Clinical Guideline for Home Birth

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v6	28/04/2023	Victoria Hastings, Home Birth Team Leader	Change to service structure Referral to Care outside of Guidance guideline ; Language use section : inclusion of green wristbands on equipment list
V6.1	23/04/2024	C Bircher	Removal of criteria to avoid duplication

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Planned Home Birth Management v5	09/12/2019
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Planned Home Birth Management v3	12/10/2012
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Planned Home Birth Management v1	06/12/2011

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:
Senior Midwives and Midwifery Team Leaders, Home Birth Team Midwives, Consultant Obstetrician, Maternity Risk Team, Practice Development Midwives.

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical procedure applicable to the Norfolk and Norwich University Hospital Trust; please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

Language Use

Please note, within this guideline when discussing 'women' we are referring to all birthing people inclusively of their pronouns or gender identity.

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Quick reference: Referral Process for Women Choosing Home Birth:

1. Introduction

1.1. Rationale

All women should be given evidence based, unbiased information around birth place options including home, and supported in their decision for place of birth. (NICE 2022)
All midwives should be able to safely and competently support women choosing to birth at home or where home birth occurs unexpectedly. Where a midwife does not feel able to provide home birth care within the limits of their competence they should seek support from their line manager, as per the NMC Code. (NMC 2018)
The cohort of women choosing to birth at home is evolving to include those with more obstetric and medical complexities. This guideline aims to provide a framework for planning and attending home births for women with both straightforward and more complex care needs.

1.2. Objective

The objective of the Clinical Guideline for Home Birth is to:

- Provide all women with appropriate counselling and informed choice for place of birth.
- Ensure that all women birthing at home are cared for safely and effectively.
- Provide guidance for attendance at unplanned home birth.

1.3. Scope

This guideline is intended for use by midwives and maternity staff providing intrapartum care at home within the Norfolk and Norwich University Hospital Trust catchment area.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
Juniper Team	Home birth team for NNUH
BBA	Born Before Arrival (of Midwife)
OOG	Outside of Guidelines
PIP	Personalised Intrapartum Plan
MMAU	Macleod Maternity Assessment Unit
NNUH	Norfolk and Norwich University Hospital Trust
CEFM	Continuous Electronic Fetal Monitoring
CTG	Cardiotocograph
E3	Electronic documentation system
SROM	Spontaneous Rupture Of Membranes
MMAU	McCleod Maternity Assessment Unit
IOL	Induction Of Labour
CallEEast	Midwifery call handler service
BMI	Body Mass Index
PBRA	Pre Birth Risk Assessment
MLBU	Midwifery led Birthing Unit
VTE	Venous Thromboembolism

2. Responsibilities

All maternity staff who provide counselling or attendance at home birth to ensure they remain up to date with this clinical guidance.

3. Service Principles

Birth place options should be discussed initially at the booking appointment, and revisited throughout the antenatal period to ensure a contemporaneous review of risks and benefits. All women should be offered the choice of planning birth at home, in a midwife-led unit, or in an obstetric-led unit. They should be advised of their individual risks/benefits to allow an informed decision.

Women choosing home birth should be referred to the Juniper home birth team following their 28/40 community midwife appointment, or asap if a decision is made later in pregnancy.

Intrapartum care is provided in accordance with the Maternity Clinical Guideline for Intrapartum Care (**Trustdocs ID: 850**) irrespective of place of birth.

3.1. Planning birth at home

3.1.1. 'Midwife led' Criteria

Home birth is particularly suitable for healthy women experiencing straightforward pregnancies with no anticipated need for additional care or equipment beyond that available at home with a midwife.

The criteria for homebirth are the same as those for the Midwife Led Birth Unit. To avoid duplication, they are not repeated here, but available in the MLBU guideline (Trust Docs 7181)

3.1.2. Women Meeting 'Midwife Led' Criteria Risk/Benefit

Rietsma et al (2020) meta-analysis of 500,000 low risk home births found that, overall, those who planned to give birth at home were less likely to experience caesarean section, operative vaginal birth, epidural analgesia, episiotomy, and oxytocin augmentation, a 3rd or 4th degree perineal tear, maternal infection or postpartum haemorrhage. They also found that there was no increase in perinatal and neonatal mortality or morbidity compared to similarly low risk women who intend to give birth in a hospital (Hutton et al 2019).

3.1.3. Women Outside 'Midwife Led' Criteria Risk/Benefit

For those with additional risk factors for pregnancy/birth there will be additional risks and benefits to discuss. All women with complexities should be booked an obstetric consultation to discuss their birth choices.

The obstetric unit provides direct access to obstetricians, anaesthetists, neonatologists and other specialist care which may significantly improve the outcomes for some women and babies.

If something does go 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 specialist care.

3.1.4. 'Outside of Guidance' Care

"Choices about birth are often informed by previous personal trauma-related experiences. It is crucial that maternity clinicians understand women's needs in maintaining psychological safety and facilitate a trauma-informed approach to all birth discussions (Greenfield et al. 2019)".

It is the midwife's responsibility to ensure all options and associated risks and benefits have been discussed and recorded and respect the choices a woman makes (NMC 2018). This initial discussion will take place with the traditional team community midwife prior to referral. Juniper team can support these discussions if needed.

For women choosing to birth outside of criteria, full discussion of the recommendations and evidence base should take place at the home birth preparation visit in accordance with the 'Care Outside of Guidance' Guideline (TrustDocs ID: 20414) and utilising the Personalised Intrapartum Plan (PIP) proformas within. On completion these should be attached to E3 and forwarded to the home birth team leader by 37/40 or asap if risk develops beyond this point. All women requiring PIP should be booked an obstetric review and added to the High Risk Home Birth Caseload on MS Teams which is disseminated to the community matron and Juniper home birth team regularly by the home birth team leader.

3.2. Juniper Team Referral

Referral to the Juniper home birth team can be offered after the 28 week antenatal contact or asap where a decision is made beyond this point, ideally allowing time for the home birth prep visit at 34/40.

The traditional team midwife should complete the Juniper Team Home Birth Referral Form (Appendix 1) and refer as per flowchart. Juniper team will commence care from the 31/40 appt for primiparous women or the 34/40 appt for multiparous women. All antenatal care prior to this point remains the responsibility of the named traditional midwifery team. Any ongoing or significant safeguarding concerns must be directly handed over, with PBRA completed and health visitor aware prior to referral.

Juniper team will contact the woman by telephone to introduce the team and book the next antenatal contact. The midwife actioning the referral will update the named midwife and team on E3, add to the named midwife's caseload and Teams home birth caseload. They will also complete and attach the accepted referral to E3 and confirm acceptance with the named midwife by email. At this point the traditional team midwife can remove the woman from her caseload to avoid duplication.

Following acceptance of referral, Juniper team will continue care as per the NICE antenatal schedule/individual need. A home birth prep visit will be booked at 34/40 at the planned place of birth. This allows a full risk assessment, information sharing, and completion of the Home Birth Prep Checklist (Appendix 2). The midwife will also thoroughly discuss and complete the Personalised Intrapartum Plan for those women choosing home birth outside of midwife led criteria and/or current guidance.

3.3. Intrapartum Care at Home

Intrapartum care is provided in accordance with the Maternity Clinical Guideline for Intrapartum Care (**Trustdocs ID: 850**) irrespective of place of birth.

All women will be advised at their home birth prep when and how to seek midwifery support at onset of labour or SROM. Juniper team midwives are solely contactable via CallEEast and individual contacts including email are not to be issued to women at any point.

3.3.1. Pre labour rupture of membranes

For planned homebirths, women reporting prelabour rupture of membranes should receive care in accordance with the clinical guideline on The Management of Pre-Labour Rupture of Membranes Over 37 weeks TrustDocs ID: 872. If labour hasn't commenced within 12 hours of SROM women should be invited to MMAU for assessment and counselling re IOL. If assessment is normal women can return home to continue with planned home birth prior to IOL. Where IOL is declined, the home birth team will complete a PIP and liaise with the obstetric team to develop an ongoing plan of care.

3.3.2. Latent Phase

Care should be offered in accordance with the Trust Guideline for the Management of Latent Phase of Labour Trustdocs ID: 15128

A face to face assessment at home to assess maternal and fetal wellbeing should be offered at the woman's request or when clinically indicated, but no later than the third telephone contact in early labour.

Where three face to face contacts have occurred and the woman has not progressed to established labour, the midwife will recommend obstetric review on MMAU at the third contact. Review will be recommended sooner if there are any concerns that progress is deviating from physiological expectation, where concerns arise about maternal or fetal wellbeing or at maternal request.

3.3.3. Midwifery Attendance

Following telephone assessment, the midwife and woman will together decide when the 1st Midwife should attend. During the 'Birth Day', the Community Helicopter Midwife and Delivery Suite Coordinator should be informed of labouring women and call outs. Overnight, the Delivery Suite Coordinator continues this role.

The role of the '1st' Midwife is that of primary care giver and clinical decision maker. Once a woman is in established labour, a midwife should remain present throughout labour and birth.

As second stage approaches, or earlier if required by a PIP, the 1st Midwife will request a 2nd Midwife to attend for the birth. The role of the '2nd' Midwife is supportive. It should be clear in the notes which midwife is providing care throughout.

From 08:00- 18:30 the second midwife will usually be a traditional team midwife, accessed via the Community Helicopter Midwife. From 18:30-08:00 the 2nd Midwife will come from NNUH following discussion with the Delivery Suite Coordinator. 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 is birthing 'outside criteria', the attendance of 2 midwives throughout labour and birth is recommended.

Students are able to attend home births where prior consent has been given. They should be accompanied by a registered midwife at all times and work under direct supervision. When arriving at a homebirth students should wait away from the property until the midwife is present.

3.3.4. Labour Care

A risk assessment should be completed on initial assessment of the woman/fetus, including the Intrapartum and Fetal Monitoring Risk Assessment Trustdocs ID:17215, and continually reviewed throughout labour and birth. Effective use of the Partogram and I-Care stickers support contemporaneous review and risk assessment and should be completed for all attendances where birth is not imminent on arrival. On arrival at planned home birth the midwife should liaise with the Community Helicopter Midwife (daytime) or Delivery Suite Coordinator (overnight) to identify who will provide the second check for I-Care and document the discussion and plan in the maternal notes. Any risks that are identified should be documented in the maternity hand-held records with an individual management plan and escalated appropriately.

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 and recorded in the maternal handheld records. The fetal heart should be monitored as per Joint Clinical Guideline for the use of Intrapartum Fetal Monitoring and Fetal Blood Sampling Trustdocs ID: 840. Transfer to Delivery Suite should be considered if there is any deviation from the normal.

Midwives should advise women choosing aromatherapy how to ensure safety for staff and others attending home birth.

3.4. Transfer to Hospital

For all women in established labour, transfer to hospital should be by ambulance accompanied by a midwife.
Ambulance transfer is arranged via 999. Where transfer is time critical, the midwife should advise the call handler that they are a midwife and that it is an 'Obstetric Emergency' which will trigger a rapid 'blue light' response.
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.

Reasons for transfer following risk assessment:

- Malpresentation/unstable lie.
- Fetal heart rate abnormalities heard on auscultation in first or second stage.
- Intrapartum haemorrhage.
- Significant meconium stained liquor.
- Cord prolapse/cord presentation
- The woman requests an epidural.
- The woman requests to be transferred.
- Hypertension in labour BP ≥150/100 on 2 or more occasions (recorded 15 minutes apart) or if the woman is symptomatic of PET.

- Maternal Pyrexia of 37.5°C or greater on two occasions, two hours apart or 38°C on one occasion.
- Lack of progress in the first or second stage of labour see Trust Guideline for the Management of: Intrapartum Care in All Settings Trustdocs Id: 850.
- Retained placenta.
- Suspected 3rd / 4th degree perineal tear.
- Postpartum haemorrhage of 500 – 1000mL if woman clinically unstable or > 1000mL.
- Maternal collapse.
- Any deviation from the norm which concerns the midwife.

  Note: The presence of non- significant meconium stained liquor should prompt a holistic review of maternal and fetal wellbeing and labour progress. All women should receive information on the option to transfer to NNUH to assess fetal wellbeing using CEFM. Where additional risk factors or deviations from normal labour are evident, the midwife will recommend transfer to NNUH for CEFM and obstetric review if safe to do so, with consideration given to transfer time.

3.4.1. Maternal Transfer

Transfer destination depends on the reason for transfer. Where there are concerns about maternal or fetal wellbeing or deviation from normal the transfer destination should be 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 and an obstetric review by a senior member of the team will take place on arrival if required.

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.

3.4.2. Neonatal Transfer

If the baby requires transfer to hospital in the immediate neonatal period (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 in A and E by the Neonatal Emergency Team, who will be pre-alerted by the Ambulance Service.

Babies born but not yet admitted will require a hospital number and admission generating prior to arrival so that treatment is not delayed, via the Delivery Suite Reception staff.

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

Two ambulances should be requested if both mother and baby require transfer. If two midwives are present at the birth, both mother and baby should be accompanied by a midwife during transfer. If there is only 1 midwife, then an assessment should be made as to whether they should stay with the mother or baby depending on need.

3.5. Unplanned Home Birth

Where home birth is not planned but a woman chooses in labour to remain at home for birth the attending midwife should complete a full risk assessment and discuss any recommendations with the woman.

Where home birth is not planned but progress is rapid and birth imminent the midwife should support birthing at home where this is safer than potential birth in transit. If all is well the woman should be supported to remain at home if she feels comfortable to do so.

3.5.1. BBA (Born Before Arrival)

Midwives will be requested to attend where BBA has or is likely to occur imminently and gestation exceeds 22 weeks. The Community Helicoptor Midwife should be alerted, who will contact Juniper team in the first instance, however a local team should also be alerted to allow most rapid response.

For gestations between 18-22 weeks an ambulance transfer to delivery suite should be requested but midwifery attendance is not required.

A Datix should be submitted for BBA's over 22 weeks gestation.

3.5.2. Unassisted birth/'Freebirth'

Unassisted or 'freebirth' is birthing planned to occur without midwifery/medical attendance. Women are legally supported in their right to choose place and care for birth, including choosing to birth without medical or midwifery care.

Where freebirth has been raised as a preference or intention antenatally, staff should recommend attendance of maternity staff and thoroughly discuss risks/benefits associated with unattended birth. Discussion should include limitations of ambulance service. All discussions should be documented and discussed with the home birth team leader and community matron.

Following unassisted birth, the midwife should continue to offer all routine care. Parents are required to notify the birth within 36hrs to either NHS England, the local Integrated Care Board or local authority.

A Datix should be submitted for all unattended births.

3.6. Postnatal Care

The midwife should remain with the woman for a minimum of two hours following the birth of her baby. They should ensure that the woman is able to void urine post-delivery. If the woman is unable to do so, they 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 blood transfusion at NNUH. 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 arrange follow up. 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 should be given contact phone numbers in case of emergencies and be informed of how to contact a midwife for general help and advice via CallEEast (01603 481222) before the midwife leaves the house. The woman should be made aware of when she will next be visited.

The Juniper team aim to complete the first postnatal visit the day following birth, and so this should be added to the Juniper team daily diary on MS Teams. The woman should be left with advice about basic safety and care principles, including:

- Safe Sleep
- Analgesia and postnatal recovery
- Infant feeding and care
- Signs of serious illness in mother and baby and how to seek help.

The midwife will complete a postnatal VTE risk assessment using the Obstetric Thromboprophylaxis Risk Assessment (TrustDocs ID: 18766) 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. They should follow the procedure outlined in the Trust Guideline for Arranging a Neonatal Examination in the Community Trustdocs ID: 820.

Parents should be offered pre and post-ductal oxygen saturation monitoring on MLBU/at home preferably within the first 24 hours of life.

3.7. Documentation and Administration

Each professional in attendance and their role should be clearly identified in the notes. Generally, the 'First Midwife' assumes the role of lead carer and decision maker. The 'Second Midwife' attends in a supportive role, often acting as scribe for the final stages of birth. It is essential that the notes identify who is providing clinical care at any time.

Each midwife remains accountable for the care they have given and for their respective written 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.

The delivery suite receptionist can be 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 'Transfer to Community' workflow should be

completed on leaving the address. The woman's antenatal and intrapartum notes are returned to the 'home birth' tray on Delivery Suite reception. Following completion of E3, the reports are printed and posted or taken to the mother postnatally. The midwife should book the next postnatal contact directly into the MS Teams diary.

3.8. Equipment and Waste Disposal

Juniper home birth team midwives each carry a supply of Entonox. 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.

All traditional team midwives have access to the standard community grab bag (Appendix 3). Juniper team midwives carry additional equipment appropriate to the additional frequency of home birth attendance (Appendix 4). It is the midwife's responsibility to ensure that all equipment is present and in date. 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.

4. Training & Competencies

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 completed annual mandatory training, PROMPT and the Saving Babies Lives package and feel competent to manage obstetric and neonatal emergencies (NMC 2019). Midwives who do not feel competent or competent should access support from the maternity Practice Development team.

Please refer to the Maternity Training Needs Analysis Trustdocs ID: 8649.

5. Related Documents

Maternity Clinical Guideline for Intrapartum Care	Trustdocs Id: 850.
Care Outside of Guidance	Trustdocs ID: 20414
The Management of Pre-Labour Rupture of Membranes Over 37 weeks	Trustdocs ID: 872.
Trust Guideline for the Management of Latent Phase of Labour	Trustdocs ID: 15128
Joint Clinical Guideline for the use of Intrapartum Fetal Monitoring and Fetal Blood Sampling	Trustdocs ID: 840
Management of: Handover of Care Guideline	Trustdocs ID 1434
Bladder Care in Labour and Postnatally	Trustdocs ID: 12617
Management of Anti-D Immunoglobulin in Pregnancy Guideline	Trustdocs ID: 827

Obstetric Thromboprophylaxis Risk Assessment	Trustdocs ID: 18766
Trust Guideline for Arranging a Neonatal Examination in the Community	Trustdocs ID: 820.
Maternity Training Needs Analysis	Trustdocs ID: 8649.
Trust Health and Safety Policy	Trustdocs ID: 607.
Intrapartum and Fetal Monitoring Risk Assessment	Trustdocs ID: 17215
Midwifery-led Birthing Unit (MLBU) Operational Guideline	Trustdocs ID: 7181

6. References

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7. Monitoring Compliance / Audit of the process/policy principles/service to be delivered

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
I-care compliance	Audit	Fetal Monitoring midwife	Maternity Risk Team	Quarterly
Intrapartum Transfer/ BBA/Emergencies	Datix process	Maternity Risk Team	Maternity Incident Review and Escalation	Weekly

The audit results are to be discussed at relevant governance meetings (weekly Maternity Review and Incident Escalation Meetings) to review the results and recommendations for further action. Then sent to Maternity Risk team who will ensure that the actions and recommendations are suitable and sufficient.

8. Appendices

Appendix 1: Referral Form for care by Juniper Home Birth Team including Process Flow Chart

Referral form for care by Juniper Home Birth Team

Please complete this form, attach to E3 and email to juniperteam@nnuh.nhs.uk.
Please see the flow chart for the referral process.

Name:	
Hospital No:	
Address:	
Contact Telephone Number:	
Email address:	
Current Team and Midwife:	
EDD and current gestation:	
Obstetric history:	
Medical history:	
E3 Alerts:	
Risk Factors: Maternal	
Risk Factors: Neonatal	
USS pathway: (circle)	LOW MOD 32/40 scan booked? Y/N HIGH 32/40 scan booked? Y/N
Other concerns: Safeguarding? Safety Issues?	
Woman aware of referral and process discussed?:	
Date of referral:	
Referring Midwife:	
Accepted by/date:	
Juniper Named Midwife:	

Process for Referral to Juniper Team

Appendix 2: Home Birth Prep Checklist

Date of Home Birth Prep Visit		**Name:** **Address:** **Hospital Number:**
EDD		
Access/Parking/ Permit		
What.three.words		PIP required? YES/NO PIP Completed? YES/NO

Contacts	Mobile Tele:	
	Landline Tele:	
	Partners Name	
	Partner Tele:	
	Wifi Name and Code:	
	Mobile Network coverage/restrictions:	
Juniper Named Midwife:		
Traditional Team for PN Care:		
E3 Alerts		
Blood Group		Requires Antid? (Arrange to be given at NNUH)
Previous obstetric history		
Current pregnancy details		
Personalised Intrapartum Plan Risk Factors:		
Consent for student		Yes ☐ No ☐
Home birth requirement list given?		Yes ☐
Birthing partners		

Home Birth Preparation Checklist	Name: Hospital Number:

	Tick when discussed	Note any risk factors	Comments
Contacting home birth team			
Fetal 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? Space to evacuate pool?			
Social Issues Safeguarding considerations			
Personal Safety issues: For Mother/Baby? For Staff? Dogs discussed?			
Limitations of service: -Multiple home births -Staffing deficit -Alternative birth plan if midwife not available for home birth -Midwife response times -Weather conditions			

Home Birth Preparation Checklist	Name: Hospital Number:

	Tick when	Note any	Comments

		discussed	Risk Factors		
If complications arise: Reasons for transfer, ie: • Slow labour progress • Concerns with fetal heart • Meconium stained liquor • Maternal choice ie pain relief Complications after birth • Mother – bleeding/suturing • Baby – resuscitation/observations **Emergency management limitations-** Equipment/skills/ambulance transfer times Childcare and partner Transport when transferring in					
Signpost to PN advice Vitamin K IM/PO MMR status				Arrange Vit K TTO if reqd	
Special requests Birth plan discussed					
Post birth checks VTE risk assessment NIPE O2 saturations Hearing Screening				Arrange Dalteparin TTO if reqd	
Any other information					
Mother's Name		Date *dd/mm/yy*		E Signature	
Midwife's Name		Date *dd/mm/yy*		E Signature	

Appendix 3: Community Midwives Grab Bag

Grab bag checking process:
Grab back to be packed as below and sealed with a Community Team Leader.

Every quarter bag to be replenished with drugs from fridge and resealed with tag corresponding to quarter. MS Teams equipment list to be updated by team leader to reflect new sealed date.

Internal back	Removable	Main Body:

pocket: • 1 self retaining catheter • 1 In/out catheter • 1 catheter bag • Cannulation grab bag: ○ 2 grey cannula ○ 1 saline flush ○ Clinell wipes ○ Tape ○ Cotton wool ○ Dressing ○ Transfer device ○ 1 pink/1 purple blood tube ○ Octopus ○ 2 sterile gloves ○ tourniquet	**pocket:** • Blood tubes (2 pink, 2 purple) • 1 scissor • 2 giving sets • 1 tourniquet • 1 vacutainer • 1 amnihook • 2 pads	• 1 delivery instruments • 1 maternal drugs grab pack: • 5 ampoules oxytocin • 2 ampoules syntometrine • 3 blunt drawing up needles • 1 x 5mLsyringe • 2 x 2mL syringes • 2 green needles • 2 drug labels for infusion • 1 rescue pack • 1 ambubag • 1 I-gel airway • 1 laryngoscope • Ambubag face masks M/L • 1 rescuer mask • 1 pack swabs • 1 500mL saline • 3 inco's
Front pocket: • 1 baby grab bag: • 2 cord clamps • 1 sterile scissors • 2 vitamin k • 1 1mL syringe • 1 orange needle • 1 purple drawing up needle • 2 labels • Cot card • Tape measure • Goggles • Baby hat	**Side Pocket 1:** • 1 sharps container (secure with Velcro-strap above pocket) • 2 orange bags • 1 apron • 2 clear bags (for used instruments) • Side Pocket 2: • Lubricant gel sachets • Non-sterile gloves	**Main Body:** • Placenta pot • Suture pack • 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

(Quarter 1- green , Quarter 2- yellow, Quarter 3- blue, Quarter 4- white)

8.1. Appendix 4: Juniper Team Home Birth Bag List

PPH	**NEONATAL RESUS**	**PPE**
5 syntometrine 6 oxytocin 6 purple top red needles 4 2ml syringes 2 5ml syringes 4 green needles 4 clinell wipes	Stethoscope Ambubag Medium mask Large mask Igel Laryngoscope Rescuvac	Orange bags Clear bags Sterile and non sterile gloves Apron goggles

POSTNATAL	LABOUR	RH NEG MOTHER
Cot cards Hand expressing pack 3 vitamin k 3 purple top red needles 3 orange needles 3 1ml syringes 2 oral syringes 2 baby labels 3 tape measures	Torch 2 swabs Amnihook 6 clamps 3 scissors 6 lubricant gel Green wristband Delivery instruments Sonicaid battery 2 amnisure	2 vacutainers 2 pink bottles 2 purple bottles 2 yellow bottles 2 clinell 2 plasters Cotton wool 10 ml syringe 2 green needles Tourniquet
INTERNAL POCKET	**CATHETER/CORD PROLAPSE**	**ADULT RESUS**
Admin- Kardex maternal and neonatal Proformas Continuation sheets I-care BOAT	500ml saline 2 SRC 2 In/Out catheter Instillagel Giving set Catheter bag Clamp or bung 2 lubricant gel	Bag Mask Orange airway Red airway
CANNULATION/IV FLUIDS	**SUTURING**	**FRONT POCKET**
1l Hartmanns 2 giving sets CANNULA KIT- 2 grey cannula 1 blue cannula Tourniquet 2 clinell wipes Cotton wool Dressing Octopus 2 pink/2 purple blood tubes Saline flush Transfer device Gloves	Head torch/torch Suturing instruments 2 Vicryl 2-0, 2 vicryl 3-0 40mls lidocaine 2 Swabs 10ml syringe 20ml syringe Clear bag 2 green needles 1 orange needle 2 red needles 2 Diclofenac 3 sterile gloves 2 lubricant gel Episcissors	Sharps bin Mirror (optional) Incos Maternity pads **CARRIED ALONGSIDE** 2 Placenta Pots Entonox cylinder, valve/tubing, mouthpiece Pinards, Sonicaid, Gel BP cuff, Sphyg Thermometer Urine test sticks

9. Equality Impact Assessment (EIA)

Type of function or policy	Existing

Division	Women and Children	**Department**	Maternity
Name of person completing form	Victoria Hastings	**Date**	27/4/23

	Potential	Impact	Which groups	Full Impact

Equality Area	Negative Impact	Positive Impact	are affected	Assessment Required YES/NO
Race	None	None	n/a	No
Pregnancy & Maternity	None	Improved counselling and choice	n/a	No
Disability	None	None	n/a	No
Religion and beliefs	None	None	n/a	No
Sex	None	None	n/a	No
Gender reassignment	None	None	n/a	No
Sexual Orientation	None	None	n/a	No
Age	None	None	n/a	No
Marriage & Civil Partnership	None	None	n/a	No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?	n/a			

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.