Clinical Guideline for Planned Home Birth Management

A Clinical Guideline

For use in:	Maternity Services
By:	Midwives
For:	Planned Home Birth – an interim Guideline in use prior to implementation of Home Birth Team for pregnant women 37+0 and 42+0 weeks gestation.
Division responsible for document:	Women and Children
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Name and job title of document author:	Pam Sizer, Midwifery Matron Dianne Fonseka, Claire Muckley, Karina Waite Registered Midwives
Name of document author's Line Manager:	Emma Hardwick
Job title of author's Line Manager:	Head of Midwifery
Supported by:	Beth Gibson, Maternity Guidelines Lead
Assessed and approved by the:	Maternity Guidelines Committee If approved by committee or Governance Lead Chair's Action; tick here
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Compliance links: *(is there any NICE related to guidance)*	No
If Yes - does the strategy/policy deviate from the recommendations of NICE? **If so why?**	N/A

Objective

To ensure that all women who chose to birth at home are cared for safely and effectively. That any deviations from normal are dealt with in the most appropriate way and transfers of mother and/or baby to the hospital are made in a timely and appropriate manner.

Rationale

All midwives should be competent to attend a home birth. However, if any Midwife feels they lack confidence in home birth, must recognise their professional responsibilities with regard to the NMC framework and raise any concerns with their immediate line manager.

Most women choosing to have a baby at home are deemed to be 'low risk' and therefore within the remit for midwifery care, however some women who do not fit the criteria may also choose to give birth at home. This guideline outlines the criteria for women wishing for a home birth, gives advice for when women who are not 'low risk' choose a home birth and provides a framework for midwives attending home births.

Broad Recommendations

The choice of place of birth, including home birth, should be documented at booking for all women and agreed later in pregnancy. However, discussion is appropriate at any stage of pregnancy.

The decision regarding planned place of birth should be made by 36 weeks to allow time for planning, or as soon as the woman has opted for a home birth if the decision is later than 36 weeks.

The Matron for Community Services should become involved where there is a perceived risk or contraindication to home birth, and the woman intends to give birth at home. They may involve a consultant obstetrician. Evidence of discussion and the plan for care should be documented in the digital maternity record (EuroKing)

Planning place of birth

All low-risk women should be offered the choice of planning birth at home, in a midwife-led unit, or in an obstetric unit. Women should be informed of the following information when discussing options:

- Giving birth, for women at low risk of complications, is generally very safe for both the woman and her baby.
- Birth at home for first time mothers is generally safe for the mother and baby but there is a slightly higher risk of an adverse outcome for the baby, compared to giving birth in a midwife-led unit or obstetric unit (NPEU 2015).
- For low risk multiparous women, giving birth at home or in a midwifery-led unit (freestanding or co-located) is advisable, as the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.
- Of locally available services, the likelihood of being transferred from home into the obstetric unit and the time this may take.
- That the obstetric unit provides direct access to obstetricians, anaesthetists, neonatologists and other specialist care including epidural analgesia.

- If something does go unexpectedly seriously wrong during labour at home, the outcome for the individual woman and baby could be worse compared to if they were in the obstetric unit with access to specialised care.

It is the responsibility of the Midwife undertaking the home birth discussion to complete the booked home birth delivery form and to send this to the Community Secretary. The Midwife will then collate the information on all impending home births and insert these in the home birth folder (kept in the Specialist Midwives office) so that Community Midwives can familiarise themselves with any forthcoming home births, the women's address and any access issues and plans in place specifically for that birth.

Criteria

The midwives responsible for discussing options and providing care should follow the criteria set out in this guideline and recognise, as well as advise women, when it may be necessary to transfer responsibility for care.

To reduce risk it is advised that any woman intending to have a planned home birth should observe the following criteria:

- Between 37+0 and 42+0 weeks gestation.
- Age: if > 40 at booking, in spontaneous labour before planned induction of labour (IOL), as agreed with consultant obstetrician.
- Para 0-5 (excluding miscarriages and terminations).
- Singleton pregnancy.
- BMI < 40 on admission in labour and good mobility – the admitting Midwife needs to calculate and assess this on admission.
- Cephalic presentation (confirmed at 36/40 using a V-scan, where available).
- Spontaneous onset of labour or Artificial Rupture of Membranes (ARM) only IOL.
- If membranes have ruptured, liquor must be clear/non-significant meconium.
- Rupture of membranes must be less than 24 hours at onset of labour.
- No epidural requested.
- No known or envisaged medical, obstetric, anaesthetic or neonatal complication.
- No previous significant obstetric history.
- No known history of HIV or Hep B.
- HB over 9.0g/l.

Some women who may not fit the above criteria will choose to have a home birth. It is the Midwife's responsibility to ensure all options and associated risks have been discussed and recorded and respect the choices a woman makes (NMC 2018). Any risk factors and the additional care that can be provided in the obstetric unit should be discussed with all women using best available evidence in order that she can make an informed choice about place of birth (RCOG 2007).

If there is a particular concern during the antenatal period, e.g. for a high risk woman, it is recommended that the management of the case be discussed with the Community Team Leader. The Matron for Community Services may also be contacted for advice. All discussions with women should be documented regarding the risks in E3. This discussion

should take place as early in the pregnancy as possible and revisited at the 36 week home visit.

If there is a discrepancy between the woman's choices versus the perceived risks of caring for her in the home setting, then the Midwife must continue to give care but should involve her manager and the team linked Obstetric Consultant. At the onset of labour, wherever possible, the Midwife involved in the care of the woman should seek support from the on-call Matron (NMC 2018).

Pre labour rupture of membranes

Those women who report suspected membrane rupture but no signs of labour, should be invited for assessment in Midwifery Assessment Unit (MAU) within 12 hours of SRM – provided the liquor is clear, the presentation is known to be cephalic, and there is no evidence of reduced fetal movements. This assessment should be to:

- Assess fetal well-being with a Cardiotocograph (CTG).
- Confirm diagnosis of membrane rupture, if in doubt, by sterile speculum examination.
- Exclude clinical evidence of infection (temp, pulse rate, uterine tenderness, vaginal discharge, fetal tachycardia).
- If labour establishes within 24 hour of rupture of membranes, where fetal movements are normal, liquor is clear and where there are no signs of infection, the planned home birth should continue if the woman wishes.

Use of Entonox in the community

Each community Midwife will be issued with a cylinder of Entonox and be instructed in its use in a community setting.

Replacement Entonox cylinders can be obtained via Delivery Suite, behind the entrance door to the elective theatre.

Ideally, Entonox should be stored at temperatures above 10°C. Separation of the gases may occur below 0°C. The cylinder may be gently agitated to recombine the gases. This will also help the Entonox to last longer if the supply is running out.

It is the responsibility of the Midwife to transport the Entonox appropriately. The Entonox cylinder needs to be kept in the dedicated Entonox bag, stored horizontally and securely in the boot of the car surrounded by the other equipment to minimise any movement.

Labour and Birth

- Once a woman is in established labour, the Midwife should remain with her. The Midwife should contact the 2nd Community Midwife for the 2nd stage of labour.

  From 5pm-8am the support of 2nd Midwife will come from the Midwife-Led Birthing Unit (MLBU).

  The 2nd Midwife does not need to attend immediately unless the woman is in advanced labour. Whilst the attendance of a 2nd Midwife is not a legal or professional requirement, it is recommended that a 2nd Midwife attend for the birth of the baby to provide support and assistance. If the woman's choice does not fit the

guideline criteria, it is considered best practice for 2 midwives to be present during the labour and birth.

- The location and time taken to travel to the home birth address should always be considered when calling for the 2nd Midwife.
- Students can only attend a home birth with a Midwife and act under direct supervision. See below for guidance relating to students.
- A risk assessment should be completed on initial assessment of the woman / fetus and is be a continuous process throughout labour and birth. Any risks that are identified should be documented in the maternity hand-held records and E3 with an individual management plan.
- All care and observations during labour and the immediate postnatal period must be in accordance with the Trust guideline for intrapartum care in all settings Trustdocs ID: 850 recorded in the maternal hand held records. The fetal heart should be monitored as per Trustdocs ID: 840. Transfer to Delivery Suite should be considered if there is any deviation from the normal.
- In order to prevent prolonged 2nd stage of labour, if there is no obvious progress in the active 2nd stage (as per Intrapartum Care Guideline Trustdocs ID: 850), the Midwife should assess the situation and make a plan taking into consideration the woman's parity and distance from the hospital. The plan of care made and the rationale must be documented in the hand held records.
- For all women **in labour,** any transfer to hospital must be by ambulance and the Midwife must accompany the woman. The handover tool must be used (Appendix 1).
- All Midwives undertaking home births should be able to manage obstetric and neonatal emergencies and should practice them regularly (NMC 2019).
- It is the responsibility of individual midwives to ensure that they have attended at least annual mandatory training, PROMPT and NNUH community drills and skills to manage obstetric and neonatal emergencies (NMC 2019).

Transfer to hospital

Calling an ambulance

Where transfer in labour or post-partum is necessary, it is the responsibility of the midwife to summon an ambulance (via a 999 call). The Midwife must make it clear to the call staff that they are a health professional and arranging a 'Health Care Professional (HCP) admission'.

The call centre staff will ask a series of questions (location/ contact telephone number/ patient's age/ is she awake/ breathing?) which will prioritise the urgency of the ambulance request, as per the ambulance protocols. The call centre staff will then ask for the reason for admission and whether a health care professional is with the woman.

If it is an emergency situation, it should be stated that it is '**an obstetric emergency'** and a **paramedic emergency ambulance requested** (as in the situation of, for example, maternal collapse, cord prolapse, post-partum haemorrhage, need for neonatal resuscitation, fetal heart rate (FHR) abnormalities).

A paramedic ambulance should only be requested if skills are required that only a paramedic can provide (i.e. IV access, intubation, extended drug administration and more

invasive techniques); if an emergency technician if first on scene and identifies that additional skills are needed he will request these from the control room.
The call centre will ask whether the situation creates an 'immediate threat to life' of the mother and/ or baby (as in the example situations described above). The response will result in one of the following three options:

Is there an immediate threat to life?	Ambulance response
No	'Normal road speed' response within a 4hour window unless sooner is specified. Unlikely to be appropriate in a home birth situation.
No, however lights and sirens required	Blue light' response graded as a 'G1' call with a target response time of 20 minutes (immediate response)
Yes	'Blue Light' response graded as an 'R2' event with a target response of eight minutes without AED (automated external defibrillator) on scene ('immediately life threatening') **Most likely to be needed for an obstetric emergency**

The Midwife may delegate the request for an ambulance to another person, e.g. the 2nd midwife present, Student Midwife or the woman's partner but where possible, the call should be made by the Midwife.

Maternal transfers

The mother should be transferred to NNUH Delivery Suite. The Midwife should phone ahead on 01603 287393 to inform the Delivery Suite Coordinator of the reason for transfer. The Coordinator will ensure that the Obstetric Team have been informed of impending transfer. An obstetric review by a senior member of the team will take place on arrival. All documentation should be continuous and contemporaneous in the intrapartum notes by both Midwife and Obstetrician.

Handover of care should be undertaken using Situation, Background, Assessment, Recommendation (SBAR sticker) (and in accordance with the Management of: Handover of Care Guideline Trustdocs ID 1434.

Transfer of the baby

If the baby requires transfer to hospital in the immediate neonatal period following the birth (e.g. resuscitation was required at birth, baby 'unwell', preterm or small-for-dates), s/he should be transferred to the NNUH Delivery Suite via ambulance. If the baby is being given active resuscitation s/he will be received on Delivery Suite by the Neonatal Emergency Team.

The Midwife or Paramedic, if in attendance, should notify the Delivery Suite (01603 287393) of any baby born at home who requires transfer for resuscitation and / or stabilisation. Delivery Suite should liaise with NICU to ensure the senior neonatal on-call team are informed of any baby potentially requiring admission from home.

Babies born but not yet admitted will require a hospital number and admission generating prior to arrival so that treatment is not delayed.

Identification labels must be secured on all babies prior to transfer to hospital.

A separate ambulance for the mother should be requested if both mother and baby require transfer. If two midwives are present at the birth, one should accompany the baby in the ambulance. If there is only 1 Midwife, then an assessment should be made as to whether she should stay with the mother or baby. **Immediate postpartum care**

The Midwife should remain with the woman for a minimum of two hours following the birth of her baby. She should ensure that the woman is able to void urine post-delivery. However, if the woman is unable to do so, she should advise the woman what action to take, and when. Refer to Guideline: Bladder Care in Labour and Postnatally Trustdocs ID: 12617

For Rhesus negative women, the relevant samples must be sent to the laboratories. It is the responsibility of the midwife attending the birth to ensure that the results are obtained and that anti-D is given if required, or to delegate appropriately as required. Refer to Management of Anti-D Immunoglobulin in Pregnancy Guideline Trustdocs ID: 827

The placenta may be kept by the woman, or taken to the hospital for disposal. If removed from the house it must be transported in a placenta pot to avoid contamination of personnel or equipment. If it is kept by the woman, she must be given advice as to its safe disposal, i.e. it should be burnt, or buried at least two feet deep, to avoid disturbance from animal wildlife. If buried then the Deeds for the property should be checked to ensure it does not need to be declared.

The woman and her partner must be given contact phone numbers in case of emergencies and be informed of how to contact a midwife for general help and advice via Medicom (01603 481222) before the midwife leaves the house. The woman should be made aware of when she will next be visited.

The woman's community team should be informed of the birth by leaving a message via Medicom (01603 481222). Plans must be made for the next visit, which should be determined according to clinical judgement and the woman's needs as well as the time of day. The woman should be left with advice about basic safety and care principles in looking after the baby, including:

- Sleeping Positions.
- Environmental Temperature.
- Analgesia.
- Recovery from the Birth.
- Infant Feed.

The delivering midwife should write an individualised care plan to address any care needs until the woman and baby receive a visit from a community midwife.

Documentation

A midwife is accountable for the documentation of the care s/he has delivered. If two midwives are present at the birth, it should be evident in the documentation who has delivered care; each midwife remains accountable for the care she has given and for her respective written entry/ entries.

If two midwives are present during labour and / or birth, they should agree which clock to use if both make written entries in the woman's notes.

Where electronic documentation is not available during the labour care episode all paper documentation should be kept and electronically recorded into E3 at the earliest opportunity or on arrival on Delivery Suite when disposing of home birth clinical waste, whichever is soonest.

General

- The 'Home Birth Checklist' booking form (Appendix 2) must be completed. This form, along with a directional map to the premises, needs to be sent to the Community Midwifery Matron to enable it to be placed in the home birth folder.
- No Midwife or Student Midwife should give their mobile or home contact numbers to women receiving their care; Medicom, as a point of contact should always be used.
- All midwives must carry the necessary standardised equipment (see Appendix 3 for standardised equipment list) for a safe home birth. It is the Midwife's responsibility to ensure that all equipment is in good working order and, where applicable, in date. All equipment must be serviced at least annually.
- It is the Midwife's responsibility to ensure that drugs carried are in date and stored appropriately. The midwife should be aware that syntocinon, oxytocin and ergometrine deteriorate at temperatures in excess of 25°C. A cool box/bag should be used when necessary.
- It is also the Midwife's responsibility to ensure that their mobile phone is adequately charged so that it is available to call assistance if necessary.
- All waste from the birth will be safely disposed of in accordance with Trust Health & Safety policy Trustdocs ID: 607.
- Ensure that the labour summary is recorded in the maternal hand-held records and on E3. The receptionist on Delivery Suite must be contacted and asked to admit the woman on PAS to the 'home ward' on arrival of the Midwife, and to transfer from 'home ward' to community when the midwives leave. The E3 documents will be printed to Delivery Suite reception with the yellow NNST labels and the receptionist should be asked to post these to the woman's address. The woman's hand-held maternity record is returned to the 'home birth' tray on Delivery Suite reception. Responsibility for ensuring continuing postnatal care for both mother and baby following birth rests solely with the Midwife attending the birth. The Midwife should inform the named Midwife or her substitute. Care must be handed over using the appropriate handover tool - SBAR handover tools.
- The Midwife must complete a postnatal VTE risk assessment using the risk assessment tool (Appendix 4) and if LWMH is required the on-call Obstetric team should be contacted to prescribe TTO's. Instructions should be given to the woman and/or her family how they organise collection from the hospital.
- The Midwife attending the birth is responsible for arranging for a qualified Midwife Neonatal Examiner (MNE) to carry out the newborn infant physical examination (NIPE) within 72 hours of the birth. She should follow the procedure outlined in the Trust Guideline for Arranging a Neonatal Examination in the Community Trustdocs ID: 820. If she is unable to arrange for a MNE, either from her team or from another team, she will arrange for the neonatal examination to be done in the postnatal ward (Blakeney) or on the MLBU at a time convenient for both the parents and the department.

- Parents are to be offered pre and post-ductal oxygen saturation monitoring on MLBU to be arranged preferably within the first 24 hours of birth in order to identify some babies with CCHD.

Guidance relating to Student Midwives

- When attending a home birth the Midwife should inform the student and arrange to meet at the woman's address. If the student arrives first, she should remain in her car out of sight until the Midwife arrives. Under no circumstances should the student enter the premises before the attending Midwife.

Clinical Audit Standards derived from the guideline

The Maternity Services are committed to the philosophy of clinical audit, as part of its Clinical Governance programme. The standards contained in this clinical guideline will be subject to continuous audit, with multi-disciplinary review of the audit results at one of the monthly departmental Clinical Governance meetings. The results will also be summarised and a list of recommendations formed into an action plan, with a commitment to re-audit within three years, resources permitting.

Summary of development and consultation process undertaken before registration and dissemination

This guideline was originally written by Glynis Moore. This version has been updated by Pam Sizer, Midwifery Matron, Dianne Fonseka, Claire Muckley and Karina Waite, Community Midwives. Input has also been obtained from community Team Leaders and members of the Guidelines Committee which includes clinically based midwives, senior midwives and members of the Obstetric Team. This guideline was approved by the Head of Midwifery and Directors of Clinical Governance.

Distribution List

Community Team Leaders
Head of Midwifery
Clinical Midwifery Matrons
Trust Intranet

References

Birthplace in England Collaborative Group (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. British Medical Journal, 343:d7400 doi: 10.1136/bmj.d7400.

Birthplace in England Research Programme: further analyses to enhance policy and service delivery decision-making for planned place of birth (2015) - Accessed via npeu.ox.ac.uk/birthplace/birthplace follow-on study

Brocklehurst P et al (2011) Perinatal and Maternal outcomes by planned place of birth for healthy women with low risk pregnancies: Birthplace in England national prospective cohort study. British Medical Journal BMJ 2011;343:d7400 https://doi,org/10.1136/bmj.d7400

Brocklehurst P (2011) The Birthplace Study. National Perinatal Epidemiology Unit, Oxford University.

Intrapartum Care Guideline Trustdocs ID: 850

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

Nursing and Midwifery Council (2019) Standards for Proficiency for Midwives, Available at https://www.nmc.org.uk/globalassets/sitedocuments/standards/standards-of-proficiency-for-midwives.pdf

Bladder Care in Labour and Postnatally Trustdocs ID: 12617

Fetal Monitoring and Blood Sampling Trustdocs ID 840

Management of Anti-D Immunoglobulin in Pregnancy Guideline Trustdocs ID: 827

Management of Handover of Care Guideline Trustdocs ID 1434.

Trust Guideline for Arranging a Neonatal Examination in the Community Trustdocs ID: 820.

Trust Guideline for Intrapartum Care in all Settings Trustdocs ID: 850

Trust Health & Safety policy Trustdocs ID: 607.

Appendix 1

Antenatal / Intrapartum Handover Sticker

(for use at each handover)

S	Date and Time Situation	BR+ score
B	Parity Gestation BMI Obstetric History	Medical History/Alerts Allergies:
A	MEOWS Bladder care Fetal Wellbeing Birth plan?	Medication/Risk Factors
R	What is the plan?	
	Midwife 1 Signature	Midwife 2 Signature

Receiver to complete and then repeat back key information to ensure understanding

S	Date and Time Situation	BR+ score
B	Parity Gestation BMI Obstetric History	Medical History/Alerts
A	Delivery details	Allergies:
R	MEOWS Bladder care P/N issue Neonatal issues	Medication/Risk Factors
	What is the plan?	

	Midwife 1	Midwife 2
	Signature	Signature

Receiver to complete and then repeat back key information to ensure understanding

Appendix 2

Date of 36 week visit: ……..

Expected date of delivery: ……..

Partners name				
Home telephone number				
Call restrictions?/network coverage	Details:			
Mobile number				
GP telephone number				
GP code				
Community Midwife				
Midwifery team				
Blood Group				
Rhesus factor				
Most recent Hb	Result		Date taken *dd/mm/yyyy*	
Previous obstetric history				
Current pregnancy details				
High/Low risk (homebirth criteria)				
Consent for student	Yes ☐ No ☐		*If no add details*	

Home birth requirement list given?	
Detailed directions to premises obtained / issues with postcode.	

	Tick when discussed	Risk Factors Yes/No	Comments
Birth Preferences Water birth requested? Pain relief preferences? Use of complimentary therapies?			
Baby monitoring in labour			
Third stage of labour Physiological Active management			
Environmental Factors: Is there adequate heating and lighting? Is there good access to the premises? Stretcher access out of the birth room? Is there adequate mobile phone signal?			
Social Issues Safeguarding issues? Social Services involvement?			
Personal Safety issues: For Mother/Baby? For Staff?			
Contact arrangements Own midwife not always on duty midwife availability e.g. sickness – simultaneous home births Distance/time to hospital Weather conditions Midwives response time Limitations of service			
Management of emergencies/transfer to hospital Why transfer may be necessary Complications in labour • Mother e.g. slow progress • Baby – problems with heart rate Complications after birth • Mother - e.g. PPH • Baby – resuscitation Equipment available Limitations of staff – e.g. cannulation Response times – e.g. paramedic – transfer to hospital times Care of other children Directions to hospital			

	Tick when discussed	Risk Factors Write Yes/No *If yes detail in comments section*	Comments
Information leaflets/sign post to NNUH website. Vitamin K IM/oral - If oral preparation is parental choice, the community MW to ensure this has been arranged.			**List:**
Special requests Birth plan discussed? Any other questions or concerns?			
Examinations/Assessments Following Delivery VTE risk assessment NIPE Pre and post Ductal O2 saturations Hearing Screening			

Discussed and acknowledged homebirth check list		Yes ☐ No☐			
Mother's Name		Date *dd/mm/yyyy*		Signature	
Midwife's Name		Date *dd/mm/yyyy*		Signature	

On completion, this form is to be sent to the Community Midwifery Matron to be filed in Community Midwives Homebirth folder

Appendix 3

Community Midwives Grab Bag

Main Body:

- 1 delivery instruments.
- 1 delivery pack.
- 1 Maternal drugs grab pack:
  - 3-5 ampoules oxytocin.
  - 2 ampoules syntometrine.
  - 4 blunt drawing up needles.
  - 1 x 5mLsyringe.
  - 3 x 2mL syringes.
  - 3 green needles.
  - 2 drug labels for infusion.
- 1 Rescue pack.
- 1 Ambubag.
- 1 rescuer mask.
- 1 pack swabs.
- 1 500mL saline.
- 3 inco's.

Removable pocket:

- Blood tubes (2 yellow, 2 pink, 2 blue, 2 purple).
- 1 scissors.
- 2 Giving sets.
- 1 Tourniquet.
- 3 Vacutainer/green needle.
- Amnihook.
- 2 pads.
- 2 charcoal swabs.
- 1 roll tape.

Internal back pocket:

- Nappies.
- 1 Self Retaining catheter.
- 1 In/Out catheter.
- 1 Catheter bag.
- 1 Cannulation grab bag:
  - 1 grey cannula.
  - 1 saline flush.
  - Clinell wipes.
  - Plaster or tape.
  - Cotton wool.
  - Dressing.

- 20mL syringe for bloods or vacutainer and blue tf needle.
- Pink/purple blood tubes.
- Octopus.
- 2 Sterile Gloves.

Front pocket:

- 1 Baby grab bag:
- 2 cord clamps.
- Sterile scissors.
- 1 x vitamin k.
- 1 x 1mL syringe.
- 1 x orange needle.
- Cot card.
- Tape measure.
- Airways.
- Ambubag face masks.
- Goggles.
- Baby hats.

Side Pocket 1:

- 1 Sharps container (secure with Velcro-strap above pocket).
- 3 Orange bags.
- 1 Apron.
- 2 Clear bags (for used instruments).

Side Pocket 2:

- Lubricant gel sachets.
- Non-sterile gloves.
- Torch.

Held separately:

- Placenta pot.
- Suture kit.
- Suture instruments.
- Suture grab bag:
- 1 x 3.0 Vicryl Rapide.
- 1 x 2.0 Vicryl Rapide.
- 2 x 10mL syringes.
- 2 x 10mL Lignocaine.
- 2 x green needles.

Appendix 4

Obstetric Thromboprophylaxis Risk Assessment (TRA)

Early mobilisation, hydration and TED stockings are important for all women in hospital

Score of 4 or more requires thromboprophylaxis from the first trimester and 6 weeks postpartum,

Score of 3 **antenatally** requires thromboprophylaxis from 28 weeks until 6 weeks postpartum,

Score of 2 or 3 **postnatally** requires thromboprophylaxis for 10 days postpartum
All women on Antenatal LMWH should have 6 weeks postnatal LMWH

For all women	**Score**
Previous VTE – unless provoked by major surgery	4
Previous VTE provoked by major surgery	3
Recurrent VTE +/- thrombophilia (see special cases in main guideline)	4 and refer to mat med
Antithrombin deficiency (see special cases in main guideline)	4 and refer to mat med
Mechanical heart valve (see special cases in main guideline)	4 and refer to mat med
Antiphospholipid syndrome with previous VTE (see special cases in main guideline)	4 and refer to mat med
Antiphospholipid syndrome with NO previous VTE	4
High Risk Thrombophillia (Protein C or S Deficiency / Homozygous Factor V Leiden or Prothrombin Gene Mutation / Compound Heterozygote)	3 and refer to mat med
Low Risk Thrombophillia (Heterozygote Factor V Leiden or Prothrombin Gene Mutation / antiphospholipid antibodies but no APS classifiable' pregnancy loss or thrombosis) N.B – if low risk thrombophilia plus family Hx of VTE is 1st degree relative, give 6 weeks postpartum throboprophylaxis	1
Family History unprovoked or oestrogen related VTE in a first degree relative, age under 50	1
Medical comorbidities: Cancer, Heart Failure, SLE, IBD, Inflammatory Arthropathy, Nephrotic Syndrome, Type 1 Diabetes + Nephropathy, Sickle Cell Disease, Current IVDU	3
Gross varicose veins	1
Age > 35	1
Obesity BMI> 30 score 1 or 2 if BMI > 40	1 or 2
Smoker	1
Parity 3 or more prior to delivery of current pregnancy	1
Multiple pregnancy or Assisted reproduction techniques	1
Pre-eclampsia in this pregnancy	1
OHSS: requires LMWH in 1st trimester	4 then 0
Hyperemesis: requires LMWH until recovered and mobile	3 then 0
Current systemic infection	1
Immobility / journey > 4hours / Dehydration	1
Surgical procedure in pregnancy (except perineal repair) until fully recovered and mobile	3 then 0
Postnatal factors	
Postnatal re-admission or prolonged admission ≥3 days	2
Prolonged immobility ≥3 days – see main text. Consider Flowtrons	4
Prolonged labour (> 24hours)	1
Elective Caeserean section	1
Emergency Caesarean section	2
Midcavity or rotational delivery	1
Delivery<37+0 weeks in this pregnancy	1
Stillbirth in this pregnancy	1
PPH > 1L/ transfusion	1
TOTAL SCORE	

Tick to say if offered TED Stockings **Booking Weight (kg)**