Newcastle upon Tyne Hospitals
NHS Foundation Trust

Royal Victoria Infirmary

DIRECTORATE OF WOMEN’S SERVICES

HOMEBIRTH GUIDELINES

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Written by: Homebirth Working Group
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HOMEBIRTH GUIDELINES

These guidelines should be read in conjunction with Women’s Services Directorate, Delivery Suite Guidelines.

ANTENATAL PLAN

• At booking a risk assessment is undertaken on all women as soon as possible.
• If the woman is deemed low risk then she should be informed about the options for place of birth. This could be at their local hospital, or hospital of their choice, or a home birth.
• If the woman is interested in a home birth she should be given verbal and written information. If the women then decides that a home birth is of interest the community midwife usually arranges a home visit so that she can spend further time discussing the benefits and risks.
• In some instances a women assessed as high risk may express an interest in a home birth. The community midwife should discuss with the woman the reasons why a home birth may not be suitable. Risk factors should be identified and discussed.
• If the woman is still interested in a home birth but the midwife thinks she is unsuitable then she must be referred to a Consultants clinic.

Low Risk Women
Once the decision has been made the community midwife:

❖ Assesses the home situation – for safety and hygiene
❖ Discuss and plan the delivery.
❖ Record choice of place of birth in the Hand Held Records and identify the Lead Professional
❖ A Home Birth Booking form is completed (Appendix 1) and sent to the Community Midwifery Secretary, a copy to the GP and Consultant if appropriate.
❖ A list of home births is then generated and circulated to all community midwives and MAU.
❖ If a new home birth is booked after 37 weeks then the booked midwife must telephone all bases and inform MAU.

High Risk Women
When a woman who is identified as high risk is referred to the Consultants Clinic she must ideally be seen by a Consultant (not a junior doctor).

• The community midwife must ensure that the reason why the woman is deemed unsuitable is clearly highlighted in the notes.
• The discussion should then focus around the complications that may arise should she deliver at home with minimal obstetric support.
• If the Consultant feels that a home birth is suitable then a clear management plan should be written in the notes (both hospital and hand-held).
• When there is an obvious high risk factor i.e twin pregnancy, previous CS, known SGA, previous PPH/ retained placenta, BMI above 35 - the Consultant should support the community midwives decision that a home birth is potentially unsafe.
• Agreeing that a high risk woman can have a home birth places the community midwives in a vulnerable position and puts the mother and baby in a compromised position.

Women’s Services Directorate
Homebirth Guidelines, March 2010
37 weeks
At 37 weeks if the woman remains low risk then plans are put in place for delivery of the home birth bag. This can be done by the midwife or the HCA. (Appendix 2 – Contents of bag)

The named midwife must also ensure that the Home Birth Consent form has been completed. This can be done at any time (whenever is most appropriate). The completed copy is kept in the hand held notes.

A letter will also be given to the woman explaining the delivery of gases and equipment (appendix 8 and 9).

Compressed Gases
- Forward completed homebirth booking form to Community Secretary. Check all details are completed including woman’s contact telephone number.

- Community Secretary will add information from homebirth booking form onto database for delivery and collection of the compressed gases.

- Community Secretary must be informed if a woman’s EDD changes or a homebirth is cancelled.

- Approximately 1 week before a woman reaches 37 weeks gestation, Community Secretary will contact North East Ambulance Service to arrange delivery of compressed gases.

- Once woman gives birth, Community Office must be contacted to arrange collection of compressed gases (appendix 10).

Onset of Labour / attendance of midwives
- When the woman suspects that labour has started she contacts MAU. The midwife will listen to the woman and decide if the community midwife should be contacted straight away.

- The community midwife will contact the woman directly and assess the situation.

- 8.30am – 4.30pm – 1 midwife may attend for labour and 2nd midwife to attend for birth (how soon the 2nd midwife attends will depend on availability/ workload/ need).

- Out of Hours – 2 midwives to attend as per Lone Worker Health & Safety Policy.

Inform:-
Co-ordinator Delivery Suite, Dect Ext ext: (28)29246
Guardian Angel Security (contact every 2 hours)
Paramedic Control Centre on 226 0280 – giving woman’s name and address.

Assessing the situation
When a woman is in established labour a partogram should be started and continued throughout labour and delivery.
Observations
The following general observations should be recorded:

<table>
<thead>
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<th>observation</th>
<th>interval</th>
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<tr>
<td>pulse</td>
<td>1 hourly</td>
</tr>
<tr>
<td>blood pressure</td>
<td>2 hourly</td>
</tr>
<tr>
<td>uterine contractions</td>
<td>30 mins</td>
</tr>
<tr>
<td>fetal heart rate</td>
<td>15 mins</td>
</tr>
<tr>
<td>temperature</td>
<td>4 hourly</td>
</tr>
<tr>
<td>bladder care</td>
<td>4 hourly</td>
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During the first stage of labour blood pressure should be measured and recorded once every 2 hours. If the systolic pressure reaches 160 mm/Hg or the diastolic reaches 100 mm/Hg it should be rechecked at 15 minute intervals. If it remains elevated for 3 consecutive readings over 45 minutes then transfer to RVI should be considered.

Vaginal examination
In general, although there is no reliable research base upon which recommendations can be made for the optimal frequency and timing of vaginal examination, this will normally be approximately every 4 hours.

Sterile gloves should be worn but swabbing the vulva with an antiseptic solution is not necessary. When the vulva is soiled, cleansing may be undertaken with tap water. At each examination, the following information should be recorded:
- verbal consent
- bladder care
- amount of head palpable abdominally
- status of vulva / vagina
- effacement, consistency, dilatation and vaginal position of the cervix
- application of the presenting part to the cervix
- membrane status, and colour of liquor if applicable
- level and position of the presenting part in relation to the ischial spines
- presence and degree of caput and moulding
- clinical estimate of pelvic size

Fetal Heart Rate Monitoring
Intermittent monitoring should take place throughout the 1st stage of labour, consisting of 1 minute of cardiac auscultation with Pinnard or Doppler every 15 minutes, immediately following a contraction. A deceleration, base line under 110 bpm or base line over 160 bpm would precipitate transfer to Delivery Suite, RVI.

In the second stage of labour the FH should be listened into **every 5 minutes** and this should be recorded on the partogram.

Fluid Balance in Labour
Record input and output in labour on partogram

Bladder care in labour
The bladder is at particular risk in labour with a prolonged second stage
Encourage spontaneous voiding 4 hourly in labour and record this on the partogram. If a woman cannot empty her bladder after 4 hours or passes small frequent amounts, an in-out catheter should be used to ensure the bladder is empty. This should coincide with a vaginal assessment and the volume drained should be recorded. If over 500 ml then further bladder care must be vigilant to avoid complications.

If the labour appears prolonged any urine samples passed should be accurately measured and tested. The presence of ketones or acetone may suggest dehydration and will need correcting either at home with milky drinks/ sugary food or if not appropriate and contractions decreasing in frequency then transfer in for IV rehydration may be required.

**Birth Environment**
Make sure good there is a good area for resuscitation should it be required. Also consider adequate heating, lighting, childcare and pet care arrangements.

**Checking of equipment**
In the unlikely event that a baby born at home will require resuscitation the midwives have a duty to check the resuscitation equipment well in advance of the delivery. The equipment should be ‘set up’ for all home births in case unanticipated resuscitation is required. An appropriate area should be made clear for the resuscitation equipment and parents should be informed why we do this.

If there are problems identified with the equipment then a home birth should be avoided unless replacement equipment can be obtained. Transfer in to hospital will be required and this should have already been discussed with the woman in the antenatal period. Equipment failure/ faults will need to be reported via datix.

**Positions for labour**
The adoption of an upright position during the first stage of labour (sitting upright, walking, squatting, kneeling, all fours) may be beneficial in encouraging strong uterine contractions with associated shortening of the time taken to reach full dilatation. An upright stance may also help to promote fetal cephalic rotation to an OA position, possibly contributing to a reduction in perceived pain. Finally, the complications attending aorto-caval compression are only encountered in women opting for recumbent positions. While respecting women’s choice, midwives may encourage mobilisation or rest in a non-recumbent position during the first stage of labour.

**Feeding in labour**
Some women may express a wish to continue taking a light diet during labour, particularly during the first stage. There is some equivocal evidence to suggest that in this population a permissive policy may help to reduce instrumental and caesarean delivery by reducing ketosis and fatigue.

The risk of acidic gastric aspiration (Mendelson’s syndrome) only appears to be increased in women with additional risk factors for delayed gastric emptying.

Women should be encouraged to have a light diet during labour.
Pain Relief
Tens, water therapy and entonox can all be used at home or other non-pharmacological analgesia e.g. aromatherapy.

Ongoing Risk Assessment
Low risk women labouring at home must still be risk assessed throughout labour. If there any deviations from normal i.e. raised BP, aph, mec liquor, maternal pyrexia, fetal tachycardia – then the woman must be transferred into hospital.

The community midwife must contact the delivery suite and speak to the co-ordinator before arranging transfer in.

DYSFUNCTIONAL LABOUR

Progress of labour is defined by the rate of cervical dilatation and the speed of descent of the presenting part into the pelvis. There is no universally accepted definition of dysfunctional labour, but slower labours are associated with an increased rate of operative delivery.

Definition of dysfunctional labour
In the following circumstances transfer to the RVI may be necessary:
- the rate of cervical dilatation is \( \leq 0.5 \text{ cm} / \text{hr} \), or where there any concerns regarding descent of the presenting part. These concerns will be discussed with the Consultant Obstetrician via the Band 7 Dect phone (28) 29246

Aetiology
It is important to emphasise that dysfunctional labour is not a diagnosis. In planning management, an attempt should be made to determine the aetiology. Causes include:
- inefficient uterine activity
- fetal malposition / malpresentation
- cephalopelvic disproportion (absolute or relative)

Note that genuine absolute CPD is very unusual in the UK population.

Factors to be assessed
- past obstetric history
- nature of the contractions
- pattern of cervical dilatation
- cervical oedema
- size of the baby
- fetal presentation and position
- caput / moulding
- pelvic size
- pelvic masses (including bladder size)
SECOND STAGE OF LABOUR

**Definition**
The second stage extends from full cervical dilatation to birth of baby. It has two components:

*Passive*  
with no maternal effort

*Active*  
with maternal effort

**Diagnosis**
The second stage of labour is diagnosed:

- when the presenting part of the baby is visible
- on routine repeat vaginal examination, or...
- on vaginal examination performed when the woman feels an urge to push

**Management**

*Passive second stage*
Plenty of time should be given for the presenting part to descend. If no obvious descent after 1 hour discuss with Delivery Suite Co-ordinator.

*Active second stage*
This should commence:

- when the head is visible
- when there is a strong urge to push

**Delivery**

- If there is no evidence of progress in second stage discuss with Delivery Suite Co-ordinator.
- If transfer deemed appropriate this should be via paramedic ambulance to Delivery Suite with a midwife accompanying woman.

During the second stage of labour, transfer to RVI should be considered if the systolic blood pressure reaches 170 mm/Hg or the diastolic reaches 110 mm/Hg for 3 consecutive readings over 15 minutes.

THIRD STAGE OF LABOUR

**DEFINITIONS**

*Active management*
The administration of a prophylactic oxytocic drug (Syntometrine), early clamping and cutting of the cord and controlled cord traction (CCT).

*Physiological (expectant or conservative) management*
No prophylactic oxytocic drug is used, no cord clamping or cutting occurs until after placental delivery and there is no cord traction. The placenta delivers with maternal effort alone.

*Piecemeal approach*
A mixture of active and physiological management. This may contribute to haemorrhage.
Physiological third stage of labour
Third stage management should be planned antenatally and documented in the notes. Midwives offering this service must however be confident in the procedure. Active versus expectant management trials demonstrate skills in expectant management takes time for midwives to gain.

Advantages
Physiological third stage offers continuation of the normal physiological process of labour. There is no evidence of clinically significant increased morbidity for low risk women.

Disadvantages
In comparison to active management, a larger blood loss may be anticipated when managing the third stage physiologically and the length of third stage is likely to be longer.

Mechanisms of physiological management of the third stage of labour

Good practice points
- the midwife needs to be confident in caring for a woman during expectant management
- the woman should never be left unattended
- pulse and blood pressure should be recorded every 30 mins
- the woman needs to be kept warm. This will reduce her risk of PPH
- leave the cord unclamped and uncut until the placenta separates
- the woman should adopt an upright position if possible
- if estimated blood loss exceeds 500ml, resort to medical management (see flow chart re PPH)
- if the woman has not delivered her placenta after 60 minutes refer to medical advice via G grade Co-ordinator, Delivery Suite.
- transfer by paramedic ambulance with midwife
active management of the third stage of labour

discuss - consent – document

Administer Syntometrine

with the anterior shoulder
or as soon after the birth of the baby as possible

clamp and cut the cord
skin to skin contact where the mother agrees

observe for external signs of separation
cord lengthening, small trickle of fresh blood, uterus firm and rising in the abdomen
then try

controlled cord traction

if signs of separation have not been recognised
after 4 minutes
carefully check uterus is firm and well contracted
then try

controlled cord traction

abandon if the cord tears or snaps

ensure the bladder is empty
try maternal effort alone
and
prepare for transfer to RVI

Arrange transfer to RVI if the placenta is not delivered within 30 minutes of birth or if estimated blood loss of more than 500 ml arises before delivery of the placenta

If actively bleeding identify
confirm that the uterus is firm and well contracted – if not manage as PPH Guidelines
estimate the blood loss and document
OBSTETRIC EMERGENCIES

IN THE EVENT OF ANY OBSTETRIC EMERGENCY IMMEDIATELY CONTACT PARAMEDICS

SHOULDER DYSTOZIA
Definition
Shoulder dystocia is the impaction of the anterior shoulder against the symphysis pubis after the fetal head has been delivered. It may be recognised clinically as a failure to deliver the shoulders with ‘normal traction’.

HELPERR
This mnemonic (figure 1) will help you to remember how to manage shoulder dystocia. It should be used in conjunction with good clinical judgement. The most experienced clinician present should co-ordinate the team’s efforts.

After the birth, the notes should be completed by the most senior clinician present. The HELPERR reporting form (appendix 5) should be completed and events recorded on the partogram.

If the baby cannot be delivered despite working through all of the HELPERR manoeuvres transfer into the RVI urgently will be required.

UNDIAGNOSED BREECH IN LABOUR

If breech presentation is diagnosed by abdominal palpation or vaginal examination when in labour the woman should be informed and prepared to transfer to Delivery Suite via paramedic ambulance following discussion with Delivery Suite Co-ordinator.

If in advanced labour when diagnosis is made the following should be undertaken:
- Contact consultant obstetrician via Delivery Suite Co-ordinators Dect Phone: 28 29246

Conduct of the delivery
Inform paramedics and Delivery Suite Co-ordinator and request further midwifery assistance if appropriate.

The fetal heart rate should be monitored throughout. Good practice points are:
- Consider delivery on all fours or squatting position
- Improvise lithotomy position
- Empty bladder
- allow spontaneous descent of the breech

As the maternal perineum stretches, consider episiotomy with careful guarding of fetal tissues. The breech should then be allowed to descend with maternal effort alone (‘hands off the breech’) with the sacrum lateral / anterior. Baby’s legs may be swept laterally or allowed to deliver spontaneously, and the arms may be delivered spontaneously, by sweeping medially across the chest or by Lovsette’s manoeuvre. For the head:
- allow descent until the occiput is visible, then use…
- Modify Mauriceau-Smellie-Weiss (but do not place a finger in the baby’s mouth) or
- Spontaneous delivery of head with gentle control
Figure 1

**H** Help  call for help
Delivery Suite
Ambulance Paramedics

**E** Episiotomy
evaluate for a generous episiotomy
may be deferred until after McRobert’s

**L** Legs
place legs in McRobert’s position
hyperflexed at the hips, slightly adducted
attempt to deliver for 30 seconds

**P** Pressure
constant suprapubic pressure
behind the anterior shoulder
attempt to deliver for 30 seconds

rocking suprapubic pressure
behind the anterior shoulder
attempt to deliver for 30 seconds

**E** Enter
finger behind the anterior shoulder
push the anterior shoulder into oblique
attempt to deliver

If unsuccessful leave fingers behind anterior shoulder and put additional finger in front of the posterior shoulder pushing the posterior shoulder into oblique
attempt to deliver

Woods screw manoeuvre – move fingers to posterior aspect of posterior shoulder
continue rotation a further 180°
attempt to deliver

**R** Remove
remove the posterior arm by grasping the grasping forearm and sweeping it across the chest
attempt to deliver

**R** Roll
roll the woman onto all fours
attempt to deliver

If all of these measures fail, start again while awaiting the arrival of paramedics.
The major PPH drill provides a guide to general resuscitative measures that should be employed in the management of major PPH. In addition to the common initial steps, the specific causes of PPH should be assessed in each individual and action taken accordingly.

**Symptomatic Postpartum Haemorrhage**

**HELP**
- Delivery Suite Co-ordinator
- Ambulance Paramedic

**POSITION**
- Rub-up contraction
- lie flat
- 0₂

**IV ACCESS**
- 2 x 14 gauge cannulae
- FBC clotting
- UE
- for cross-match blood
- colloid infusion

**Empty Bladder**

**Consideration should be given to:**

**TISSUE**
- Retained placenta

**TONES**
- uterine atony

**TRAUMA**
- genital trauma

**IV Erogmetrine**

**colloid infusion**

**VE**
- bimanual compression
- analgesia
- repair

Women’s Services Directorate
Homebirth Guidelines, March 2010
PROCEDURE IN THE EVENT OF CORD PROLAPSE WHILST IN LABOUR

Definition

Cord presentation is the presence of the fetal umbilical cord in advance of any other fetal part. This may occur with or without rupture of the membranes.

Cord prolapse is the protrusion of the cord through the cervical os. This usually only occurs in the absence of membranes.

Management

When faced with cord prolapse, the aim of management is to:

• keep pressure off the cord
• keep the cord warm
• deliver the baby…
• without jeopardising the mother’s safety

See the algorithm below.

cord prolapse

stay calm

call for help

Ambulance paramedic    Delivery Suite Co-ordinator

use the fingers of your examining hand to apply
pressure
to the presenting fetal part
if the cord is lying outside the vagina
replace
it gently into the vagina
then
insert foley catheter into bladder and fill with 500mls normal saline, clamp and keep bladder full throughout transfer to hospital

roll **** check this out
the woman onto all fours
“Exagerated Sims” position for transfer in ambulance
and
transfer
her to Delivery Suite, RVI
PERINEAL REPAIR

Whenever possible the person delivering a woman should undertake perineal assessment and any necessary repair, under experienced supervision if necessary, with minimum delay. This should be done by vaginal and rectal examination, using the finger lift technique, under adequate light.

Classification of perineal trauma

1st degree – fourchette, superficial perineal and vaginal tissues

2nd degree – the above, plus muscles of perineal body

3rd degree – the above, plus partial or complete disruption of the anal sphincter

   3a - under 50 % of the external anal sphincter involved
   3b - over 50 % of the external anal sphincter involved
   3c - internal anal sphincter torn

4th degree – the above, plus anal epithelium

Analgesia

Adequate analgesia is essential. For local infiltration, 1% lidocaine may be used up to a total of 20 ml, this total including any lidocaine infiltrated prior to episiotomy.

Second degree tears

The management of a second degree tear is usually surgical since functional outcome after conservative management is unclear – there is little clear evidence to guide a woman so that she can make an informed choice. When a decision is made not to suture, the reasoning should be documented and the notes signed by the attending midwives.

In suturing a second degree tear, the aims are to achieve:

- anatomical re-alignment
- haemostasis
- healing by first intention

thereby reducing the risk of infection and restoring normal function.

Suture material

Vicryl and Vicryl Rapide are the suture materials of choice as they cause less perineal pain than other materials. Of the two, Rapide is absorbed more quickly (42 days versus 90 days), but there is no clear evidence to show that either one has a clinical advantage over the other.
Suture to the vaginal wall
As there is no firm evidence to inform practice, the vaginal wall may be closed with either a locking or a non locking continuous suture. The default position in this Trust however is to close this layer with a non locking suture.

Suture to the perineal body
Either continuous or interrupted sutures may be used to appose the disrupted muscles of the perineal body, moving from deep to superficial tissues in order. The default position in this Trust is to close this layer with a continuous suture.

Suture to the skin
The use of a subcutaneous suture on the perineal skin is associated with less short-term pain than interrupted sutures and is the technique of choice. The incidence of dysparunia after 3 months is similar in both groups. Non-closure of perineal skin is equally effective but offers no particular benefit in terms of healing or pain.

Operator skill
Practitioners should be appropriately trained and supervised to ensure a consistent high standard of perineal repair. (A competent trained practitioner should have completed the perineal repair package and be confident that they can repair the tear adequately).

NB 3rd & 4th degree tear require transfer to the RVI

Documentation
The repair should be documented in full on a perineal repair sheet. Needles, instruments and swabs should be counted and documented at the beginning and at the end of the procedure. The operator is responsible for safe sharp disposal.

Transfer in to hospital
These guidelines are to be followed should either the mother and/or baby need to be transferred in to hospital at any stage.

- A paramedic ambulance should be summoned and the delivery suite co-ordinator should be informed of the reason for transfer.
- One of the community midwives should accompany the woman in the ambulance to the hospital.
- The second midwife will stay at the home to tidy up as appropriate. The partner should follow in his own transport.

Mother - Intra-partum complications
- Regular monitoring of the fetal heart should be undertaken in the ambulance and recorded as appropriate.
- Entonox should be offered and used to discourage active pushing in the second stage of labour.
- The second paramedic should assist if required in a complicated delivery i.e. breech, cord prolapse etc.
- It may be appropriate to consider IV access i.e. antepartum haemorrhage.

Mother – Post-partum complications
- IV access must be obtained before leaving the scene.
- Regular observations of pv loss, BP and P should be recorded.
• If atonic uterus (PPH) consider Bi-manual compression
• The baby may be transferred with the mother if the paramedics are happy with this. Try to avoid separation of mother and baby but maternal wellbeing will be paramount.

Baby complications – NON-URGENT
• If the baby does not require urgent treatment i.e. grunting, congenital abnormality, low birth weight, it should be brought to the delivery suite with the mother. A paediatrician from ward 35 will be informed by the delivery suite co-ordinator and be on-standby for admission.

Baby complications - URGENT
• If the baby requires active resuscitation it should be taken to the A&E department. They should be alerted to this in advance and the delivery suite co-ordinator should inform ward 35 in case their assistance is required.
• One midwife should accompany the baby in the ambulance and assist the paramedics with the resuscitation.
• The second midwife will remain at home with the parents, ensure the mother is safe and that the third stage is complete. At an appropriate time an ambulance should be summoned so that the parents can attend A&E. The second midwife should then travel in the ambulance with the mother and remain with her at A&E. (Remember that this mother will only have delivered an hour or so ago and may be physically compromised as well as emotionally).
• Contact delivery suite and try and arrange for a hospital midwife to come over to A&E and relieve the community midwives.
• At an appropriate time to suit all arrange for collection of all equipment from the home.

Criteria for Transfer to RVI
• Maternal hypertension.
• Raise in maternal temperature after re check.
• Any deviation from the normal fetal heart rate.
• Meconium stained liquor.
• PV bleeding (APH or PPH).
• Prolonged 1st stage.
• Prolonged 2nd stage.
• Abnormal 3rd stage.
• Any obstetric emergency
• Malpresentation
• Unwell mother or baby post delivery

Documentation
If a mother and / or baby requires transfer into hospital at any stage then an SBAR tool must be completed and placed on the front of the notes. This transfer communication sheet ensures good communication and handover of essential information. It should be completed by the transferring midwife and signed by the accepting midwife. It should then be filed in the hospital notes.

There are 3 different SBAR tools:
1. transfer in of an intrapartum woman
2. transfer in of a postpartum woman
3. transfer in of an unwell neonate

SBAR – Situation, Background, Assessment and Transfer
(see Appendix 5, 6, 7)
USE OF WATERBIRTH AT HOME

Inclusion Criteria
- Between 37 weeks and 42 weeks gestation.
- Singleton pregnancy.
- Established labour.
- Informed choice of mother.

Exclusion Criteria
- Malpresentation.
- Intrauterine growth retardation.
- Antepartum haemorrhage and previous PPH.
- Meconium stained liquor.
- Known medical condition.
- Previous obstetric complication.
- Grand multiparity.
- A current history of epilepsy.
- BMI >30.

Women carrying GBS and women with risk factors for the development of neonatal GBS sepsis should not automatically be excluded from using the birthing pool.

ANTENATAL

Midwives Responsibility
- Discussion with named midwife regarding parents choices to include benefits and Risks.
- Agreed plan for pregnancy and birth to be documented in hand held records.
- Initial risk assessment as to suitability of facilities and Health and Safety assessment.
- Further risk assessment once pool has been delivered to ensure parents have fulfilled Their responsibility in terms of structural suitability.
- At 37 weeks gestation deliver home birth pack plus:
  Waterproof sonicaid
  Gauntlet gloves can be worn

Parents Responsibility
- Investigate and order appropriate pool.
- Purchase/hire room thermometer, pool thermometer and plastic sieve.
- Ensure home premises are suitable for a birthing pool i.e. structural suitability, facilities Or emptying and filling pool, suitable spaces and facilities around pool for delivery Outwith pool.
INTRAPARTUM CARE

First Stage of Labour

Before entering the pool:
- Labour should be established.
- Maternal and fetal observations are recorded and should be within normal limits.
- The woman should be encouraged to empty her bladder.
- Record temperature of pool and document on partogram (must not exceed 37°C).
  Recommended range 35 -37°C. ½ hourly on partogram.
- Room temperature should be 21-22°C – record on partogram hourly.
- Ensure all electrical equipment is kept away from the pool and water creating a safe
  environment.
- Inform Co-ordinator on Delivery Suite that you are attending a home waterbirth.
- Inform ambulance control.
- The mother should be aware of the criteria that would contraindicate waterbirth.
- The mother should be made aware that she can leave the pool at any time she wishes.

Once the woman has entered the pool:
- Water should be to the level of the woman’s breasts.
- The water temperature should be checked half-hourly and recorded on partogram.
- The woman should adopt any position she finds comfortable with the support of her
  Birth partner.
- The midwife should encourage oral fluids to prevent dehydration.
- Debris to be sieved out of the pool regularly to minimise the risk of infection.
- The woman can use entonox if required.
- Leave the pool at regular intervals to pass urine and also to avoid prolonged
  Immersion.
- At least one midwife should be in constant attendance during the 1st stage of labour,
  consideration should be given to the Lone Worker Policy.

Reason to leave pool – first stage of labour
- Elevated maternal temperature – an increase by 1°C above baseline or above 37.5°C.
- Vaginal examination.
- If the woman feels faint.
- Any deviation from normal.

Second Stage of Labour

- Two midwives should be in constant attendance in the 2nd stage of labour.
- Water temperature should be recorded every 5 minutes, ensure this stays between
  37 –37.5°C.
- Gauntlet gloves must be worn.
- Birth should be ‘hands off’ until baby is born.
- Pushing should be physiological (non directed) i.e. the mother should only be encouraged to
  Push when she has the urge, this should not be hurried.
- Do not routinely feel for cord around the neck – if the body is not delivered with the
  next contraction the woman must leave the pool.
• The baby should be born completely underwater and then immediately brought to the Surface for the mother to hold.
• Be aware of undue traction on the cord, taking appropriate steps if necessary i.e. Standing woman up.
• **Do not re-submerge baby.**
• Keep the body in the water – higher than uterine level to keep the baby warm.

**Reasons to leave pool – second stage**
• Any Fetal heart rate abnormality.
• Raised maternal temperature ↑ 37.5
• To perform an episiotomy.
• If body is not delivered with next contraction following expulsion of the head.

**Third Stage of Labour**

• Manage 3rd stage as per birth plan or clinical condition of mother i.e. physiological or active.
• If the third stage is going to be ‘active’, assist the mother out of the pool as soon as practical
  Administer oxytocic drug.
• An oxytocic drug should be available.
• Physiological Third Stage – The cord is left unclamped until the placenta and membranes are Expelled by the mother, whilst she is in the pool.
• When the placenta is expelled the mother should be encouraged to leave the pool as soon as practically possible.

**Baby Care**

• No need to clear airways actively unless clinically indicated.
• The baby may take a little longer to cry and may remain blue for longer than a birth on Dry land.
• Observation of the baby is required i.e. colour, tone, respirations and temperature. Record Observations in baby notes for **2 hours following delivery**.

**If a Woman Refuses Midwifery Advice**

• Re-emphasise the reason for her to leave the pool or be transferred to hospital for Reasons of safety.
• Inform staff at the RVI and to on-call Supervisor of Midwives.
• Ensure accurate record keeping.

**Support for Midwives is available via:**

• **The on-call Supervisor of Midwives**
• **Delivery Suite Co-ordinator**
CARE FOLLOWING HOME BIRTH

1. All clinical waste including placenta to be placed in labelled placenta bin. Contact Eurocare Hygiene Services as per protocol (Appendix 10).

2. Information to be entered onto OMS database. Print x 1 extra copy to be sent to Midwifery Manager, Community Services.

3. Notification of birth via NHS Numbers (Nathan) to be complete print labels and x1 birth notification.

4. Notification of birth is made to Midwifery Manager via the Community Secretary. Community Secretary will inform each base and arrange collection of gases.

5. Contact GP to inform of delivery and request neonatal examination which is to be recorded on baby notes and PCHR.

6. Collect a set of Hospital Baby Notes from Delivery Suite.

7. Postnatal visits following delivery are made in accordance with the unit guidelines. Collection of vitamin K for B/F babies should be organised via postnatal paediatrician following policy guidelines.

8. If homebirth **not** achieved complete audit form (appendix 11) and send to Midwifery Manager (community) via Community Secretary.

If women are RH Negative
- Bloods sent via delivery suite to transfusion
- A named midwife to be given to delivery suite co-ordinator for contact.
- Result returned to delivery suite
- Delivery suite Co-ordinator to contact community midwife via phone.
- Collect anti D from postnatal wards. Ensure prescribed on appropriate document by the midwife.
Newcastle Upon Tyne Hospitals NHS Trust

DIRECTORATE OF WOMEN’S SERVICES
HOME BIRTH BOOKING

THIS FORM IS TO BE COMPLETED FOLLOWING THE INITIAL VISIT AND FORWARDED TO COMMUNITY MIDWIFERY OFFICE

Name: ............................................  EDD: ......................................
Address: ..............................................  Hospital No: ............................

..................................................  DOB: ...........................................

Telephone No: ...............................

GP Details: .................................  Consultant
(if applicable) ............................... 

Parity: ............................

Prev Obstetric History: ...........................

Planned Waterbirth  Yes  No

Relevant Information/ Requests:

Name of Community Midwife: ......................

Base/Contact Tel No: ............................

Signature: .................................  Date of Completion: ..........................

Original copy – Homebirth Central File, Community Office
1 copy - GP
1 copy - Hospital Records
1 copy – Consultant Obstetrician (if applicable)

Women’s Services Directorate
Homebirth Guidelines, March 2010
Homebirth Equipment

- The delivery bag should be taken to the woman’s home at 37 weeks gestation in preparation for the homebirth.
- Stress to the women that it is her responsibility to store the equipment safely in view of the contents, in particular sharp items. Woman to sign relevant form accepting responsibility. Give information leaflet.
- It is the responsibility of the Midwife or Health Care Assistant returning the bag following delivery to ensure that it is replaced and re-stocked correctly. Sign and date the book in the store cupboard.
- It is essential that the Midwife/HCA collecting the equipment should also check the contents of the bag prior to delivery to the women’s home.
- Attending midwife to re check contents when woman in established labour.

Equipment

Sterile Packs
- Delivery pack plus “extra’s” bag
- Catheterisation packs x 2
- Midwives suture pack

Additional Disposable Sterile Equipment
- Disposable gloves sizes 5 ½ - 8 ½
- Bag of disposable gloves (medium/large)
- Entonox mouthpiece and filter/mask
- Amniihooks x 2
- In and Out catheters x 4
- Sachets of normal saline x 2
- Aqua gel sachets – for VE’s
- 2ml syringes x 10
- 10ml syringes x 4
- Green needles x 10
- Orange needles x 4
- Steret’s
- Vicryl rapide sutures x 2
- Foley Catheter
- Catheter pack

Rhescus Negative Pack
- Purple Haemotology bottle x 1
- Pink Transfusion bottles x 3
- Vacutainer
- Green/black vacutainer needles
- Blood transfusion forms x 2
- Haemotology form x 1
- Cotton wool balls
- Plasters x 2

Additional Disposable Equipment
- Green plastic aprons x 2
- Plastic drawsheets x 2
- Large yellow clinical waste bags
• Placenta bag
• Placenta bin – separate to collect
• Small sharps box
• 2 x vomit bowls

Emergency Kit
• Oxygen mask x 1
• Grey venflons x 4
• I V Dressings x 2
• Blood giving set x 2
• 1 litre Hartmanns
• Gelofusin 500mls x 2
• Sterets
• 1 litre normal saline

Additional Neonatal Equipment
• Mucous extractors x 2
• Additional cord clamp

Drug Box
• Syntometrine - 1 ampoule
• 20mls 1% lignociane
• Ergometrine 500mcg x 2

Laminated Sheets Information
• Telephone Numbers
• HELPERR
• Flowchart PPH
• Flowchart Neonatal Resuscitation

Notes
• Baby notes (need a hospital numbered set from Delivery Suite following birth)
• Partogram
• Proforma for OMS

**Neonatal Bag**

• Oxygen Cylinder
• Blow off Valve and ventilation t piece and circuit
• Stethoscope
• Face mask x 2 (Term and Preterm)
• Airways 00 x 1, 000 x 1
• Mucus extractor
• Entonox regulator & tubing
**SHOULDERS DYSTOCIA – Reporting Form**

Date ........................................

Delivery of head Spontaneous ☐ Instrumental ☐ addressograph

**HELP CALLED** Time ..........

Registrar called Yes ☐ No ☐ Time .......... Arrived .......... Name .................

Senior midwife called Yes ☐ No ☐ Time .......... Arrived .......... Name .................

Paediatrician called Yes ☐ No ☐ Time .......... Arrived .......... Name .................

Other persons in attendance ........................................................................................................

**PROCEDURE USED TO ASSIST DELIVERY OF THE SHOULDERS**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Tick</th>
<th>Time</th>
<th>Performed by (print name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H - Help called</td>
<td>☐</td>
<td>......</td>
<td>N/A</td>
</tr>
<tr>
<td>E - Evaluation for episiotomy (reason if not performed)</td>
<td>☐</td>
<td>......</td>
<td>........................................</td>
</tr>
<tr>
<td>L - Legs into McRoberts</td>
<td>☐</td>
<td>......</td>
<td>........................................</td>
</tr>
<tr>
<td>P - Pressure - Suprapubic pressure</td>
<td>☐</td>
<td>......</td>
<td>........................................</td>
</tr>
<tr>
<td>E - Enter - Wood screw manoeuvre</td>
<td>☐</td>
<td>......</td>
<td>........................................</td>
</tr>
<tr>
<td>R - Remove posterior arm</td>
<td>☐</td>
<td>......</td>
<td>........................................</td>
</tr>
<tr>
<td>R- Roll &amp;/or repeat</td>
<td>☐</td>
<td>......</td>
<td>........................................</td>
</tr>
<tr>
<td>Additional manoeuvres</td>
<td>☐</td>
<td>......</td>
<td>........................................</td>
</tr>
</tbody>
</table>

Mother on all fours/other ☐ ...... ........................................

**Time of delivery of head ..........** Time of delivery of body .......... Delivery interval .........mins

State which shoulder impacted: Left ☐ Right ☐

Traction: Routine (normal)* ☐ Increased* ☐

**FETAL CONDITION**

Weight .............. kg Apgar 1 minute ☐ minutes ☐

Cord pH: Arterial .......... Venous ............

Paediatric assessment at delivery (if required)

* Routine traction refers to the traction required for delivery of the shoulders in a normal vaginal delivery where there is no difficulty with the shoulders. *If increased traction is applied a detailed account must be documented in the notes.*

Signed .............................................. Print name .............................................

Adapted from the RCOG Guideline No. 42/ RVI Maternity Unit HELPERR form ADL Oct 2009
# Handover tool

## SITUATION

Date: 
Current status: 

## BACKGROUND

<table>
<thead>
<tr>
<th>Parity:</th>
<th>Gestation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies:</td>
<td>Medical history:</td>
</tr>
</tbody>
</table>

## ASSESSMENT

<table>
<thead>
<tr>
<th>P</th>
<th>BP</th>
<th>Temp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of last VE:</td>
<td>Dilatation and descent:</td>
<td></td>
</tr>
<tr>
<td>Membranes:</td>
<td>INTACT</td>
<td>SRM</td>
</tr>
<tr>
<td>Time of rupture:</td>
<td>Length of rupture:</td>
<td></td>
</tr>
</tbody>
</table>

## RECOMMENDATIONS: (Reason for transfer)

Delivery suite aware: ......................

SIGNATURE of person completing form: ......................

Time of transfer:

SIGNATURE of person receiving patient: ......................

Time of arrival onto Delivery Suite:

Medical staff informed of admission: Yes / No
For transfer of postpartum women from Home Birth to Hospital

Handover tool

Affix patient identification label in box below or complete details

<table>
<thead>
<tr>
<th>Surname</th>
<th>Patient I.D. No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forename</td>
<td>DOB</td>
</tr>
<tr>
<td>NHS No.</td>
<td>Sex. Male / Female</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Postcode</td>
<td></td>
</tr>
</tbody>
</table>

SITUATION
Date:
Current status:

---------------------------------------------------------------------------------------------------------------------------

BACKGROUND
Parity: Time of birth:
Allergies: Medical history:

---------------------------------------------------------------------------------------------------------------------------

ASSESSMENT

P  BP  Temp  Urinalysis

Actively bleeding yes / no  EBL ..............................
IV access yes / no  IV fluids .................................
Placenta delivered yes / no  Drugs given ..........................

---------------------------------------------------------------------------------------------------------------------------

RECOMMENDATIONS (Reason for transfer)

Delivery suite aware .................................

---------------------------------------------------------------------------------------------------------------------------

SIGNATURE of person completing form: ......................................
Time of transfer:
SIGNATURE of person receiving patient: ......................................
Time of arrival onto Delivery Suite:
Medical staff informed of admission Yes/ No

---------------------------------------------------------------------------------------------------------------------------
Handover tool

SITUATION
Date:
Current status:

----------------------------------------

BACKGROUND
Parity:      Time of birth:
Maternal Medical history:   Length of ruptured membranes:

----------------------------------------

ASSESSMENT
Apgars  -               /1  /5 /10
Resuscitation required :

Colour :  Tone :   Resps :   Temp:
Other :

----------------------------------------

RECOMMENDATIONS (Reason for transfer)

Delivery suite / Paeds aware .................................................................
Transfer plans for mother .................................................................
SIGNATURE of person completing form: ..............................................
Time of transfer :
SIGNATURE of person receiving patient: ............................................
Time of arrival onto Delivery Suite / Ward 35:

----------------------------------------
Dear

As you have chosen to deliver your baby at home it is essential that we provide you with items of equipment after your 37th week of pregnancy to be used by the midwife at the birth.

The equipment is contained within a transportable trolley bag and can be stored easily. The bag is sealed by a zipper and does not hold a secure lock.

As the delivery bag contains sharp/breakable articles, such as needles and bottles it is strongly advised that you store this bag safely and in particular out the reach of children.

Please note: the bag does not contain any drug items.

Entonox and oxygen cylinders will be delivered separately to your home at 37 weeks by North East Ambulance Service. We have included a letter on how to store these safely.

Arrangements will also be made to collect them from your home following the birth of your baby.

Please ensure that the bag and equipment are available for your midwife at the time of delivery. Equipment found to be missing or tampered with may affect our ability to conduct your delivery.

The Newcastle Upon Tyne Hospitals NHS Trust must request that you assume total responsibility for the safe storage of this equipment in our own home prior to delivery and thank you for your cooperation in this matter.

Can I take this opportunity to wish you well throughout the remainder of your pregnancy and a safe delivery of a healthy baby.

Yours sincerely

Community Midwife
APPENDIX 9

SAFE STORAGE OF MEDICAL GASES IN THE HOME
(Home Delivery Only)

Medical gases can be dangerous as they are flammable and can be explosive if exposed to inappropriate conditions. Could you please read the following instructions carefully and ensure that you store the medical gases safely in your home.

1) Gases must be stored in an upright position against an outside wall

2) The area must be well ventilated

3) Free from sources of ignition, heat sources and flammable substances

4) Children should not have access to the storage area/room

5) The container which the gases are stored in, must not be tampered with in any way and must be kept locked at all times, until the time of delivery.

6) Once the container with the medical gases is stored in a secure position it must not be relocated or handled in any way

7) In the unusual event of a fire you must evacuate your home, call the fire brigade and inform them of the medical gas hazard and its location in your home

8) Once your home delivery has taken place the Ambulance Service will remove the medical gases

9) If you require any further advice and guidance please contact the Trust Health and Safety Advisor
Newcastle Upon Tyne Hospitals NHS Trust

Directorate of Women’s Services

Protocol for Home Births Collection Service

Trust Facilitator                        Service Provider

Contract arrangements                                 Eurocare Hygiene Services
Phil Punton, Estates Department                                 Telephone General: (0191) 295 0071
Freeman Hospital                                                         Fax:                          (0191) 295 1541
Ext: 31293

Eurocare Contact Details

Monday-Friday 09.00 – 17.00 Telephone: (0191) 295 0071

Collection Response Times

Normal; 24 hours max 36 hours
A request on Friday will be collected on Saturday
A request on Saturday will be collected on Monday

Details Required

When logging a call to Eurocare provide following details:-

House Number, Street Name, Area & Postcode
Telephone Number
Contact No for Community Midwife (0191) 282 5711 (Mon-Fri 10am – 2pm)

The closed rigid waste container with EN 3291 should be available for collection and stored safely inside the house. The container should be labelled with the unique Duty of Care label which will provide an audit trail if required.

Enter following details in logbook in Community Store, RVI

37 Weeks

• Name and address of client
• Waste Bin Number…………………………

Post Delivery

• Waste to be collected       Yes □ No □
• Waste bin returned unused   □
HOME BIRTH UPDATE

To be completed by the named midwife following delivery if home birth was NOT achieved and sent to Midwifery Manager, Community Services.

Named Midwife

____________________________________

NAME AND ADDRESS OF WOMAN

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

1) why did she transfer into hospital care?

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

2) Did she labour at home? □ Yes □ No

If yes, please complete Question 3 & 4

3) Was she transferred into hospital:

   In the first stage of labour? □
   Second stage of labour? □
   Third stage of labour? □
4) What reason?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

5) What was the outcome of delivery?

__________________________________________________________________________________

6) Gestation at time of delivery: _________

7) Date of delivery: ___________ 2 0 0

8) Sex of baby:  Male □  Female □

9) Weight of baby: ________________

10) Any Other Comments: ________________________________
                                               ________________________________
                                               ________________________________
                                               ________________________________
                                               ________________________________

Thank you for taking the time to complete this information.
References


