24/7 and aim to increase the home birth rate in line with other Trusts.

Midwives are accountable for their practice and work in partnership with pregnant women and people and their families to give support, care and advice during pregnancy, labour and the postnatal period. Areas of clinical practice include the home, Community, Birth Centres and the Hospital setting. Midwives practicing within low-risk settings require well developed midwifery skills and confidence to work with

the level of autonomy and decision making needed to provide optimal individualised care.

Related UHL documents:

- Booking Process and Risk Assessment UHL Obstetric Guideline.pdf
- Intrapartum Care UHL Obstetric Guideline.pdf
- Escalation Transfer of Activity and Closure UHL Obstetric Guideline.pdf
- Lone Worker UHL Policy.pdf
- Criteria for Transfer of Women from LGH to LRI with Expected Need for Neonatal Intensive Care UHL Obstetric Guideline.pdf
- Supporting Birth Outside of Trust Guidance in Low Risk Midwifery Birth Settings UHL Obstetrics Guideline.pdf

2. Guidance

Cover arrangements / Hand over

24-hour service

Day	07.00 -19.30 with 1 hour break = 11.5 hours
Night	19.00 – 07.30 with 1 hour break = 11.5 hours
Early	07.00 – 15.00 with 30-minute break = 7.5hrs
Late	12.00 – 20.00 with 30-minute break = 7.5 hours

Roles/ responsibilities

All staff

- Must be on duty at commencement of duty time at Glenfield Hospital base or at patient address to receive home birth mobile phone.
- Named coordinating midwife to be responsible for carrying and answering the allocated home birth mobile phone.
- Early labour assessments for low-risk pregnant women and people, helping pregnant women and people to feel supported and encourage pregnant women and people to stay at home during the latent phase of labour.
- Telephone advice.
- Answering patient queries and recording actions from these.
- Chasing results for patients and taking appropriate action where required.
- Daily checking of homebirth equipment stored at the homebirth team office.
- E-learning and training – including using the opportunity to update or gain competencies to allow more choice for pregnant women and people e.g. alternative therapies etc.
- Must be working towards providing a robust continuity of carer model within the defined criteria.
- Promotion of home birth and development of the home birth service– within UHL and also in public places/media/web/info packs, the Head of Midwifery and/or deputy and UHL Communications team must be informed of media interaction.
- An auditable record should be available of all work undertaken by each midwife providing care to women and a central electronic diary.
- Audit of records in line with the UHL audit programme.
- All visits (antenatal) and all telephone contacts (antenatal, intrapartum and postnatal) must be documented on the electronic maternity record.

Day/Early/Late shift – minimum two midwives every day 07.00-19.30

- Night shift midwives will contact day shift midwives by phone with details if they are required to relieve night shift midwives attending a home birth.
- Team leads/community office to be informed of home births being attended before 17.00. After 17.00 St Mary's birth centre need to be informed.
- Provide antenatal care for pregnant women and people choosing to have a homebirth.
- Facilitating homebirth that has been requested against medical advice by liaising closely with the multidisciplinary team to provide a safe plan of care. Please refer to birth outside of recommendations guidance (Supporting Birth Outside of Trust Guidance in Low Risk Midwifery Birth Settings UHL Obstetrics Guideline.pdf)
- Postnatal visits at home.
- Communication with community midwives, so all pregnant women and people can easily access clear information about homebirth and make an informed choice.
- Supporting the other community teams with visits and clinics when required if this does not affect the provision of the homebirth service.
- If two homebirths are happening at the same time during the day shift, homebirth team to liaise with community teams so they can attend with a homebirth team midwife so women get their birthplace choice.
- Checking the community drive and actioning any out of hours work.
- Attending parent craft classes and other groups to promote home birth.

Night/Late shifts – minimum two home birth team midwives 19.00 – 07.30

- Day shift midwives will contact night shift midwives by phone with details if they are required to relieve day shift midwives attending a home birth.
- St Mary's Birth Centre to be informed of homebirths being attended.
- Attending births at St Mary's birth centre as a second midwife.
- Answering calls and providing out of hours community midwifery care.

Contact

Effective communication between team members to provide excellent care provision for women booked for homebirth. Contact will be made by:

- Voicemail information. All staff to ensure voicemail is activated on their work mobile phones
- Text information.
- The home birth mobile phone.

Storage of equipment

The central base for the midwives on day and night shifts will be the homebirth team office at the Glenfield Hospital.

Homebirth equipment bags, resuscitation bags and Entonox bags will be kept in the following locations;
3 x the homebirth team office (Glenfield Hospital),
1 x the community store cupboard (Leicester General Hospital),

The homebirth bags will be clearly labelled and will be kept fully stocked and checked by the homebirth team. The gas cylinders will be checked daily by the homebirth team.

If called out between 17.00 – 07.30 to carry out early assessments or assist in the acute units during periods of extremely high acuity, homebirth team midwives should carry the homebirth, resuscitation and Entonox bags in their car.
Stock will be kept in the community store cupboard at the Leicester General Hospital and also in the homebirth team office at the Glenfield Hospital.

Supporting other areas

St Mary's Cover out of Hours

If there is a birth in progress at St Mary's, the midwife in charge of the homebirth mobile phone will be contacted.

- On arrival midwives will phone 01664 854854 (St Mary's phone number) to gain access to the unit.
- If all midwives are out at homebirths – St Mary's will call their on-call midwife.
- If a homebirth requires attendance from a midwife who is at St Mary's, the on-call midwife will be called to attend the St Mary's birth.
- St Mary's staff to be informed of any homebirth being attended.

Supporting other clinical areas

If homebirth team midwives are not out at a homebirth or St Mary's birth centre but the birth centres and/or the acute Delivery Suites at either the Leicester General Hospital or Leicester Royal Infirmary are experiencing staffing and/or capacity issues, they may be requested to offer support. This decision can only be made through the escalation policy, therefore must be discussed with the manager on-call. This support however should be considered in terms of their area of expertise.

- Firstly, by supporting low risk pregnant women and people in labour or giving immediate postnatal care within and alongside the birth centre midwives.
- Secondly by acting as the second or third midwife on a ward.
- Thirdly, and only at times of extremely high acuity and if there is no other alternative, assisting on the main delivery suites. If one acute unit's Delivery Suite is much busier than another, the transfer of hospital-based midwives to support should be considered as they are more skilled in high-risk care.

Coordinators must keep in mind that the homebirth team midwives may be required to attend a homebirth, St Mary's birth centre or a community emergency at any time, and they must be freed up immediately in order to do so.
If there is any concern of this being possible, this must be discussed urgently with the on-call manager. If suspension of the home birth service is being considered this must be discussed with and authorised by the Head of Midwifery. If out of hours, this must be discussed with the manager on-call and director on-call (via switch).

Personal Safety

Parking

All homebirth team midwives will have a 3Ps priority parking permit.

Lone working

Midwives and students visit patients in their own homes including those patients who live in inner city and remote rural areas, exposing members of the homebirth team to particular health and safety risks.
The key risks for midwives visiting patients in the community and in their homes include:

- Dealing with known and unknown people in an unfamiliar environment.
- Travelling and visiting people in remote country roads and in unknown areas.
- Inner city areas are known to carry a higher risk of violence especially where there may be concealed spaces or poorly lit areas such as lifts in tower blocks or similar buildings.
- Members of staff are seen as targets as some people may believe they are carrying money or equipment of value.
- Late evenings/early mornings carry an increased risk due to areas being deserted.
- Encountering other members of the public or situations whilst visiting the patient.
- The number of hours spent travelling.

Recommendations

- The midwives on the night shifts work in pairs and when called out will either travel together or arrange for a place of safety at which to meet.
- The team lead/St Mary's birth centre/Delivery Suite coordinator is informed of where the midwives are attending and this information is passed on at handover. Homebirth team midwives to keep in contact with all colleagues and to contact them if they need any further support.
- Out of hours, St Mary's birth Centre should be informed of whereabouts.
- Home Birth team midwives to keep in contact with all colleagues and to contact them if they need any further support.
- If there are known safeguarding issues, a plan is put in place which is available for all midwives at their base.
- In any high-risk situation e.g. Illegal firearms known to have been kept at the house, the police are called and must be in attendance prior to the midwives entering the building.

In addition to the above Midwives should:

- Ensure they have adequate fuel for the journey.
- Inform St Mary's of any address they are attending.
- Once inside the vehicle all doors should be locked, especially when travelling at slow speed or when stopped at traffic lights.
- Always park as close as possible to the patients' house. Do not take any short cuts. E.g. through back entries to save time.
- Carry their ID badge until they are at the patient's home rather than wearing it in a public place.
- Not display on their person any items which may cause harm e.g. scissors, pens.
- Take their mobile phone on all visits and ensure that it is fully charged and switched on at all times when out of the hospital and on official duty.
- An emergency contact number should be kept on speed dial in the mobile phone in order to speed up the process of summoning help quickly.
- Useful telephone numbers should be pre-set into the mobile phone such as the Community office, Delivery Suite, and Switchboard in order to contact quickly.

- Attend any personal safety or violence prevention training available and identify any training deficits with their line manager.

Risk Assessment:

- Appropriate place of care/birth is discussed and documented at booking. This should take into account risk assessment for suitability of low or high-risk care. (Women can intend to birth at home from booking, in line with the continuity of carer pathway for Better Births but will still have a 36-week risk assessment to ensure they still meet the midwife led criteria.)

- The Personal Maternity Record for every pregnant woman and person is sent into the Consultant Unit. (The personal maternity record is completed on E3 and sent electronically) the Antenatal Core Midwives review the history and documentation that has been made by the Community Midwife. The Core Midwives will identify if the pregnant woman and person can have Midwife led care or will require Consultant led care and document this on the front of the Personal Maternity Record.

- If there are any queries about or gaps in the obstetric history and the pregnant woman and person has previously delivered at UHL her previous obstetric record will be used to complete the assessment.

- Antenatal care for pregnant women and people who following risk assessment have been identified as having an uncomplicated pregnancy will be identified as Midwife Led. They will only be referred to the Obstetric Unit for their first trimester screening / dating scan and detailed scan.

- If the pregnant woman and person requires an appointment this is stated on the front of the Personal Maternity Record. The Core Midwives will then allocate the appropriate appointments which will be made and sent out by the Antenatal Clinic Coordinators.

- A risk assessment should be completed at each contact. A formal risk assessment should be performed at around 36 weeks and completed the Community home birth team midwives. This should be documented within the Personal maternity Record. If any risk factors are identified referral to a Consultant led clinic should be considered or discussed with the Obstetric Team.

- Document that the 36-week risk assessment has been completed and the pregnant woman and person is suitable for Midwife Led Care (appendix 2).

- Confirm that the pregnant woman and person is aware of the limitations of the Midwifery Led Service and the need to transfer for Obstetric / Neonatal care if there are deviations from normality. See Criteria for Transfer of Women from LGH to LRI with Expected Need for Neonatal Intensive Care UHL Obstetric Guideline.pdf

- Document advice that the process of transfer may delay emergency care and that an ambulance is requested at the time it is required. Inform the pregnant woman and person and document that an ambulance is not routinely on standby outside the centre. Also, document that there may be an unavoidable time delay in the arrival of any additional midwives if they are required.

- Full home birth checklist completed outlining limitations of the service and transfer requirements including possible delay of emergency treatment (see checklist in maternity notes)

- Document that the UHL hospital records have been requested and the past Obstetric history and the current pregnancy events reviewed to ensure suitability for Midwife Led Care.

- Should the identified lead professional change at any point in the pregnancy this will be documented in the health care records.

- Advice on appropriate place of birth should be revised accordingly where the pregnant woman and person moves from low to high risk.

- Where the pregnant woman and person is known to be outside of low-risk guidelines, please see flowchart (appendix 1).

Women known to be high risk but requesting a homebirth

Those pregnant women and people who following risk assessment have been identified as having a complicated pregnancy will need to attend an Obstetric Consultant or see the Consultant Midwife.

Women known to be high risk but requesting a home birth - please see Supporting Birth Outside of Trust Guidance in Low Risk Midwifery Birth Settings UHL Obstetrics Guideline.pdf

A plan of care should be made by the Community Midwife with support from the linked consultant/Consultant Midwife before 34 weeks and a face-to-face appointment considered if necessary.

A copy of this individualised care plan should be placed in the pregnant woman or persons handheld notes, E3, home birth team office and updated on the live high risk drive accessible by all senior staff; both delivery suites and the Head of Midwifery and Deputy need a copy of all women with risk factors having a home birth against advice on a monthly basis

Planned Labour at home

- Pregnant women and people who telephone in labour are risk assessed further over the telephone to ensure there are no prohibitive factors for Midwife Led Care e.g. meconium-stained liquor. This must be documented on E3 on the phone triage.

Deviations from normal

- Once present, If there are any deviations from normality as a result of the risk assessment or during the pregnant woman or persons labour or postnatal stay the pregnant woman or pregnant person / baby must be transferred to Obstetric / Neonatal care via a 999 call and ambulance from home to the Delivery Suite from the Hospital based Birth Centres at LRI and LGH. See Criteria for Transfer of Women from LGH to LRI with Expected Need for Neonatal Intensive Care UHL Obstetric Guideline.pdf A midwife must accompany the pregnant woman or person.

- Where the pregnant woman or person is known to be outside of low-risk guidelines and has requested a home birth, identify the risks using the intrapartum risk assessment form in the handheld records and notify the Delivery Suite Coordinator.

- All transfers are recorded on the electronic system

Unplanned labour / birth at home

Where the delivery suite has been contacted directly an ambulance must be dispatched by the delivery suite by telephoning 999 and the Homebirth team contacted who will advise if they are within 5 minutes of the address and able to attend, if not EMAS to be directed to transfer straight to Delivery Suite.

Labour:

- All pregnant women and people who have not booked for a home birth or who no longer meet the criteria for a home birth and are in advanced labour at home must be transferred into the hospital immediately by ambulance.

- Pregnant women and people who are in early labour and not booked for a home birth or who no longer meet the criteria for a home birth must be advised to go into hospital

- Where the ambulance has already been called and is in attendance prior to the arrival of the midwife, the midwife must introduce themselves on arrival and ensure that the ambulance crew are clear that they will take the lead for further management of the woman or person.

- The ambulance crew must give the midwife an SBAR handover at this point

- The midwife must take their own delivery pack to the pregnant woman or person's home.

- The midwife must contact the delivery suite and give an SBAR handover to the coordinator prior to transferring the pregnant woman or person immediately into hospital the midwife must accompany the pregnant woman or person to hospital.

- Further communication by telephone or social media must not take place unless clinically indicated.

- Whilst awaiting transfer by ambulance the pregnant woman or person must be transferred downstairs immediately if not already there.

Baby born before arrival:

- All postnatal women, people and babies must be transferred into the hospital at the earliest opportunity following a BBA. In line with NEWTT2 guidance, babies will require 12 hours of observations.

- Where the delivery suite has been contacted directly, a midwife will be contacted to attend as well as an ambulance by the delivery suite, but only if the midwife is within a 5 minute radius of address.

- The ambulance crew must give the midwife an SBAR handover at this point

- The midwife must take their own delivery pack to the postnatal woman or person's home.

- The midwife must contact the delivery suite and give an SBAR handover to the coordinator prior to transferring the postnatal woman or person immediately into hospital if required.

- Further communication by telephone or social media must not take place unless clinically indicated.

- Whilst awaiting transfer by ambulance the postnatal woman or person must be transferred downstairs immediately if not already there.

- The midwife, following assessment of the newborn, which includes taking the temperature, should dry the baby and encourage immediate skin contact if it is safe to do so.

- The baby must be transferred in in suitable clothing and a hat.

- The baby must be in a car seat for transfer if possible

- Consider use of a trans-warmer if there are concerns about the baby's temperature.

3. Education and Training

Must be up to date and familiarise themselves with equipment and lay out of St Mary's Birth centre.

Must have attended training in changing of air and oxygen cylinders on the resuscitaires and should know how to check they are working

- Midwifery training – NMC standards

- Midwifery registration – NMC standards. Registration checked on appointment and annually

- Post registration education and practice – NMC

- Annual mandatory training including Multidisciplinary Obstetric Training Day with skills drills

- Skills drills carried out in local area

- Band 5 competencies (Band 5 midwives are supported by a band 6 midwife)

- To be competent in resuscitation of the newborn (part of essential to job role mandatory training but advance life support course desirable)

- Where possible to be competent to carry out perineal suturing (competency assessed)

- To be competent in supporting water births

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Number of unplanned home births	Numbers from E3	Community Team Leads	Yearly	Maternity Governance
Standards against guideline	Audit	Community Team Leads	Yearly	Maternity Governance

5. Supporting References

Birthplace in England Collaborative Group, Brocklehurst P, Hardy P, Hollowell J, Linsell L, Macfarlane A, McCourt C, Marlow N, Miller A, Newburn M, Petrou S, Puddicombe D, Redshaw M, Rowe R, Sandall J, Silverton L, Stewart M. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. Br Med J. 2011;343.

6. Key Words

Baby born before arrival (BBA), Community midwife, Continuity of carer, Low risk maternity care, Risk assessment

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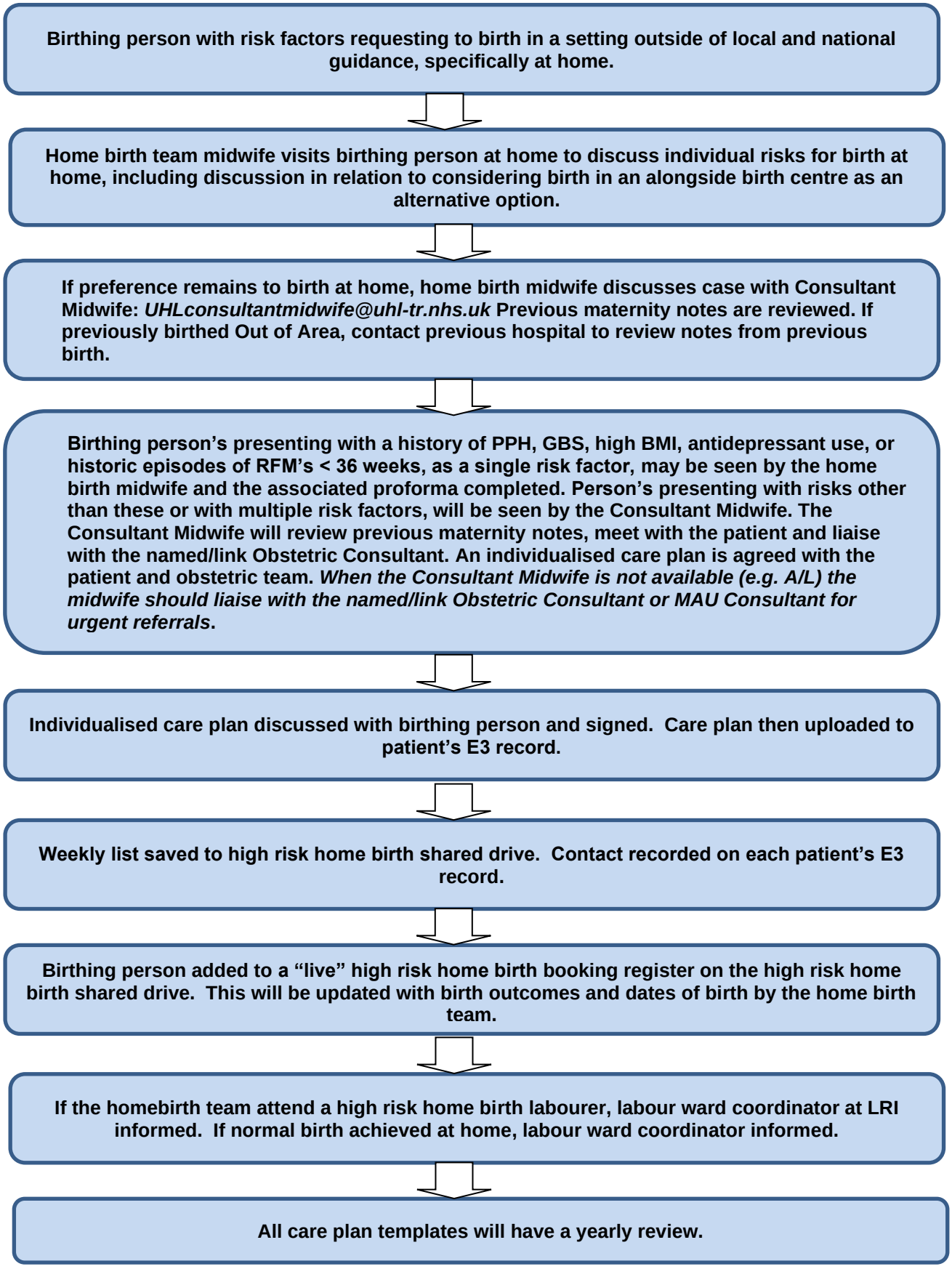
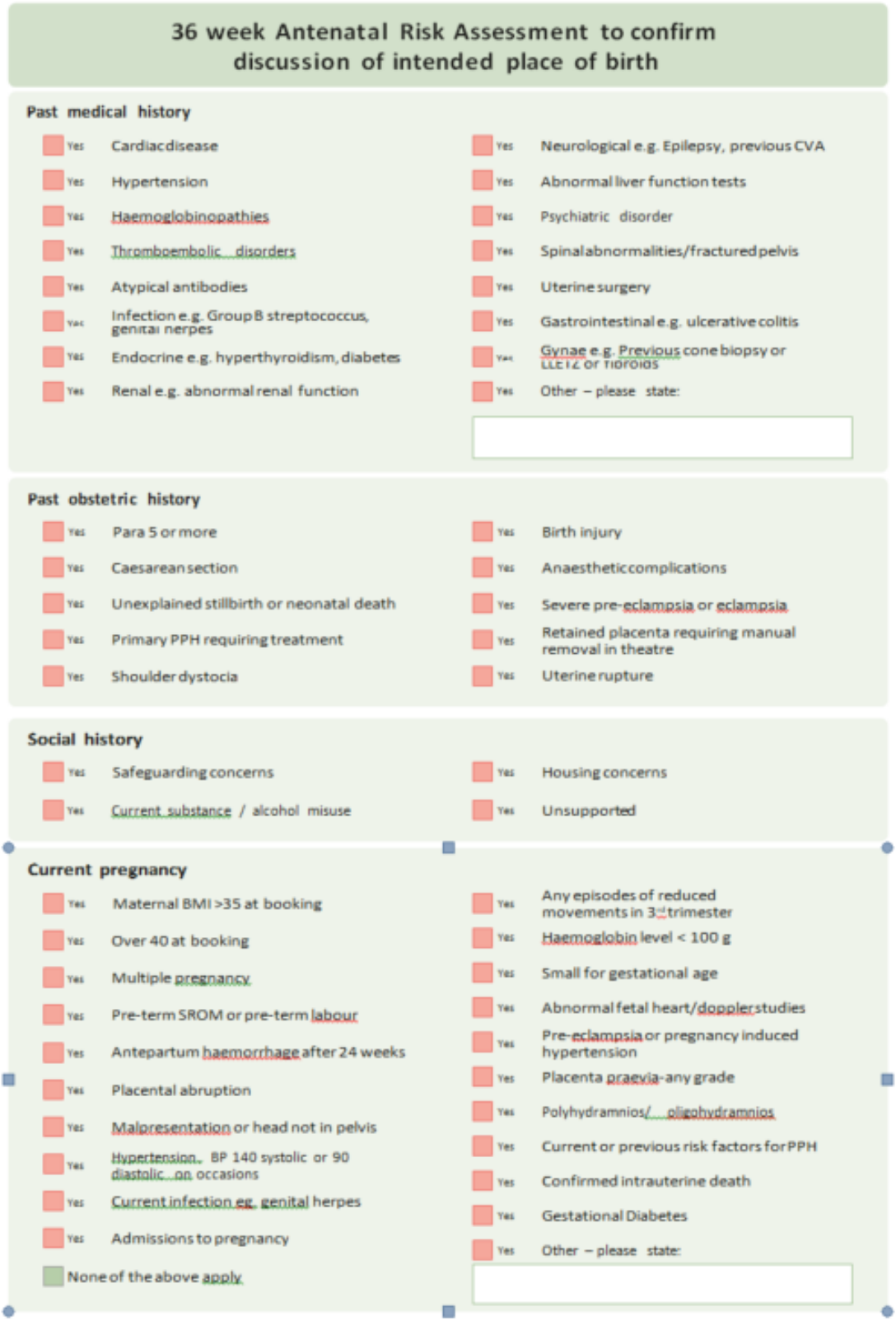
The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Contact and review details	
Author: Community Team Leads and F Cox **Guideline Lead** **Annabelle Foxwell, Matron for Community Services**	**Executive Lead:** **Chief Nurse**
Details of Changes made during review: **September 2024** pg 2-3 & 8 Added ref's to birth outside of guidance g/l and MWL birth choices. Removed ref's to parent craft/mw sessions. pg 4 Updated staff cover section. pg 5 Removed ref to sat nav systems. pg 7 Added ref to 2 checklist completion pg 9 Added ref to completion of checklist and outlining the limitations of the service and transfer requirements pg 11 added ref to BBA and requirement to transfer in, in line with NEWTT2	

Appendix 1 - High Risk Homebirth Pathway



Appendix 2: 36 week antenatal risk assessment form



36 week Antenatal Risk Assessment to confirm discussion of intended place of birth

Past medical history

- Yes Cardiac disease
- Yes Hypertension
- Yes Haemoglobinopathies
- Yes Thromboembolic disorders
- Yes Atypical antibodies
- Yes Infection e.g. Group B streptococcus, genital herpes
- Yes Endocrine e.g. hyperthyroidism, diabetes
- Yes Renal e.g. abnormal renal function
- Yes Neurological e.g. Epilepsy, previous CVA
- Yes Abnormal liver function tests
- Yes Psychiatric disorder
- Yes Spinal abnormalities/fractured pelvis
- Yes Uterine surgery
- Yes Gastrointestinal e.g. ulcerative colitis
- Yes Gynae e.g. Previous cone biopsy or LLETZ or fibroids
- Yes Other – please state:

Past obstetric history

- Yes Para 5 or more
- Yes Caesarean section
- Yes Unexplained stillbirth or neonatal death
- Yes Primary PPH requiring treatment
- Yes Shoulder dystocia
- Yes Birth injury
- Yes Anaesthetic complications
- Yes Severe pre-eclampsia or eclampsia
- Yes Retained placenta requiring manual removal in theatre
- Yes Uterine rupture

Social history

- Yes Safeguarding concerns
- Yes Current substance / alcohol misuse
- Yes Housing concerns
- Yes Unsupported

Current pregnancy

- Yes Maternal BMI >35 at booking
- Yes Over 40 at booking
- Yes Multiple pregnancy
- Yes Pre-term SROM or pre-term labour
- Yes Antepartum haemorrhage after 24 weeks
- Yes Placental abruption
- Yes Malpresentation or head not in pelvis
- Yes Hypertension, BP 140 systolic or 90 diastolic on occasions
- Yes Current infection eg. genital herpes
- Yes Admissions to pregnancy
- None of the above apply
- Yes Any episodes of reduced movements in 3rd trimester
- Yes Haemoglobin level < 100 g
- Yes Small for gestational age
- Yes Abnormal fetal heart/doppler studies
- Yes Pre-eclampsia or pregnancy induced hypertension
- Yes Placenta praevia-any grade
- Yes Polyhydramnios/ oligohydramnios
- Yes Current or previous risk factors for PPH
- Yes Confirmed intrauterine death
- Yes Gestational Diabetes
- Yes Other – please state:

36 week Antenatal Risk Assessment to confirm discussion of intended place of birth

Please refer to 'Intrapartum Care: healthy women and their babies' guideline for full and comprehensive list.

Please refer to the appropriate pathway

LOW RISK
Birth Place Options:

☐ Home ☐ SMBC ☐ OBC ☐ MBC

HIGH RISK
Birth Place Options:

☐ D/S LRI ☐ D/S LGH ☐ Other

If any query regarding categorisation/birth options - refer for medical review/advice ☐

Signature of person completing risk assessment: .....

Date completed: .....

Print name: .....

Designation: .....

Client signature: .....

Medical review for suitability for Midwife led care

Date: .....

Outcome of review:

☐ Suitable for Midwife Led care
☐ Advised to birth in Obstetric unit

Signature of reviewer: .....

Print: .....

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