


Title: <b>Midwifery practice guideline and management of a planned home birth</b>		<b>Barnsley Hospital</b>  NHS Foundation Trust	
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Appendix 1 – Obstetric Guideline Outline

## Introduction

### Rationale

To provide an evidence based, professional service promoting choice for women in relation to place of birth, including access to midwifery care for home birth (NMC 2006, Maternity Matters DOH 2007)

### Scope

This guideline applies to all Community Midwives who offer care to women in the Barnsley area

### Principles

To ensure that the care delivered by the Community Midwives working in the Barnsley area is evidence based and follows best practice guidance.

## **Guideline Outline:**

1. Principles of practice including provision for medical support
2. Criteria for hospital transfer
3. 'On call' arrangements
4. Equipment
5. Drugs required

## **Principles of practice**

The notification of the client's choice for home delivery and any relevant information should be completed by the named Community Midwife and circulated to all Community Midwives, Labour Ward, Supervisors of Midwives, and the Head of Midwifery, as early as possible ideally by 37 weeks gestation.

Women booking for home delivery should fulfil the criteria for 'Low Risk' (please refer to antenatal care pathway for specific criteria). The **named Community Midwife** is the lead professional for women requesting home delivery and has the responsibility for briefing the women regarding emergency transfer details and providing supporting information.

If the woman is deemed to be 'High Risk' the midwife should discuss the specific details with the woman and refer to a Consultant Obstetrician and Supervisor of Midwives for support where appropriate. The consultant who reviews the case is not assuming responsibility should the woman proceed with her request for home delivery. Risk Assessments should be in place for the safety of the mother and the support of the midwife.

If there are any deviations from normal the midwife must seek medical advice and /or transfer without delay. (NMC 2004) Implications and explanations must be discussed with the woman prior to transfer.

Emergency transfer to be arranged by 999 call by the midwives in attendance, requesting appropriate ambulance transfer to hospital. **Do not contact Labour Ward as this can cause delay.** Communication with the Labour Ward can be made after 999 emergency call and the appropriate 'stand by' plan to be arranged with the shift leader. The midwife must accompany the mother (and baby if delivered) in the ambulance.

### **Inclusion criteria for labour/delivery at home:**

- Low risk antenatal criteria
- 37 week gestation or more
- Clear liquor
- Cephalic presentation confirmed on ultrasound scan at 36 weeks.
- Normal blood pressure
- Normal temperature and pulse rate
- No evidence of fetal distress
- Stable lie
- No previous caesarean section
- No previous retained placenta/post partum haemorrhage
- Normal blood profile

### **Criteria for intra-partum transfer**

- Fresh meconium stained liquor
- Fetal distress detected as per monitoring in labour following NICE Guidelines recommendations.
- Ante-partum haemorrhage
- Hypertension/eclampsia
- Pyrexia
- Maternal tachycardia
- Failure to progress/malpositions
- Malpresentations
- Maternal request

### **Criteria for Post partum transfer**

- Retained placenta
- Post partum haemorrhage
- Extensive perineal trauma.
- Hypertension/eclampsia

### **Criteria for neonatal transfer**

- Low apgar / advanced resuscitation
- Hypothermia, suspected hypoglycaemia
- Congenital abnormalities which necessitate urgent review
- Fresh Meconium liquor prior / at delivery
- Birth trauma

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

- **Two** Community Midwives must attend the delivery.
- All Community Midwives should be aware of the intrapartum management in accordance with NICE guidelines on intrapartum care.
- In the event of 'High risk' cases delivering at home the Obstetric Team must be informed when the woman is in established labour by the labour ward shift leader following communication from the 'on call' Community Midwife. However, it must be noted that the Obstetric Team cannot be held responsible for the outcome of the home delivery. A Supervisor of Midwives can be called for additional support if required.
- Arrangements for the medical examination of the baby must be made within 72 hours of birth.
- Hearing screening to be arranged by the Community Midwives attending the delivery

**NB** At the initial interview with the women it is important that the Community Midwife informs the woman that in exceptional circumstances the 'on call' Community Midwives may not be available due to demands within the unit/elsewhere. This discussion should be recorded.

### **All discussions must be recorded in the client's records (NMC 2004b)**

### **SROM after 37 weeks of pregnancy**

SROM (Spontaneous Rupture of Membranes) after 37 weeks of pregnancy, not in labour.

#### Management

Between 0900 and 1700 a Community Midwife will attend the woman either at home / or local ANC to confirm SROM by undertaking to:

- Confirm SROM by fluid collection at vulva in a sterile container.
- Sterile speculum examination (not necessary if there is obvious liquor draining)
- Avoid digital examination

- Pulse/temp/FBC
- Record FH
- Make arrangements for admission to labour suite for augmentation within 36 hours if spontaneous labour does not occur.
- FBC result to be obtained as soon as possible. A raised White cell count may necessitate admission to the Maternity unit (inform registrar).
- Women are advised to contact labour suite immediately if feeling generally unwell or liquor changes colour, or any reduction in fetal movements.
- If prolonged SROM >48 hrs obtain swabs from neonate, ears and umbilicus.

**Out of hours: The woman should contact Labour Ward and attend for review and care as above.**

### **'On call' arrangements**

**Two** community midwives will be on call from 5pm till 9am every day.

- When a call is received from the labour ward with information that the woman is in labour, the labour ward staff will contact the Community Midwives 'on call'. The Community Midwives called will then liaise accordingly and identify the lead midwife for the case. The second midwife will collect the equipment/gases from BHNFT. It may be essential to rendezvous in certain circumstances and arrive together. (Please see lone worker guideline.)
- During the day the Team Leader should be informed to co-ordinate staff.
- The Labour Ward staff obtains the woman's notes following the call and records the details, and will update if any further developments.
- For security purposes on arrival at the clients' home the Community Midwife will inform Labour Ward of their arrival. It is the Community Midwives responsibility to ensure her lone worker device is charged and activated.
- The Community Midwife is accountable for the care in the Community but should inform the Labour Ward shift leader should any potential problems arise in order to provide a co-ordinated approach to ongoing care.
- The Labour Ward shift leader during the handover **must** highlight the details of the case and this will be recorded on the labour Ward information board.

## **Essential home delivery equipment to be left in client's home**

- Equipment and drugs should be stored safely at the woman's home address by 37 week gestation. (See Home Delivery equipment list, and Standing Operating Procedures, related to checking of equipment and collecting and returning of equipment.)
- Drugs to be stored safely in the woman's own refrigerator.

All drugs and medicine should be given in accordance with the statutory codes and local policy (NMC 2004). The named Community Midwife should discuss pain relief options with the woman prior to labour including non-pharmacological preparations.

## **Management of 1<sup>st</sup> stage of labour**

The allocated midwife will attend the woman and will perform a full antenatal examination including:

- Abdominal palpation
- Baseline observations
- Vaginal examination
- Risk assessment/management plan

Once the woman is confirmed to be in the active phase of labour, progress and observations will be recorded on the partogram.

## **Observations**

Temperature (4 hourly)

Blood pressure (2 hourly)

Pulse (1/2 hourly)

Fetal heart ¼ hourly)

## **Vaginal examinations**

Vaginal examinations are used to determine the onset of labour and thereafter to assess progress by measuring cervical dilatation and descent of the presenting part. Consider examinations 4 hourly to ensure satisfactory progress.

## **Amniotomy**

An amniotomy may only be performed at home with informed consent if the head is engaged

## **Pain relief**

Entonox should be available.

## **Management of 2<sup>nd</sup> stage of labour**

- Protective clothing to be worn by midwives in attendance (Universal precautions).
- If the woman has a period of passive 2<sup>nd</sup> stage the fetal heart is to be recorded every 15 minutes and maternal observations every 30 minutes
- During active 2<sup>nd</sup> stage fetal heart to be recorded after every contraction and maternal observations every 15 minutes

### **Management of 3<sup>rd</sup> stage of labour**

**Discussions would have taken place within the birth plan as to active or physiological management of the third stage of labour.**

#### **Active management**

- Syntometrine IM is given with delivery of the anterior shoulder.
- The placenta and membranes are delivered using controlled cord traction.
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#### **Physiological Management**

- Await spontaneous unassisted delivery of the placenta and membranes, avoiding traction, can be supported by maternal effort, encourage early feeding and closely observe for excessive blood loss.

#### **In all third stages of labour**

- Inspect the perineum and vagina for trauma and repair as appropriate.
- Inspect the placenta and membranes and ensure they are complete. Obtain cord samples if necessary.
- Check maternal observations and support with feeding as appropriate, encourage skin to skin contact.

### **PLEASE INFORM LABOUR WARD OF THE DELIVERY OUTCOME**

- Prior to leaving the home check the uterus, lochia, blood pressure, pulse and obtain maternal samples if necessary and arrange for the administration of anti D if required.
- Ensure record keeping is completed, postnatal records completed for mother and baby remains at the home.

- **Leave contact numbers**

**On completion of delivery:**

1. The placenta is transported to Labour ward for disposal. If the woman requests to keep the placenta she must be made aware of safe methods of disposal.
2. Cleaned equipment and clinical waste must be returned to the hospital for appropriate and safe disposal. Please refer to the Trust policy regarding transport of clinical waste. All midwives must carry the required documentation for the transportation of clinical waste.
3. The Community Midwives must remain in attendance until the mother and baby are stable and arranges handover of the care.
4. On return to BHNFT all equipment is returned and restocked according to Standard operating procedures.
5. Community Midwife to complete Birth Notification and the Home Birth Register. Complete data inputting-computerised maternity information system. Copies of information to be forwarded to the woman.

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