



Aneurin Bevan University Health Board

Homebirth Guideline

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1 Executive Summary

Quick Guide to a Home Birth

1. Ensure that women are informed of choices in respect of choice of place of birth, and are allowed time to make a truly informed decision. Utilize birth place decisions leaflet (Coxon, 2014).
2. Use the booking criteria for place of birth outlined for Midwifery-led care (MLC) or that in the All Wales Midwife-led Care Guidelines (Davies and Lewis, 2017).
3. Complete booking form for a home birth and ensure that details are kept on file in the community office.
4. If a woman requests a home birth, but has additional complications that may be of concern, the midwife must inform her manager and the clinical supervisor for midwives.
5. The midwife must complete the Clinical Alert Form (Appendix 1) as it is important for the mother and baby's safety that there is a detailed plan of care.
This document should be loaded onto CWS and an alert put on CSC.
6. Midwives should continue to provide care and support and make appropriate arrangements for the labour and birth of the baby.
7. The Information for Homebirth form is to be completed (Appendix 2).
8. The midwife may offer women the opportunity to access an ultrasound scan for fetal presentation at 37 weeks gestation if there is any concern about the presentation.
9. A birth plan should be discussed with women using the information detailed in the Information for Homebirth form (Appendix 2).

10. Community midwives will be made aware of all planned home births and street maps with OS grid reference provided where possible in the homebirth file in the community office.
11. Two midwives should attend a woman for the second stage of labour to provide assistance and support. Consideration must be given to the Lone Worker Policy. If at any time a midwife feels the need for extra support at a home birth, she must call a second midwife or the Clinical Supervisor for Midwives on call for advice.
12. Complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event (Nursing and Midwifery Council (NMC), 2018a) using the All Wales Clinical Pathway for Normal Labour (2003).
13. The GP will be informed of the birth. Neonatal examination will need to be arranged by the midwife within 72 hours of the birth. This may be performed by an appropriately qualified midwife, G.P., or hospital Paediatrician.
14. Any emergency procedures will be dealt with in accordance with the Standards of Competence for Registered Midwives(NMC, 2018b), The Code (NMC, 2018a) and the All Wales Midwife-led Care Guidelines (Davies and Lewis, 2017). The woman/baby is transferred into hospital if their condition warrants admission. An emergency ambulance is called to attend with paramedics. The Midwife will inform the receiving unit of the impending admission and condition of the woman/baby using the SBAR format, ensuring prompt attendance, review and treatment on arrival by a Consultant Obstetrician or a senior member of the team. The transfer form (Appendix 3) must be completed.
15. The midwife will remain with the woman/family for a minimum of one hour after home birth, or for as long as necessary to ensure wellbeing.
16. Following the birth the midwife will dispose of the equipment and placenta at the local maternity department, where computer records of delivery will be completed and the handheld notes

containing the midwife's hand written records of the birth and can be returned.

2 Scope of guideline

Aneurin Bevan University Health Board Maternity Services will provide women with information to enable them to make an informed decision about where to give birth. Midwives support women in their choice of home birth providing information on available local services and ensure that those who choose to give birth at home are supported throughout their experience.

3 Aims

This guideline aims to inform all healthcare professional providing maternity services for women and their families with the information regarding home birth. Aneurin Bevan University Health Board Maternity Services will provide women with information to enable them to make an informed decision about where to give birth. Midwives support women in their choice of home birth by providing information on available local services and ensure that those that women who choose to give birth at home are suitable for this place of birth, or that their individual circumstances are explored in detail in order that they are supported throughout their experience.

4 Guideline Statement

There is significant global variation in the acceptance of home birth as a positive choice for women and their families (Ashley and Weaver, 2012). The home birth rate in the Netherlands is the highest in the developed world at 30%, whereas the United States, Sweden, Finland and Ireland have rates of less than 1% (Hendrix et al, 2009). The UK is perceived to have a positive attitude towards homebirth, however, with a homebirth rate of 2.5% in Wales (Office for National Statistics, 2019), it could be argued that many women continue to view a

hospital or birth centre birth as the most realistic option. It is important to note that the National Maternity Review (2016) found that 10% of women would prefer a homebirth but only 2% of women realised their goal to have a homebirth. The recent 'Your Birth – We Care' survey (Consultant Midwives Cymru, 2018) found that in Wales, 7.5% of women planned a home birth and 4.9% of women had a homebirth. This was further segregated into 4.6% of nulliparous women planning a homebirth and 2.8% of nulliparous women achieving a homebirth, and 10.4% of multiparous women planning a homebirth and 7.1% of multiparous women achieving a homebirth (Consultant Midwives Cymru, 2018).

The Department of Health and Welsh Government support home birth as an option for women (Welsh Assembly Government, 2019). This is a recommendation which is echoed by the National Institute for Health and Care Excellence (NICE) (2017) guidelines for *Intrapartum care for healthy women and babies*, which states that women should be advised that planning to birth at home or in a midwifery led area has positive associations with increased rates of spontaneous vaginal births. Some regions in the UK have improved their home birth rate with dedicated teams of midwives supporting and promoting home birth. In 2011 a team of midwives from Northampton General Hospital gained one of the UK's top midwifery prizes for their work on home births (NGH, 2011).

Maternity Matters (DOH, 2007) recognized the evidence in favour of home birth, advocating that women should be offered access to a wide choice of services when deciding where to give birth. This was echoed in *Midwifery 2020 – Delivering Expectations* (DOH, 2010), where there is a proposed shift of focus from hospital to community based services, with the emphasis on encouraging normal birth and reducing unnecessary intervention. The vision for maternity services in Wales (Welsh Assembly Government, 2019) supports women's choice to give birth at home, however, sets no target rates for this.

The recent Birthplace in England prospective cohort study (Birthplace in England Collaborative Group, 2011) suggests that for women planning to give birth to their **second or subsequent baby** at home,

there appears to be no difference in outcomes for babies when compared to planned births in obstetric units. For women having their **first baby**, however, it is suggested that a planned home birth increases the risk for the baby compared to giving birth in an obstetric unit. For nulliparous women, there were 9.3 adverse perinatal outcome events per 1000 planned home births compared with 5.3 per 1000 births for births planned in obstetric units, and this finding was statistically significant. Additionally the study found that for women having a first baby, the peripartum transfer rate was 45% for planned home births, compared to 10% in women having a second or subsequent baby at home.

A distinction needs to be made between women who plan for a home birth and those who have an unintended home birth, as unintended home births or women who received no antenatal care are linked to a higher rate of both maternal and perinatal complications (Lazić and Takač, 2011).

There is no reason why home birth should not be offered to women at low risk of complications, however, this recent information regarding the differing risks for babies in first and subsequent home births should be clearly discussed with them and documented in the records of care. Anthony et al (2005) suggest that women have the ability to balance the issues of risk and safety and according to Cheyney (2008), women considering home birth acquire knowledge and assess risk, sometimes using this knowledge to challenge negative attitudes they encounter.

Midwives lead the way in providing choice for women (Edwards, 2006), however, according to Madi and Crow (2003) midwives also hold the power to facilitate decision making or to act as barriers by the lack of information they provide; many women being unaware of home birth as a realistic option. A Study conducted by Andrews (2004a) found that some women seeking home birth perceived a negative attitude from midwives. Interestingly, the women who participated in the 'Your Birth – We Care' survey (Consultant Midwives Cymru, 2018) expressed a lack of meaningful discussion around place of birth, and particularly homebirth, and they felt that this needed to be addressed in order for them to make a fully

informed choice.

Home birth may confer considerable benefits for women and their families. The Birthplace study (Birthplace in England Collaborative Group, 2011) acknowledges the lack of intervention and reduced risk of caesarean section associated with labouring in the home environment. A recent study by social scientists in Southampton (Nove *et al*, 2012), found there to be a significant decrease in the risk of postpartum haemorrhage with women who planned a home birth, however, they acknowledge that further research is required to fully understand the factors influencing this variation.

Women choose to birth at home for many reasons. On occasions a previous negative experience of birth in a hospital environment motivates them to stay at home to maintain control over the birth environment and reduce the risk of medical intervention. Familiarity of environment supports the development of an equal partnership with the attending midwife and a lack of institutional agenda and power. Women often associate home with safety (Andrews, 2004ab; Boucher et al 2009).

Symon et al (2009) suggest that for some women birth at home is an attempt to ensure individualized, continuity of care. Kontoyannis and Katsetos (2008) acknowledge that home is the best place to achieve normality. Women experience less pain at home and use less pharmacological pain relief. The desire to home birth can be viewed as women's rejection of technology in what is a normal physiological process (Van der Hulst et al, 2004). According to Andrews (2004b) partners are more involved in birth at home and it is more likely to feel like a celebratory family event.

A valuable source of information to aid choice can be found at <http://www.nct.org.uk/birth/home-birth-safe>

5 Responsibilities

It is the responsibility of all midwives to outline appropriate choices regarding place of birth to all women. Homebirth is supported and

promoted by the Head of Midwifery and whole maternity team. Every midwife has a responsibility to familiarise themselves with the homebirth guideline.

6 Skills and Training

Midwives are experts in normal birth and should be confident and competent to support women to give birth in a variety of settings including the woman's home (Department of Health, 2010). Birth at home is physiologically the same as birth in hospital however; some midwives may consider they do not have the experience to provide care for women requesting a home birth. It is therefore essential that all midwives have the opportunity to discuss their individual training requirements with their supervisor of midwives/line manager to address their learning needs in line with revalidation (NMC, 2019) and maintaining their own competence as per The Code (NMC, 2018a; NMC 2018b).

Midwives must be competent within the home birth environment and may require enhancement or updating of their existing midwifery skills prior to providing home birth services (NMC, 2018b). Midwives are personally accountable for their acts and omissions and must only undertake duties for which they have been trained and assessed as competent as set out in the Code (NMC, 2018a).

Two midwives usually attend a home birth. Although not a legal requirement it is suggested best practice as each midwife provides support to the other and it demonstrates a proactive approach to risk management and security.

All midwives must undertake annual emergency drills updates to enhance their confidence in managing emergencies effectively. All staff should be provided with the opportunity to debrief following an emergency situation to facilitate reflection and promote individual development. In addition to midwives maintaining and updating their own skills and knowledge they are required to undertake the role of mentor to students. Inclusive in the role is facilitating learning

opportunities for students to participate in providing care for women who choose a home birth.

The use of the PADR by The Clinical Supervisors for Midwives or manager will help midwives to identify areas in which they feel they require additional training and education.

7 Supporting Women's Choice for a Home Birth

The woman's decision regarding place of birth does not have to be made at the booking appointment. The choice can be made at any stage during pregnancy or at the onset of labour as long as her medical and obstetric history indicates she is low risk. However, all women should be provided with verbal and written information about local services available (also available on the Health Board intranet) and the risks for both home and hospital birth should be discussed and recorded. One of the recommendations of the 'Your Birth – We Care' survey advocated that women should be given information about birthplace choices as early as possible in the pregnancy so that they have time and information to make an informed choice (Consultant Midwives Cymru, 2018). Women can be directed to the published results of the 'Birthplace Study' (Birthplace in England Collaborative Group, 2011) in the form of the Birth Place Decisions leaflet (Coxon, 2014). This study reviewed the place of birth for healthy women experiencing a straight forward pregnancy and in terms of adverse perinatal outcomes for babies. This study found that there was no difference between consultant obstetric units, alongside midwifery led units or free standing birth centres. The study did conclude that when healthy women gave birth in a consultant obstetric unit they were more likely to have interventions and less likely to achieve a normal birth. The only statistical difference found in this study was the perinatal mortality rate was increased in women giving birth at home with their first baby. There was a significant increased probability that women having their first baby may need transfer to an obstetric unit compared to women experiencing subsequent births.

When a woman with obstetric or medical risk factors chooses a home birth, a meeting between the woman, her family and the named midwife should be arranged to discuss the potential risks involved. At this point the Pathway for Midwifery Clinical Alerts should be accessed (see Appendix 1) and completed. The Clinical Supervisors for Midwives should be available to discuss cases with midwives after they have seen the woman and devised a plan. The CSfM can go through the plan and support improvement if needed. These must then be uploaded to CWS and a clinic alert placed on CSC.

The woman must be informed about the available emergency services with the anticipation that additional back up may be required. Women must be given accurate information as to the expected times for arrival / transfer by ambulance to the nearest obstetric unit. The midwife will call a 999 emergency ambulance with paramedic team if transfer to a main obstetric unit is required. Ambulance response rates vary according to geographical area and availability. All discussions, advice given and plans for care should be recorded on the Information for homebirth checklist (see Appendix 2) to be filed in the woman's notes (NMC, 2018a).

All women should be advised that a normal labour is considered to commence between 37 and 42 weeks. If labour commences before the 37th week they should be informed that a hospital birth is recommended. Women may be offered a membrane sweep at 41 weeks in line with the NICE guideline for antenatal care (2008) and ABUHB guidelines for midwives giving care in community settings (2014). Additionally, if labour does not commence by Term + 12 days the offer of a consultation with a consultant obstetrician to discuss the options for managing post-dates pregnancy should be made. When a woman agrees to induction of labour care is transferred to the obstetrician and a hospital birth will be recommended.

Booking a Home Birth

When a woman has made a decision to book a home birth the community midwife is responsible for completing the relevant

documentation. The Information for Homebirths (Appendix 2) should be discussed, completed and signed. The woman's address and clear instructions about its location should be available for every community midwife working within the geographical area. This should be loaded onto the woman's electronic notes and placed in the home birth file.

Provision of Antenatal Care

The midwife will be the lead professional for women who choose a home birth if their history is in line with Midwifery Led Care guidelines. There may be occasions when women choosing a home birth do not comply with Midwife Led Care and in such cases it may be possible to share care with a consultant obstetrician whilst still facilitating a woman's choice to birth at home. The pattern of antenatal care should follow NICE antenatal care guideline (2008) and ABUHB guidelines for midwives giving care in community settings guidelines (2014), however; the number of appointments may be individually tailored according to the woman's needs.

The full range of blood and screening tests should be offered as per hospital services. If the woman and her family choose to have screening ultrasound scans this will be arranged via the local services. In addition the opportunity for a presentation ultrasound scan at 37 weeks may be offered if there are concerns regarding fetal presentation. If a deviation from the normal growth pattern as plotted on the woman's individual growth chart is suspected a referral for a Consultant Obstetric opinion or a midwifery USS should be offered.

Preparation for a Home Birth

- It is the responsibility of the midwife booking the home birth to ensure all community midwives are aware of the address, location, relevant obstetric details and have access to a map of the local area

- All women should have the opportunity to discuss their birth plan with their named midwife at any time. However, between 30-36 weeks gestation, all women should be offered a structured appointment to discuss their wishes for labour and birth. During this appointment the midwife should facilitate the opportunity to discuss non-pharmacological and pharmacological methods of dealing with pain and how to organise the woman's analgesia of choice. The *Information for Homebirths checklist* should be completed (See Appendix 2)
- Community midwives should carry a complete range of intrapartum equipment in accordance with Health Board guidance. This should include the following drugs:

Syntocinon	10units for injection
Ergometrine	500mcg/ml
Lidocaine 1%	10mg/ml
Konakion Paediatric	1mg/ml

It is the midwives personal responsibility to ensure her equipment is clean, complete and up to date. Regular checks in line with the NMC Code (2018a) will be conducted by the supervisor of midwives at each annual review or by the team manager.

Arranging Support /or Pain Relief

Support in Labour

It is the woman's choice as to who is present at the birth. Women generally rely on their partners/ birth partner for assistance with breathing and to provide comfort. The wishes of the mother are paramount and must be respected, including the presence of other siblings at the birth.

Water in labour

Women may choose to use water for relaxation in labour and / or for birth at home. Women are responsible for providing and setting up of the pool for labour with advice from and discussion with the midwife regarding the most appropriate area to situate a birthing pool, time to fill and emptying the pool in an emergency in the home. Refer to All Wales Midwife-led Care Guidelines for further guidelines

surrounding the use of water in labour and birth (Davies and Lewis, 2017).

Entonox

- The process for ordering Entonox for the home birth will be discussed during the antenatal period and ordered at 36 weeks gestation
- A full risk assessment of the premises must be completed and filed in the woman's records
- The woman must receive clear advice regarding the safety and information relating to Entonox, i.e. storage, smoking, etc.
- Entonox will be delivered as per local policy
- Unless specifically requested, only 2 cylinders of Entonox (approx. 1.5.hours supply) will be delivered. It is advisable to ask for 4/8 cylinders to be delivered.

Going into Labour

Contacting the midwife

- All women will have telephone numbers and instructions when they book to give birth with the local midwifery team. Back-up numbers for the local hospital will also be made available in case communication fails at any time, enabling the woman access to midwifery advice at all times. Women should also be informed of what to do in an emergency and to use 999 as appropriate.
- When the woman telephones the unit / on call midwife reporting labour as starting, the midwife will assess whether a visit is necessary at that time using Part 1 of the All Wales Clinical Pathway for Normal Labour (AWCPNL) (2003).
- It is the midwife's responsibility to identify when he/she requires relief in attending the woman, i.e. change of shift, and to duly arrange for colleagues to relieve him/her. Consideration must be given to complying with European Working Time Directive and most importantly to ensure safety of mother and midwife.
- Lone worker policy should be adhered to and regular updates to birth centre/LWC (ABUHB, 2017).

Labour

- The midwife will provide care for the woman throughout labour.
- All drugs will be administered in accordance with the NMC Code (2018a) and the Midwives Exemptions (2010).
- A second midwife will be called when the midwife considers it necessary, clinically or otherwise indicated. This provides assistance and support during the birth.

Record Keeping

- Midwives will maintain accurate and detailed records throughout the pregnancy, labour and puerperium in accordance with the All Wales Clinical Pathway for Normal Labour (WAG, 2003) and NMC Code (2018a).
- All antenatal and intrapartum records should be repatriated with the hospital records as soon as practical after the home birth, usually within 72 hours. It is the responsibility of the midwife who delivered the baby to ensure repatriation of these records.
- All postnatal records will remain with the woman until her care is completed, when they are repatriated with her antenatal and intrapartum notes on completion of her care by the discharging midwife within 6 weeks of the birth of the baby.

Who do midwives call in an emergency?

- Emergency paramedic ambulance is requested for transfer.
- Medical support will be triggered depending on the circumstances of the emergency.
- Social services support may be required if the emergency is in relation to a safeguarding issue that has not previously been identified.
- The woman/ baby will be stabilised and transferred to the nearest hospital with a consultant obstetric unit.
- The transfer form contained in the All Wales Normal Birth Pathway must be completed with all relevant details, including ambulance call and arrival times.
- The receiving unit must be informed of the condition of mother/ baby in preparation for arrival using the SBAT format, and the woman must be seen by a senior obstetrician, or the baby by a senior paediatrician on arrival and must therefore be directed straight to the labour ward and not A&E.

- The woman and her family must be kept informed of events during any transfer.
- At the earliest opportunity following-on from the event, the midwife should inform a senior midwife and her supervisor of the incident. This will promote communication between professionals, identify an avenue for support if/when indicated and enable the local manager to be aware of the case/outcome. If appropriate an incident form (Datix) may need to be completed as per the trigger list.

Initial Care Following Birth

- The midwife will remain with the woman/family for a minimum of one hour after home birth, or for as long as necessary to ensure wellbeing.
- The GP will be informed of the birth. Neonatal examination will need to be arranged by the midwife within 72 hours of the birth. This may be performed by an appropriately qualified midwife or hospital Paediatrician.
- The midwife will discuss a plan of care for the immediate postnatal period with the woman and her family and this must be documented.
- The midwife will ensure the family has written information on how they can access 24-hour professional advice/support.
- The midwife will advise the woman about the process for the return of the Entonox cylinders.

Disposal of Equipment Following Birth

- The midwife will be responsible for ensuring that all equipment including Entonox and waste is removed from the woman's premises following birth in accordance with local policy.
- All non-disposable equipment will be returned for sterilisation in line with local policy.

8 Roles & Responsibilities

The practising midwife is responsible for providing care to women and babies during the antenatal, intrapartum and postnatal periods (NMC, 2018b). There is a duty of care to women, who have a right to expect safe and competent care (NMC, 2018a; NMC, 2018b). It is a

requirement of revalidation that midwives maintain their competence (NMC, 2019) and this includes providing care in the home environment.

8.1 Home or birth centre birth against medical/ midwifery advice

There may be occasions when a woman may choose to give birth at home or at a birth centre against the advice of either a midwife or medical practitioner because her medical or obstetric history increases risk factors. In such circumstances the following guidance should be followed. The overall aim must be to ensure that safe and effective care is provided to mother and baby whilst allowing women to make an informed choice on place of birth. It is important to initiate and implement a clear plan of care in partnership with the woman and her family. The midwife should aim to maintain trust and open lines of communication with the woman so that all options can be discussed openly, with the possibility of agreeing an alternate plan of care that is acceptable to all.

The rapid transfer of the woman into a consultant-led unit when the choice of birth environment is no longer advisable or appropriate should be agreed with the woman.

In the event of a woman informing a midwife that she wishes to have a home or birth centre birth and where she falls outside the criteria for low risk women the midwife should do the following:

- The midwife should contact the consultant obstetrician for an appointment or guidance on future management.
- Any interviews or discussions which take place should be documented fully in the handheld record which the woman may be asked to counter sign.
- Clinical alert to be completed and sent to midwives who may care for the woman, lead midwife, CSfM. The plan should be uploaded to CWS and an alert put on CSC.
- A care plan must be completed in the handheld records to maximise safety of both woman and baby. In the event of this

care plan not being fulfilled the woman should be encouraged to transfer to a main obstetric unit.

- The Information for homebirth checklist is to be completed and signed.
- Labour notes to be maintained in full, rather than the use of the normal labour pathway
- Send appropriate information to paramedics.
- Inform main obstetric unit when woman is in labour.
- During the postnatal period midwives should offer the family an opportunity to discuss their care.

8.2 Are midwives obliged to attend a woman requesting a home birth?

A midwife should work in partnership with women and their families, facilitating informed decision making (NMC, 2018a; NMC, 2018b). Midwives are responsible for providing care to women and they also have a responsibility to perform their duties as per local ABUHB contract. However, a midwife cannot be asked to do anything that contravenes the Standards of Competence for Registered Midwives (NMC, 2018b) or anything that is illegal. There is no legal requirement for a woman to go into hospital to give birth (Dimond, 2000), and thus the midwife must accept the woman's right to refuse advice given, following clear explanation. The midwife must document all discussion and may seek support from a clinical supervisor for midwives (NMC, 2018a; NMC, 2018b).

8.3 General Practitioner (G.P.) role

A G.P. can prescribe Pethidine for a homebirth but most are reluctant to do so as they have no control over who is using it. The G.P. would not be called to attend a homebirth. GPs are not responsible for care provided by midwives. A woman / baby must be transferred to a main obstetric unit if any assistance is required. Emergency transfer care is sought from the ambulance service.

9 Security

Midwives must consider their own safety at all times. Any anticipated difficulties in maintaining safety should be noted on the homebirth booking form where risk assessment is documented. Mobile phones should be carried at all times, with rigorous local arrangements if there is no phone signal at the home. Two midwives should be present for birth as far as possible.

Midwives attending a home birth should maintain contact with their local receiving maternity unit. Midwives must adhere to the Lone Worker Policy (Aneurin Bevan University Health Board (ABUHB), 2017) and be aware of the Violence and Aggression Policy (Aneurin Bevan University Health Board (ABUHB), 2014). They must also be mindful of the time they have worked and not leave themselves or women and babies at risk from tiredness having worked long hours.

Continual professional development should include training for the midwife on security and personal safety in accordance with local LHB policy (Aneurin Bevan University Health Board (ABUHB), 2017). Where there are social factors or known safety concerns, midwives must ensure support services, i.e. social services and/or police, are involved at all stages. A multidisciplinary approach/ plan should be developed and communicated prior to the planned homebirth.

10 Monitoring and Effectiveness

The guideline will be audited annually after implementation date.

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12 Appendices

Appendix 1

Midwifery Clinical Alert

Name:

Address:

Postcode:

Telephone number:

EDD:

Gravida:

Para:

Reason for clinical alert (SBAR):

SITUATION:

BACKGROUND:

ASSESSMENT:

RECOMMENDATIONS:

NB

Please attach directions & grid reference

Has Management Plan been updated	Yes/No
Copied to:	
Senior Midwifery Manager	Yes/No
Midwifery Team	Yes/No
SOM's	Yes/No
Ambulance	Yes/No

Appendix 2

INFORMATION FOR HOMEBIRTHS

To be discussed with your midwife

Having a baby is a very special event and deciding where to give birth is an important decision. We are here to support you to make the right choice for you and your family and are happy to answer any questions or seek the appropriate help or advice for you. Research has shown that for women who are healthy and experiencing a straight-forward pregnancy ("low-risk"), having their baby at home is a safe option and is encouraged by the Welsh Assembly Government. Recent research suggests that for women planning to give birth to their **second or subsequent baby** at home, there appears to be no difference in outcomes for babies when compared to planned births in obstetric units. For women having their **first baby**, however, it is suggested that a planned home birth increases the risk for the baby compared to giving birth in an obstetric unit (Birth place in England Collaborative Group, 2011). The **positive aspects** of birth at home are as follows: -

- ❖ You are in your own environment with your own family around you
- ❖ Greater privacy
- ❖ There is less intervention in the labour process
- ❖ There is a higher chance of your baby being born normally
- ❖ You use fewer pain relieving drugs
- ❖ You are less likely to require stitches
- ❖ You feel more relaxed and in control and can move around freely
- ❖ You and your partner have a positive birth experience.
- ❖ You are more likely to be cared for by a midwife you know and have continuity of carer
- ❖ It reduces your chances of having a Caesarean section.

However, some women can develop problems during their pregnancy and/or labour, and may require a referral for a consultant obstetrician opinion, or transfer to hospital based care. If all is well at that consultation, then you can be referred back to the midwife for continuing care and home birth. These include: -

Antenatal complications: -

- ❖ High blood pressure (consistently, not an isolated incident)
- ❖ Pregnancy induced diabetes
- ❖ Bleeding in pregnancy (early pregnancy bleeding may not be relevant)
- ❖ Problems with baby's growth
- ❖ Twins, breech or baby lying across the abdomen (transverse lie)
- ❖ Premature labour (before 37 weeks)
- ❖ Post maturity requiring the offer of induction of labour (after term+14)
- ❖ Prolonged rupture of membranes (more than 24 hours)

Labour complications: -

- ❖ Failure to progress in labour (slow progress)
- ❖ Breech presentation diagnosed in labour
- ❖ Meconium in the liquor (this needs to be judged in individual situations)
- ❖ Fetal Distress (problems with baby's heart rate)
- ❖ Bleeding
- ❖ Retained placenta
- ❖ Difficult suturing of the perineum after birth

Baby complications: -

- ❖ If baby needs assessment by neonatal doctors

This list is not complete, and there may be other reasons where your choice for having your baby at home may be reconsidered at any time. You may also change your mind at any time during the process. A valuable source of information to aid choice can be found at <http://www.nct.org.uk/birth/home-birth-safe>

The following are to be considered / discussed with your midwife:

COPING STRATEGIES FOR LABOUR	COMMENTS	SIGN	DATE
Natural methods			
Entonox: storage			

Order			
Pethidine: prescription Storage			

PRACTICAL PLANS	COMMENTS	SIGN	DATE
Birth plan: include All Wales Clinical Pathway for Normal Labour			
Phone numbers			
Equipment			
Previous hospital notes checked			
Use of birth pool at home: appropriate size, space, weight of water, insurance			

ASSESSMENT OF HOME	COMMENTS	SIGN	DATE
Telephone / mobile cover			
Water / electricity / heating			
Emergency access			
Detailed map / directions			

Your baby's heartbeat will be recorded through active labour intermittently using a Pinnards stethoscope or a hand-held sonicaid. The recommended guidelines for the monitoring of your baby's heart rate are at least every 15minutes during the first stage of labour and every 5 minutes (or after every contraction) in the second stage of labour. If the midwife is unhappy with the baby's heart rate then she will advise transfer, usually by ambulance, to the obstetric unit at the hospital. The midwife is the lead professional at your homebirth and a second midwife attends for the birth.

Other things that the midwife will need to discuss with you are emergency procedures at home and resuscitation of the baby if it should be required.

EMERGENCY PROCEDURES	COMMENTS	SIGN	DATE
Resuscitation of the new born			
Shoulder dystocia			
Postpartum haemorrhage			
Retained Placenta			
Transfer into hospital / paramedic services. Time for transfer			

I have read and discussed this form with my midwife and understand it fully.

------(Mother) Date-----

------(Midwife) Date-----