



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

**Midwifery Practice Guidelines
HSE Home Birth Service**

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1. Guideline Statement

- 1.1. These guidelines shall support and guide midwifery practice for the HSE Home Birth Service based on the Royal College of Midwifery (RCM) Evidence Based Guidelines for Midwifery Led Care in Labour (2008) and the National Institute for Health & Care Excellence (NICE) Guidelines for Intrapartum Care of Healthy Women and their Babies during Childbirth (2014).
- 1.2. NICE 2014 suggest that there is a higher likelihood of a normal birth, with less intervention, among women who plan to give birth at home or in a midwife-led unit. The National Maternity Strategy (DOH 2016), Royal College of Midwives (RCM Position Paper, 2002) and the Royal College of Obstetricians and Gynaecologists (RCOG/RCM 2007) support home birth for women with uncomplicated pregnancies.
- 1.3. Hanafin and O'Reilly (p.52, 2015) state: "Home birth for multiparous women appears to be safe for mothers and babies, and offers benefits to both, while there is an increased risk (although modest) for primiparous women with planned home birth", supported by Hollowell et al 2011, The Birthplace National Prospective Cohort Study.
- 1.4. These guidelines shall not replace clinical judgement and shall be read in conjunction with the regulatory, professional and legislative documents outlined. Midwives are obliged to ensure currency with regard to relevant regulatory, professional and legislative matters.

2. Purpose

These guidelines shall

- 2.1 Guide midwifery practices within the HSE Home Birth Service and have been adapted from the RCM Evidence Based Guidelines for Midwifery Led Care in Labour (RCM 2008) and the NICE Guidelines for Intrapartum Care of Healthy Women and their Babies during Childbirth.
- 2.2 Support the Self-Employed Community Midwives (SECMs) to provide evidence-based information to women so that they can make informed choices when considering birthing at home.

3. Scope

These guidelines apply to Self-Employed Community Midwives who have an agreement with the HSE to provide home birth services for eligible women.

4. Legislation, Codes of Practice, Standards and Guidance

- 4.1 Health Acts, 1947 to 2015 and regulations made thereunder
- 4.2 Nurses and Midwives Act, 2011
- 4.3 The Scope of Nursing and Midwifery Practice Framework (NMBI 2015)
- 4.4 The Code of Professional and Ethical Conduct (NMBI 2014)
- 4.5 Practice Standards for Midwives (NMBI 2015)
- 4.6 Recording Clinical Practice (NMBI 2015)
- 4.7 Guidance for Nurses and Midwives on Medication Management (ABA 2007)
- 4.8 NICE Clinical Guideline 190 – Intrapartum Care: Care of Healthy Women and their Babies during Childbirth (NICE 2014)
- 4.9 Evidence Based Guidelines for Midwifery Care in Labour (RCM 2008)
- 4.10 The Irish Maternity Early Warning System (IMEWS) NCEC (DOH 2014)

- 4.11 Communication (Clinical Handover) in Maternity Services NCEC (DOH 2014)
- 4.12 Sepsis Management NCEC (DOH 2014)
- 4.13 HSE Policy and Procedure for Notification of Home Births to the National Ambulance Service (National Ambulance Service HSE 2015)
- 4.14 Standards and Recommended Practices for Healthcare Records Management (HSE 2011)
- 4.15 National Consent Policy (HSE 2013)
- 4.16 Safety Incident Management Policy (HSE 2014)
- 4.17 Children First National Guidance for the Protection and Welfare of Children (HSE 2011)
- 4.18 National Maternity Strategy 2016-2026 (DOH 2016)

This list is not exhaustive and reference should be made at all times to the guideline for reference sources and the database of legislation, codes of practice, standards and guidance (Clinical Governance Group for the HSE Home Birth Service 2016).

5. Terms and Definitions

5.1. Supported Care Pathway: This care pathway is intended for normal-risk mothers and babies, with midwives leading and delivering care within a multidisciplinary framework. Responsibility for the coordination of a woman's care will be assigned to a named clinical midwife manager, and care will be delivered by the community midwifery team, with most antenatal and postnatal care being provided in the community and home settings. The woman can exercise a choice with her healthcare professional with regard to the birth setting, which may be in an *alongside birth centre* in the hospital, or at home. A woman may need to transfer, either temporarily or permanently, to another model of care because of an emerging risk. She may also choose to transfer to another care pathway, e.g. if she wants an epidural, or if she chooses to be under the care of an obstetrician (DOH 2016). The lead clinical midwife is the Self-Employed Community Midwife (SECM) in this guideline.

5.2. Assisted Care Pathway: The *assisted care pathway* is intended for mothers and babies considered to be at medium risk, and for normal-risk women who choose an obstetric service. Responsibility for the co-ordination of a woman's care will be assigned to a named obstetrician, and care will be delivered by obstetricians and midwives as part of a multidisciplinary team. Care will be provided across both the hospital and community, and births will take place within a hospital setting in a *specialised birth centre*. Postnatal care will start in the hospital and transition to the community on discharge from hospital (DOH 2016).

5.3. Specialised Care Pathway: The *specialised care pathway* for high-risk mothers and babies will be led by a named obstetrician, and will be delivered by obstetricians and midwives as part of a multidisciplinary team. Care will, in the main, be provided in the hospital, and births will take place in the hospital in a *specialised birth centre*. An individualised, multidisciplinary, multispecialty approach to care and care planning (for both hospital and woman) should be utilised. Where possible, antenatal care should be provided in the community. Postnatal care will start in the hospital and transition to the community on discharge from hospital (DOH 2016).

5.4. Terms:

- SECM: Self-Employed Community Midwife
- DMO: Designated Midwifery Officer
- NICE: National Institute for Health and Care Excellence
- RCM: Royal College of Midwives
- RCOG: Royal College of Obstetricians and Gynaecologists
- HSE: Health Service Executive
- SCBU: Special Care Baby Unit
- IMEWS: The Irish Maternity Early Warning System

Terms and definitions are also outlined in the Quality and Risk Taxonomy Governance Group Report on Glossary of Quality and Risk Terms and Definitions (HSE, 2009).

6. Roles and Responsibilities

6.1. The Director of Primary Care shall ensure:

- 6.1.1 The provision of appropriate systems and structures to support the SECM to provide midwifery care for women and their families availing of the HSE Home Birth Service.

6.2. The HSE Chief Officer shall:

- 6.2.1 Implement systems and structures for the SECM to provide midwifery care for women and their families availing of the HSE Home Birth Service.
- 6.2.2 Communicate with the SECM and the DMO if a case conference or alternate plan of care for the woman is required.
- 6.2.3 Require the SECM and DMO to report any adverse incidents to the National Incident Management System (NIMS) as per HSE Safety Incident Management Policy (2014).

6.3. The Designated Midwifery Officer (DMO) shall:

- 6.3.1 Ensure that the appropriate systems and structures are in place to implement these guidelines.
- 6.3.2 Facilitate communication between the maternity hospital healthcare professionals, SECM and the woman as appropriate.
- 6.3.3 Support and communicate with the SECM regarding the expected clinical midwifery care to be provided for women and babies.
- 6.3.4 Require the SECM to report any adverse incidents via the DMO to the National Incident Management System (NIMS) as per HSE Safety Incident Management Policy 2014.
- 6.3.5 Ensure that all other key stakeholders are notified if there is a change in care plan for the woman and baby.
- 6.3.6 Liaise with Ambulance Control as per National Policy for Communication with National Ambulance Service (HSE 2015).
- 6.3.7 Ensure that the SECM receives these guidelines and records same.
- 6.3.8 Audit adherence to guidelines and act upon audit results.

6.4. The Self-employed Community Midwife (SECM) shall:

- 6.4.1 Ensure competence in managing obstetric emergencies through attendance at obstetric emergency skills training.
- 6.4.2 Maintain and demonstrate ongoing competence in all aspects of maternity care.
- 6.4.3 Have all equipment required for obstetric emergencies and as stated in the home birth equipment list (Appendix I).
- 6.4.4 Ensure that the woman and her partner at the booking interview (Appendix II) have read the home birth information letter (Appendix III), the application

- and consent form agreeing to transfer for obstetric/medical care, and sign the form at booking with the SECM (Appendix IV).
- 6.4.5 Ensure that the woman understands the conditions referred to in Tables 1 to 6, the eligibility criteria for the HSE Home Birth Service (Appendix IV).
 - 6.4.6 Ensure that the woman and her partner are prepared during pregnancy for the possibility of transfer of maternity care before, during or after the home birth, by ambulance if necessary.
 - 6.4.7 Communicate with the DMO and ensure that all other key health professionals are notified if there is a change in care plan for the woman and baby.
 - 6.4.8 Report any adverse incidents via the DMO to the National Incident Management System (NIMS) as per HSE Safety Incident Management Policy 2014.
 - 6.4.9 Liaise with Ambulance Control as per National Policy for Communication with National Ambulance Service (HSE, 2015).
 - 6.4.10 Ensure adherence with these guidelines and all relevant HSE policies, procedures and guidelines.
 - 6.4.11 Consider their own safety at all times, following the HSE Guidelines for Lone Workers (2012).
 - 6.4.12 Have a second SECM on call for attendance at the home birth.

7. Procedure

7.1. Guide to the Antenatal Booking Interview

The antenatal booking interview is considered to be the most important aspect of midwifery care undertaken. It lays the foundation for the development of the essential relationship between mother and SECM. Refer to Appendix II for guidance on the detailed booking interview.

- 7.1.1. The SECM should ensure that the following points are discussed, completed and documented at the booking interview. The SECM must refer to the HSE Policy to Support Self-employed Community Midwives to Assess the Eligibility and Suitability of Women for Inclusion/Exclusion for Planned Home Birth (HSE 2016) and McCourt et al (2011) Birthplace Study.
 - 7.1.2.1. The home birth information leaflet (Appendix III) is given and explained to the woman.
 - 7.1.2.2. Discuss and explain the application/consent form, Appendix IV, which includes a risk assessment as per the HSE Home Birth Service Agreement.
 - 7.1.2.3. The application/consent form for the HSE Home Birth Service is signed by the woman and SECM and forwarded to the DMO.
 - 7.1.2.4. The National Ambulance Service form is completed for place of birth (if place of birth confirmed at booking) and forwarded to the DMO.
 - 7.1.2.5. Inform the woman of the mandatory requirement for the attendance of a second SECM at the home birth.
 - 7.1.2.6. Inform the woman that it is essential she is booked into a maternity unit/hospital and is advised to register with a general practitioner (GP) who provides combined/shared maternity care to women planning a home birth.
 - 7.1.2.7. Inform the woman of the schedule of visits as per the Maternity and Infant Care Scheme (Appendix V). Shared antenatal care may be carried out by the Self-Employed Community Midwives and GP (if he/she is agreeable), with referrals to the maternity unit/hospital as appropriate.
 - 7.1.2.8. It is desirable that an appropriate clinician undertakes the newborn examination within the first days of life. It may be

- necessary to transfer the baby into hospital for the newborn examination.
- 7.1.2.9. The woman should be aware that Entonox is the only pain relief medication available at a home birth, but the midwife and woman can discuss other pain-relieving strategies as the antenatal period progresses.
 - 7.1.2.10. Wherever possible, the SECM should include the woman's birth partner in the care provided and she/he should provide the partner with information to support the woman's decision to birth at home. The midwife should ensure that the woman has adequate support from her birth partner/s.
 - 7.1.2.11. At the initial assessment, the woman must be informed of the possibility of transfer to the maternity unit/hospital before, during or after the birth. She must also be informed of the possible indications for transfer in the first, second and third stages of labour and must agree with the plan to transfer if clinically indicated. Transfer in labour may or may not involve the woman continuing to receive midwifery care from the SECM, depending on the agreement in place in the maternity unit/hospital involved in the transfer.
 - 7.1.2.12. It is desirable that all home birth women would carry their hand-held hospital notes.
 - 7.1.2.13. Women who are particularly vulnerable or who lack social support need careful consideration when choosing a place of birth.
 - 7.1.2.14. Develop a plan of care with the woman and her partner based on the booking interview and the risk assessment. Refer as appropriate to the following:
 - a. Obstetrician
 - b. Physicians
 - c. Social worker
 - d. Dietician
 - e. Physiotherapist
 - f. Counsellor/mental health liaison team
 - g. Smoking cessation officer or appropriate person
 - h. Ultrasonographer
 - i. GP
 - j. Other healthcare providers as appropriate
 - 7.1.2.15. Psychological, social and physical assessment are undertaken at the booking visit and at each subsequent antenatal appointment, taking note of the:
 - a. History of pregnancy since last visit
 - b. Concerns and worries discussed and addressed at each visit
 - c. Emotional wellbeing discussed.
 - 7.1.3. Suitability for planning a home birth can be, at times, undetermined at the initial interview.
 - 7.1.3.1. Women may be deemed suitable for a home birth pending individual assessment by a consultant obstetrician.
 - 7.1.3.2. Women may require assessment throughout pregnancy, receiving combined care from the Self-Employed Community Midwife and hospital obstetrician in the antenatal period. The final decision of place of birth may have to be deferred towards the end of the pregnancy.
 - 7.1.4. The SECM informs the woman and her partner that risk assessment continues throughout pregnancy, labour and following the birth.
 - 7.1.5. Ensure that documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and the HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).

7.1.6. **Auditable Standards:**

- 7.1.6.1. Is there documented evidence of an information leaflet given to the woman?
- 7.1.6.2. Is there evidence of discussion regarding HSE eligibility criteria for home births with the woman?
- 7.1.6.3. Is there evidence of referral, where appropriate, to the liaison obstetrician or other relevant healthcare professionals?

7.2. Guide to Antenatal Risk Assessment

- 7.2.1 The SECM has a clinical responsibility to recognise potential risk and to refer the woman appropriately. Midwives have a professional responsibility to adhere to the Nursing and Midwifery Board of Ireland (NMBI) standards and guidelines.
- 7.2.2 Risk assessment must be an ongoing process. All eligibility criteria tables for risk assessment will be available to the woman (Appendix III) and all personnel involved in the woman's care. The important feature of risk assessment is the identification of the problem, recording of information, and the identified risk must be referred to the correct healthcare professional in a timely manner so that the problem may be dealt with appropriately and effectively.
 - 7.2.2.1. Tables 1 & 2 identify areas of **high risk**. If a woman presents with any of the conditions/factors within Tables 1 and 2 she is deemed ineligible for home birth. This list is not exhaustive but should give the midwife an objective dimension.
 - 7.2.2.2. Tables 3 and 4 identify women who may be considered **medium-risk** and therefore need to have a review by a consultant obstetrician before a decision is taken, i.e. where it may be deemed that the woman is eligible (or not) based on the clinical opinion of that consultant. This list is not exhaustive but should give the midwife an objective dimension.
 - 7.2.2.3. Women who do not relate to the conditions in Tables 1-4 are deemed eligible based on an assessment of **low risk**. The tables are not exhaustive; if the SECM has any other concerns or the woman has any other condition not listed on the tables then obstetric opinion should be sought.
- 7.2.3 Procedure for initial risk assessment:
 - 7.2.3.1. Individualised risk assessment must be carried out for each pregnant woman.
 - 7.2.3.2. The midwife **and** the woman sign and complete the risk assessment tables within the application/consent form for home births and send to the DMO.
 - 7.2.3.3. The DMO should copy the completed application form, return a copy to the woman and accompany this with a phone call to go through the assessment, explain the purpose of it (i.e. the safety of the woman and her baby) and to have the woman verify the information in it.
 - 7.2.3.4. If there are no risk factors identified, the woman can be offered a **supported care pathway** and can be provided with an initial confirmation of eligibility for the service based on continual risk assessment.
 - 7.2.3.5. If conditions on Tables 1 and 2 were identified, then the HSE cannot offer the woman the HSE Home Birth Service and an alternative pathway of maternity care is proposed: either an **assisted care pathway or specialised care pathway**.

- 7.2.3.6. If conditions or factors are identified on Tables 3 and 4 the woman can be given a 'pending approval status' and advised that she will need to have obstetric review. In conducting such a review, the obstetrician needs to be aware of the criteria against which he/she is reviewing the approval and approve eligibility (or not) based on this assessment. Obstetric review must be documented and provided to the DMO who can then, on the basis of that assessment, provide **initial confirmation to proceed on a supported care pathway** (or not) on the understanding that this will be revisited later in her pregnancy and may change, depending on her medical condition, to an **assisted care pathway or specialised care pathway**.
- 7.2.3.7. The SECM provides ongoing risk assessment through the observation and monitoring of the mother and baby at each antenatal appointment, during labour and birth, and in the postnatal period up to and including day 14.
- 7.2.3.8. Risk factors may change and therefore a woman deemed originally to be low-risk may, during the course of her pregnancy, develop a condition on one of the tables that may either deem her high risk and therefore ineligible, or medium risk requiring review by an obstetrician.
- 7.2.3.9. Ongoing communication between mother, SECM, DMO and any other healthcare personnel involved is paramount.
- 7.2.3.10. Any risks identified must be explained to the woman with available supporting written literature.
- 7.2.3.11. The woman must consent to transfer to hospital maternity care if the SECM identifies the need to do so during the antenatal, intranatal and postnatal periods.
- 7.2.3.12. The SECM shall refer and/or transfer the care of the woman and/or baby using the Policy to Support Self-Employed Community Midwives to Assess the Eligibility and Suitability of Women for Inclusion/Exclusion for Planned Home Birth with the HSE Home Birth Service and the Transfer Policy for the HSE Home Birth Service.
- 7.2.3.13. The SECM is required to document evidence in the midwifery notes of the risk assessments carried out at each antenatal appointment and if pregnancy is prolonged at 40 weeks +10 days.
- 7.2.3.14. If the SECM and/or DMO identify any change in relation to the risk status of the woman then the eligibility may be reconsidered; e.g. if the woman moves from low to medium risk a consultant review may be requested and the eligibility status changed to 'pending' until a consultant assessment is received. The woman may require an **assisted care pathway or specialised care pathway**.
- 7.2.3.15. If the woman's status moves from medium or low risk to high risk the eligibility can be withdrawn and the woman referred immediately to an obstetric unit and offered an alternative pathway of maternity care; either **assisted care pathway or specialised care pathway**.
- 7.2.3.16. The SECM shall transfer the woman to obstetric care if any of the conditions listed in Tables 1 and 2 are identified antenatally. The SECM shall refer the woman to obstetric care if any of the conditions listed in Tables 3 and 4 are identified antenatally. These tables are not exhaustive and if the SECM has any other concerns or the woman has developed any other condition not listed on the tables then obstetric opinion should be sought. When and if the identified problem is corrected it may be possible to transfer the woman back to the SECM, who will continue care.

- 7.2.3.17. The SECM should reconfirm to the DMO by 36 weeks that the woman is eligible for a home birth; the name/s of the second midwife and a birth pack can be organised for the expectant woman. The SECM must reconfirm, at this stage, the woman's contact details, address, and send the directions to the place of birth to the DMO as per ambulance control protocol.
- 7.2.4. Ensure that documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).
- 7.2.5. **Auditable Standards**
 - 7.2.5.1. Is there documented evidence of continuous risk assessment throughout the pregnancy, labour and postnatal period?
 - 7.2.5.2. Has the DMO been informed that all women at 36 weeks' gestation are eligible for homebirth?
 - 7.2.5.3. Is there evidence of referral, where appropriate, to the liaison obstetrician or other relevant healthcare professionals?
 - 7.2.5.4. Is there documented evidence regarding this guideline in the midwifery record?

7.3. Guideline to Stretch and Sweep Cervical Membranes

NICE (2008) report evidence to suggest that at 40 weeks of gestation only 58% of women had delivered their babies. This increased to 74% by 41 weeks and to 82% by 42 weeks. NICE (2008) state that in women who are healthy and have otherwise uncomplicated pregnancies, perinatal mortality and morbidity are increased in pregnancies of longer duration than 42 weeks. Sweeping the membranes as a general policy from 38 to 40 weeks onwards decreased the frequency of prolonged pregnancy. Membrane-sweeping reduced the frequency of using other methods to induce labour.

- 7.3.1. Sweeping the membranes increased the likelihood of both:
 - a. Spontaneous labour within 48 hours (63% vs. 83%)
 - b. Birth within one week (48% vs. 66%) (RCOG 2001).
- 7.3.2. At 40 and 41 weeks gestation nulliparous women should be offered a sweeping of the membranes at the antenatal appointment (see procedure Appendix VI).
- 7.3.3. At 41 weeks' gestation, parous women shall be offered a sweeping of the membranes at the antenatal appointment.
- 7.3.4. Ensure that documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).
- 7.3.5. **Auditable Standards**
 - 7.3.5.1. Is there documented discussion with the woman of a plan of care for post-maturity?
 - 7.3.5.2. Is there documented evidence regarding this guideline in the midwifery record?

7.4. Guideline for Referral to Maternity Unit/Hospital for Prolonged Pregnancy

Prolonged pregnancy is defined as continuing past 41 weeks from the first day of the last menstrual period (NICE 2008). The SECM will discuss the reasons for referral, the various methods of induction of labour that may be used, and the potential risks and benefits for accepting or declining induction, based on the current evidence.

- 7.4.1. This will enable the couple to make informed choices in regard to induction of labour.
- 7.4.2. The woman, her partner and the SECM will then decide on a plan of care.

- 7.4.3. The SECM should adhere to the local maternity unit's guideline on induction of labour.
- 7.4.4. At 40 weeks' gestation: nulliparous women shall be offered a sweeping of the membranes.
- 7.4.5. At 41 weeks, multiparous women shall be offered a membrane sweep.
- 7.4.6. The woman will be referred to the maternity unit for assessment at **40 weeks +10 days/according to local policy**, where a plan of care will be established with the woman, the obstetrician and the SECM.
- 7.4.7. Ensure that documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).
- 7.4.8. **Auditable Standards**
 - 7.4.8.1. Is there a documented plan of care for the management of post-maturity with the woman in this pregnancy?
 - 7.4.8.2. Is there documented evidence regarding this guideline in the midwifery record?

7.5. Guideline for the Care of Women with Pre-labour Rupture of Membranes at Term (After 37 Weeks of Gestation)

- 7.5.1 To ensure an accurate diagnosis of ruptured membranes the SECM should:
 - 7.5.1.1. Carry out a timely home visit based on professional clinical judgement or refer immediately to hospital if there is a problem (individual assessment) – advise woman to wear a sanitary pad.
 - 7.5.1.2. Obtain a full and accurate history.
 - 7.5.1.3. Record TPR/BP, noting any signs of maternal pyrexia or tachycardia.
 - 7.5.1.4. Perform an abdominal palpation noting lie, presentation and degree of engagement of the baby's head (if non-fixed, transfer to hospital).
 - 7.5.1.5. Auscultate foetal heart rate and note foetal movements.
 - 7.5.1.6. Inspect to assess the amount, colour and odour of liquor draining.
 - 7.5.1.7. Where there is ambiguity about the possibility of actual SROM the woman should be referred to her local maternity unit for a full assessment.
 - 7.5.1.8. Document findings.
- 7.5.2 It is recommended that in the absence of contractions no vaginal examinations should be conducted. If there is doubt as to whether the membranes are ruptured the woman should be referred to hospital for a speculum examination +/- an ultrasound scan.
- 7.5.3 Women presenting with pre-labour rupture of membranes (ROM) at term should be advised that:
 - 7.5.3.1. The serious risk of neonatal infection is 1% rather than 0.5% for women with intact membranes.
 - 7.5.3.2. Intravenous antibiotics are advised after 18 hours post ROM.
 - 7.5.3.3. 90% of all women with pre-labour rupture of membranes will go into labour within 24 hours.
 - 7.5.3.4. Induction of labour is appropriate approximately 24 hours after a rupture of membranes (RCOG, 2012).
- 7.5.4 In the absence of complications the woman should be offered the choice to stay at home provided she is able to:
 - 7.5.4.1. Monitor her temperature four-hourly to exclude pyrexia.
 - 7.5.4.2. Observe PV loss, foetal movements and the onset of contractions.
 - 7.5.4.3. The woman is advised to inform the SECM if there is any evidence of onset of labour, pyrexia, feeling unwell, tachycardia, blood-

- stained or meconium-stained liquor or reduction of foetal movements occurs.
- 7.5.4.4. Following the initial assessment at home the SECM should discuss a plan of care with the woman.
 - 7.5.4.5. If labour has not started 18 hours after rupture of the membranes, advise the woman to give birth in the hospital where she has booked and if labour has not started within 24 hours to stay in hospital for at least 12 hours after the birth (NICE 2014).
 - 7.5.4.6. If there are no contractions after 12 hours the SECM should contact the maternity unit to which the woman is registered and liaise with senior midwives/obstetricians regarding plan of care.
 - 7.5.4.7. If there are no contractions after **18** hours post-SROM refer the woman to the local maternity unit.
- 7.5.5 Ensure that documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).
- 7.5.6 **Auditable Standards**
- 7.5.6.1. Is there evidence of a documented discussion with the woman being informed of possible risks of infection in the presence of SROM?
 - 7.5.6.2. Is there evidence of appropriate referral in the records?
 - 7.5.6.3. Is there documented evidence regarding this guideline in the midwifery record?

7.6. Guide for Care in the First Stage of Labour at Planned Home Birth

- 7.6.1. Definition of established labour is confirmed by:
 - 7.6.1.1. **Latent first stage of labour** – a period of time, not necessarily continuous, when there are painful contractions and there is some cervical change, including cervical effacement and dilatation up to 4 cm.
 - 7.6.1.2. **Established first stage of labour** – when there are regular painful contractions and there is progressive cervical dilatation from 4 cm **(NICE, 2014)**.
- 7.6.2. It is usual practice to carry out a number of maternal and foetal observations during the first stage of labour to detect changes in maternal or foetal health. These provide an important overview of how the woman is progressing during her labour and what her needs are over time. These observations can be recorded in the woman's records or on a pre-designed chart (NICE, 2014).
- 7.6.3. Women usually determine the onset of labour themselves and contact the SECM.
- 7.6.4. On arrival at the woman's house the SECM should determine the onset of labour based on the following assessments:
 - 7.6.4.1. Taking a detailed history, identifying risk factors, ascertaining concerns and worries.
 - 7.6.4.2. Perform an abdominal palpation to determine length, strength, frequency and duration of the contractions/lie, presentation, position, engagement of the foetus in between contractions.
 - 7.6.4.3. If contracting, offer a vaginal examination and, with the woman's consent, confirm the onset of labour and to establish a baseline for further progress/assessments.
 - 7.6.4.4. If breech presentation or any malpresentation is diagnosed following assessment, then the SECM should call an ambulance and transfer the woman to the nearest maternity unit/hospital ASAP. (Refer to Transfer Policy for the HSE Home Birth Service, HSE 2016. All SECMs, in the case of an imminent birth, will have

- undertaken drills and skills training in the management of undiagnosed breech in labour through obstetric emergency training.)
- 7.6.4.5. Record the following observations during the first stage of labour:
 - a. Half-hourly documentation of frequency of contractions.
 - b. Auscultate the foetal heart rate for one full minute using a sonicaid or pinnard after contraction, every 15 minutes.
 - c. Any foetal movements felt should be noted and recorded.
 - d. Hourly pulse or more frequently if indicated.
 - e. Four-hourly temperature and blood pressure or more frequently if indicated.
 - f. Frequency of emptying the bladder.
 - g. Offer a vaginal examination four-hourly or if there is concern about progress or in response to the woman's wishes (after abdominal palpation and assessment of vaginal loss).
 - 7.6.5. Following the assessment of the woman and if she is in labour:
 - 7.6.5.1. The SECM should contact the second on-call SECM and inform her/him of impending birth, if not already contacted.
 - 7.6.5.2. Ambulance Control must be informed as per HSE Procedure for the Notification of Home Births to the National Ambulance Service (2015).
 - 7.6.6. Delay in progress of first-stage labour is defined as cervical dilatation of less than 2 cm in four hours for first labours, and cervical dilatation of less than 2 cm in four hours or a slowing in the progress of labour for second or subsequent labours.
 - 7.6.6.1. To define delay in established first stage, take the following into account:
 - a. parity
 - b. cervical dilatation and rate of change
 - c. uterine contractions
 - d. station and position of presenting part
 - e. the woman's emotional state
 - f. Referral to the appropriate healthcare professional and length of time this may take.
 - 7.6.6.2. If delay in the established first stage is suspected, assess all aspects of progress in labour when diagnosing delay, including:
 - a. cervical dilatation of less than 2 cm in four hours for first labours
 - b. cervical dilatation of less than 2 cm in four hours or a slowing in the progress of labour for second or subsequent labours
 - c. descent and rotation of the baby's head
 - d. Changes in the strength, duration and frequency of uterine contractions.
 - 7.6.6.3. If delay is diagnosed, transfer the woman to obstetric care.
 - 7.6.7. In the event of slow progress in the first stage of labour
 - 7.6.7.1. Perform an abdominal palpation to assess descent of the baby's head and note the strength, frequency and duration of the uterine contractions and how the woman is coping.
 - 7.6.7.2. Perform a vaginal examination to assess progress, noting cervical dilatation, descent of the head in relation to the ischial spines, the position of the foetus, and the presence of caput or moulding. If membranes are ruptured note the colour and the amount of liquor draining.
 - 7.6.7.3. Decisions regarding the need to perform an amniotomy should be made using professional clinical judgement. The reason for doing so must be documented. Amniotomy is an intervention in normal

labour. The woman is labouring in the ideal environment and therefore caution should be exercised.

- 7.6.8 Transfer to hospital: The SECM shall refer to Tables 5 & 6 (Appendix IV) or the Policy to Support Self-Employed Community Midwives to assess the eligibility and suitability of women for Inclusion/Exclusion for Planned Home Birth for indications for transfer to hospital and to the Transfer Policy for the HSE Home Birth Service (HSE 2016).
- 7.6.9 Ensure that documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).
- 7.6.10 **Auditable Standards:**
 - 7.6.10.1. Is there documented evidence of appropriate evidence-based care in the first stage of labour?
 - 7.6.10.2. Is there evidence of transfer to a hospital for medical care as per eligibility criteria and where appropriate?
 - 7.6.10.3. Is there accurate diagnosis of delay in the first stage of labour and evidence of appropriate transfer?
 - 7.6.10.4. Is there documented evidence regarding this guideline in the midwifery record?

7.7. Guideline for Pain Relief Methods for Labour at Home

- 7.7.1. Most women will choose to use some kind of pain-relieving strategies during labour, and many will use several different ones. What is important is that as far as possible the women feel in control and confident. It is important to remember that relatively simple things can make a difference. Women appreciate having someone whom they know and trust with them in labour. Women should be able to choose to play music of their own choice and drink and eat a light diet if they want to during labour.
- 7.7.2. Women can choose to walk, move around, find comfortable positions, sit, stand up, or lie down on their sides. However, if they lie on their backs they are likely to feel the pain more intensely.
- 7.7.3. Entonox has the advantage that it acts very quickly and rapidly passes out of the system without affecting the baby, and it can be used anywhere – even in the bath.
- 7.7.4. Women who choose to use breathing and relaxation techniques or massage by their birth partner should be supported.
- 7.7.5. Women who choose to use acupuncture or hypnosis should be able to, although this may not be provided by the midwives. The little evidence available shows that they may reduce the pain of labour and do not appear to adversely affect either maternal or neonatal outcomes (NICE, 2014).
- 7.7.6. Immersion in water provides effective pain relief, so encouraging women to get into a warm bath or birthing pool will help reduce the pain of the first stage of labour, and mean they are less likely to need transfer to hospital for pain relief. When using water in labour refer to the HSE Home Birth Service Water Birth Guideline (HSE 2016).
- 7.7.7. Ensure that documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).
- 7.7.8. **Auditable Standard:**
 - 7.7.8.1. Is there evidence of adequate discussion regarding pain relief in labour?
 - 7.7.8.2. If water was used in labour, was the pool temperature measured and documented hourly?

- 7.7.8.3. Is there documented evidence regarding this guideline in the midwifery record?

7.8. Guide to Care in the Second Stage of Labour at a Planned Home Birth

- 7.8.1 Definition of second stage of labour
 - 7.8.1.1. Passive second stage of labour: the finding of full dilatation of the cervix before or in the absence of involuntary expulsive contractions.
 - 7.8.1.2. Onset of the active second stage of labour:
 - a. the baby is visible
 - b. expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix
 - c. active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions (NICE, 2014).
- 7.8.2 Monitoring progress in the second stage of labour
 - 7.8.2.1. Hourly blood pressure and 15 minutes' maternal pulse are assessed for the duration of labour and documented.
 - 7.8.2.2. The length, strength, frequency and duration of the contractions are observed.
 - 7.8.2.3. Foetal heart rate is recorded at five-minute intervals along with maternal pulse or, after each contraction, for one full minute.
 - 7.8.2.4. Any evidence of amniotic fluid draining is observed, noting colour and amount.
 - 7.8.2.5. Note general condition and hydration; bladder should be empty.
 - 7.8.2.6. The woman should be encouraged to adopt a position that is most comfortable and effective for her (provided that the maternal and foetal position are satisfactory and there is progressive descent of the presenting part with each contraction.).
 - 7.8.2.7. Non-directive pushing should be encouraged, enabling the woman to be directed by her own body.
 - 7.8.2.8. NICE 2014 states that indications for performing episiotomies should be restricted to foetal indications only, i.e. foetal compromise – however, the midwife's clinical judgement should also prevail here.
 - 7.8.2.9. Vaginal examination should be offered after one hour if there is no progress in the active second stage.
- 7.8.3. Delay of progress on the second stage of labour
 - 7.8.3.1. Nulliparous woman:
 - a. birth would be expected to take place within three hours of the start of the active second stage in most women.
 - b. diagnose delay in the active second stage when it has lasted two hours and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent (NICE, 2014).
 - c. SECMs must take into account the transfer time to the local maternity unit, knowing that birth would be expected to take place within three hours maximum from the start of the active second stage.
 - d. In nulliparous women, if after one hour of the active second stage progress is inadequate, delay is suspected. Following vaginal examination, amniotomy should be offered if the membranes are intact.
 - 7.8.3.2. Multiparous woman:

- a. Birth would be expected to take place within two hours of the start of the active second stage in most women.
 - b. When the active second stage has lasted one hour or more, delay should be diagnosed and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent (NICE 2014).
 - c. Midwives will need to take into account the transfer time to the local maternity unit, knowing that birth would be expected to take place within two hours maximum from the start of the active second stage.
 - d. For a multiparous woman, suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 30 minutes of active second stage. Offer vaginal examination and then offer amniotomy if the membranes are intact (NICE 2014).
- 7.8.4 **Transfer to hospital:** The SECM shall refer to Tables 5 & 6 (Appendix IV) or the Policy to Support Self-employed Community Midwives to Assess the Eligibility and Suitability of Women for Inclusion/Exclusion for Planned Home Birth for indications for transfer to hospital and to the Transfer Policy for the HSE Home Birth Service (HSE 2016).
- 7.8.5 Ensure that documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).
- 7.8.6 **Auditable Standards:**
- 7.8.6.1. Is there documented evidence of appropriate evidence-based care in the second stage of labour?
 - 7.8.6.2. Is there evidence of transfer to a hospital for medical care as per eligibility criteria and where appropriate?
 - 7.8.6.3. Is there accurate diagnosis of delay in the second stage of labour and evidence of appropriate transfer?
 - 7.8.6.4. Is there documented evidence regarding this guideline in the midwifery record?

7.9. Guideline for Care in the Third Stage of Labour at a Home Birth

- 7.9.1. Definition of the third stage of labour
 - 7.9.1.1. The third stage of labour is the time from the birth of the baby to the expulsion of the placenta and membranes and achievement of haemostasis.
- 7.9.2. Modified active management of the third stage involves a package of care comprising the following components:
 - 7.9.2.1. routine use of uterotonic drugs
 - 7.9.2.2. deferred clamping and cutting of the cord
 - 7.9.2.3. controlled cord traction after signs of separation of the placenta.
- 7.9.3. Physiological management of the third stage involves a package of care comprising the following components:
 - 7.9.3.1. no routine use of uterotonic drugs
 - 7.9.3.2. no clamping of the cord until pulsation has stopped
 - 7.9.3.3. delivery of the placenta by maternal effort (NICE2014).
- 7.9.4. Take cord blood and blood for Kleihauer, if mother is rhesus-negative
- 7.9.5. Provided the woman is haemodynamically stable and requests physiological management of the third stage, no cord clamping until pulsation has ceased, allowing the placenta to deliver spontaneously aided by gravity, nipple stimulation, breastfeeding and skin-to-skin. Ensure that the woman has an empty bladder.

- 7.9.6. If the placenta is undelivered after one hour of physiological management, consider active management.
- 7.9.7. The placenta should deliver within a maximum period of one hour and 15 minutes. If not delivered, refer to Transfer Policy for the HSE Home Birth Service and transfer to a maternity unit via ambulance.
- 7.9.8. Diagnose a prolonged third stage of labour if it is not completed within 30 minutes of the birth with modified active management or within 60 minutes of the birth with physiological management (NICE 2014).
- 7.9.9. After the placenta has delivered, examine it for completeness and health.
- 7.9.10. Estimate blood loss (as per PPH guideline for HSE Home Birth Service) and record in maternity record.
- 7.9.11. **Transfer to Maternity Unit/Hospital:** The SECM shall refer to Tables 5 and 6 (Appendix IV) or the Policy to Support Self-Employed Community Midwives to Assess the Eligibility and Suitability of Women for Inclusion/Exclusion for Planned Home Birth for indications for transfer to hospital and to the Transfer Policy for the HSE Home Birth Service (HSE 2016).
- 7.9.12. Ensure that documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).
- 7.9.13. **Auditable Standards:**
 - 7.9.13.1. Is there documented evidence of appropriate evidence-based care in the third stage of labour?
 - 7.9.13.2. Is there evidence of transfer to a hospital for medical care as per eligibility criteria and where appropriate?
 - 7.9.13.3. Is there accurate diagnosis of delay in the third stage of labour and evidence of appropriate transfer?
 - 7.9.13.4. Is there documented evidence regarding this guideline in the midwifery record?

7.10. Guide for Immediate Care of Newborn

- 7.10.1. In the first minutes after birth:
 - 7.10.1.1. Evaluate the condition of the baby – specifically respiration, heart rate and tone – **in order to determine whether resuscitation is required.** Kleihauer resuscitation is required both SECMs in attendance at the birth who are trained and skilled in neonatal resuscitation shall:
 - a. Ensure there is a designated area prepared and equipment is set up for resuscitation prior to the birth.
 - b. Resuscitate the baby as per neonatal resuscitation programme (Appendix XI).
 - c. If necessary, call 999 or 112 emergency services.
 - d. Throughout the emergency situation in which the baby needs resuscitation, support and communicate with the mother and her birth companions.
 - e. The SECM should contact the midwifery manager in the receiving maternity unit/hospital and transfer the newborn as per the HSE Home Birth Service transfer policy.
 - f. Minimise separation of the baby and mother, where clinically appropriate.
 - 7.10.1.2. Record the time of birth to the onset of regular respirations (NICE 2014).
 - 7.10.1.3. Record the Apgar score routinely at one and five minutes.
- 7.10.2. In most instances only subdued lighting is necessary. If bright lights are required, the baby should be shielded from their full impact. Excessive noise

- should be avoided. Gentle handling and minimal activity around a new baby are required.
- 7.10.3. Routine practices such as mucous extraction following birth should be avoided unless clinically indicated.
 - 7.10.4. Mothers and partners should name the sex of the baby themselves.
 - 7.10.5. Babies should be kept warm post-delivery as loss of body heat is a threat to foetal well-being. Drying the newborn is essential and the baby can be nursed in contact with mother's skin (naked baby inside mother's nightgown). The birth room should be kept warm.
 - 7.10.6. All babies should be offered the opportunity of skin-to-skin contact post-birth and encouraged to breastfeed within the first hour, ideally. Post-delivery routines should not take precedence over the establishment of feeding. The SECM should remain with the woman until the first feed is completed.
 - 7.10.7. Ensure that a second clamp is available to allow double-clamping of the cord in all birth settings.
 - 7.10.8. Encourage the parents to cut the cord if they want to.
 - 7.10.9. Parents must be allowed some time after birth to be alone with their baby; this should be unhurried and not compromised because of routines.
 - 7.10.10. Babies should be dressed, where appropriate, by their parents, in order to maintain normal body temperature.
 - 7.10.11. A detailed documented head-to-toe examination of the newborn baby is carried out by the SECM in view of the parents to rule out any major physical abnormalities and to identify any problems that require referral. The examination should include:
 - 7.10.11.1. A review of family, maternal and antenatal history.
 - 7.10.11.2. Birth weight, head circumference and body temperature are recorded.
 - 7.10.11.3. Observation of the baby's general condition including colour, breathing, behaviour, activity and posture.
 - 7.10.11.4. Examination of the exposed parts of the baby first: scalp, head (including fontanelles), face, nose, mouth including palate, ears, neck and general symmetry of head and facial features.
 - 7.10.11.5. Examination of the baby's eyes (size, position, absence of discharge).
 - 7.10.11.6. Examination of the baby's neck and clavicles, limbs, hands, feet and digits, assessing proportions and symmetry. Unwrap baby to complete the exam.
 - 7.10.11.7. Assessment of the baby's cardiovascular system – colour, heart rate, rhythm, oxygen saturation.
 - 7.10.11.8. Respiratory effort and rate.
 - 7.10.11.9. Observation of the baby's abdomen – colour, shape and examination of the condition of the umbilical cord.
 - 7.10.11.10. Observation of the baby's genitalia and anus, to check completeness and patency.
 - 7.10.11.11. Inspection of the bony structures and skin of the baby's spine, with the baby prone.
 - 7.10.11.12. Noting the colour and texture of the skin as well as any birthmarks or rashes.
 - 7.10.11.13. Observation of the tone, behaviour, movements and posture to complete the assessment of the central nervous system (CNS).
 - 7.10.11.14. If concerned, undertake more detailed neurological examination, e.g. eliciting newborn reflexes.
 - 7.10.11.15. To provisionally assess newborn's hips, check symmetry of the limbs and skin folds. The hips require further examination during the examination of the newborn.
 - 7.10.11.16. Noting sound of baby's cry.

- 7.10.12. The baby will require a full examination, recommended within 72 hours, by an appropriate practitioner who holds the relevant skills/qualifications or has been approved to undertake this by the HSE.
- 7.10.13. Ensure that parents know how to assess their baby's general condition and to contact an SECM, doctor or emergency services if required.
- 7.10.14. Information on the screening test is given:
 - 7.10.14.1. A referral for a newborn hearing screen shall be requested as per Newborn Hearing Screening Policy for the HSE Home Birth Service (HSE 2016).
 - 7.10.14.2. Newborn bloodspot screening shall be carried out by the SECM on day four to seven as per Newborn Bloodspot Screening Policy, HSE Home Birth Service (HSE 2016).
 - 7.10.14.3. Baby check by GP: two and six weeks.
- 7.10.15. Information shall be provided to the mother on:
 - 7.10.15.1. How to access BCG vaccination (a waiting list may be in operation).
 - 7.10.15.2. Vitamin D supplementation.
 - 7.10.15.3. Vitamin K prophylaxis.
- 7.10.16. Vitamin K is administered with informed consent and administration or non-administration documented as per Administration of Vitamin K Prophylaxis Policy (HSE 2016).
- 7.10.17. Ensure that documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).
- 7.10.18. **Auditable Standards**
 - 7.10.18.1. Is there evidence of examination of the newborn?
 - 7.10.18.2. Is there evidence that advice and information regarding screening tests for newborn was given?
 - 7.10.18.3. Is there evidence of written consent for Vitamin K prophylaxis administration/non administration?
 - 7.10.18.4. Is there documented evidence regarding this guideline in the midwifery record?
 - 7.10.18.5. Is there evidence of transfer to a hospital for medical care as per eligibility criteria and where appropriate?

7.11. Guide for postnatal care of the mother

- 7.11.1. Immediate postnatal care following delivery
 - 7.11.1.1. Observe uterine involution and lochia.
 - 7.11.1.2. Carry out maternal observations (temperature, pulse, respirations, blood pressure) and document on the IMEWS chart (Appendix VII).
 - a. IMEWS should be used to record the vital signs of women who are up to 42 days post-delivery.
 - b. All triggers should be added up and documented at the bottom of the IMEWS each time observations are recorded.
 - c. If the woman triggers any yellows, observations should be repeated after 30 minutes and not later than 60 minutes.
 - d. If the woman continues to trigger any further yellow and/or pink scores her care should be referred to an obstetrician.
 - 7.11.1.3. If the SECM is concerned about a woman, escalate care to an obstetrician regardless of triggers.
- 7.11.2. Inspect perineum to assess trauma, inform mother of extent of trauma and carry out suturing with consent as per Guideline on Perineal Repair, HSE Home Birth Service (HSE 2016).
- 7.11.3. Ensure mother has passed urine before SECM's departure.

- 7.11.4. Assess maternal emotional/psychological condition in response to labour and birth.
- 7.11.5. The SECM should stay with the mother and baby for a minimum of two hours following completion of the third stage and she is confident of their safety and wellbeing.
- 7.11.6. When the SECM leaves she must ensure that the family has appropriate contact telephone numbers.
- 7.11.7. Ensure that equipment and all other items are disposed of correctly.
- 7.11.8. Arrange for anti-D as required.
- 7.11.9. The SECM must visit the mother and baby the next day or sooner as appropriate.
- 7.11.10. Good practice suggests that if the baby is born in the morning, then a postnatal visit should be carried out later the same day. If the baby is born at night, then aim for a morning visit the next day. The midwife should use her clinical judgement regarding these timelines.
- 7.11.11. Advise the parents on the physical examination of the newborn, recommended to be undertaken within 72 hours of birth.
- 7.11.12. Arrange for the collection of any remaining equipment and/or medical gases as soon as possible.
- 7.11.13. Inform the Designated Midwifery Officer of the birth.
- 7.11.14. Complete BNF01 form as per NPRS guideline (Appendix VIII).
- 7.11.15. Complete local birth notification to DPHN/CHO e.g. (Appendix IX).
- 7.11.16. Ensure that all clinical midwifery documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and the HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).
- 7.11.17. **Auditable Standard:**
 - 7.11.17.1. Is there evidence of maternal observations recorded on the IMEWS chart?
 - 7.11.17.2. Is there evidence of transfer to a hospital for medical care as per eligibility criteria and where appropriate?
 - 7.11.17.3. Is there evidence of the completed BNF01 form and birth notification to the DPHN/CHO?
 - 7.11.17.4. Is there documented evidence regarding this guideline in the midwifery record?

7.12. Guideline for Postnatal Examination of the Mother and Baby

- 7.12.1. The aim of postnatal care is to enable the SECM to assess, monitor and promote the physical, emotional and psychological wellbeing of mother and baby and to provide parents with an opportunity to discuss the birth experience.
- 7.12.2. A comprehensive holistic postnatal care examination is completed at each visit by the SECM, and will provide the plan for the continuous postnatal care required throughout the next 24 hours.
- 7.12.3. Selective postnatal visiting is recommended up to a period of 14 days. The SECM should exercise her/his professional judgement in determining the number of visits and any additional visits required in the postnatal period. The range of postnatal care, including timing of visits, should be discussed and planned by the SECM with the mother.
- 7.12.4. Develop a plan of postnatal care with the woman and her partner, to involve:
 - 7.12.4.1. The number and timing of postnatal visits required.
 - 7.12.4.2. The SECM's contact number and a number for advice and consultation in case that the SECM may be otherwise engaged at another birth.

- 7.12.4.3. The baby should have a full examination, recommended within the first 72 hours, by a paediatrician or a practitioner who holds the relevant skills/qualifications and has been approved to undertake this by the HSE.
- 7.12.4.4. Inform the local public health nurse of the birth and liaise as necessary.
- 7.12.4.5. The plan of care may change as the postnatal period progresses.
- 7.12.4.6. Document all findings in the postnatal care plan.
- 7.12.4.7. The SECM shall be aware of her responsibilities in relation to child protection and welfare (Children First Guideline, HSE 2011).
- 7.12.5. Physiological assessment and care shall be based on:
 - 7.12.5.1. Baseline observations, temperature, pulse, respirations, blood pressure and breast assessment if necessary.
 - 7.12.5.2. Note previous family, maternal and obstetric history i.e. PPH, wound infection, depression, other infection.
 - 7.12.5.3. Lochia observed for amount, colour and odour. Intra-uterine infection should be considered in all women with postpartum pyrexia.
- 7.12.6. **Abnormal Bleeding** – the woman is asked to inform the SECM if bleeding becomes:
 - 7.12.6.1. Heavier.
 - 7.12.6.2. Bright red after the first week of delivery.
 - 7.12.6.3. If a larger clot is passed on more than one occasion.
 - 7.12.6.4. Offensive.
 - 7.12.6.5. Ask mother the length of time the heavier loss is experienced. Exclude other factors such as (e.g.) breastfeeding, rising up from lying and sitting position.
 - 7.12.6.6. Ask the mother to describe pad, is loss offensive now or has been or flu like symptoms or tenderness. Describe and record current pad, size of clots passed, examine for placental tissues or membranes.
 - 7.12.6.7. Record temperature and palpate uterus.
 - 7.12.6.8. Exclude association with other factors and poor personal hygiene.
 - 7.12.6.9. Ask woman if colour is different from previously.
- 7.12.7. **Other Physiological Care**
 - 7.12.7.1. Personal hygiene – bath or shower and bidet if available.
 - 7.12.7.2. Perineum observed – advised to keep clean and dry. Examine perineum to detect signs of infection, oedema, haematoma, haemorrhoids or inadequate repair.
 - 7.12.7.3. Obtain mid-stream sample of urine (MSU) if mother complains of dysuria. Obtain history of urinary symptoms – frequency, incontinence, voiding difficulties; dipstick fresh urine sample and send MSU, refer to doctor.
 - 7.12.7.4. Stress urinary incontinence – exclude causes e.g. UTI, retention of urine, and give instruction on pelvic floor exercises to perform daily; refer to physiotherapist and to obstetrician.
 - 7.12.7.5. Bowel care – enquire if bowel opened since delivery. Ask about specific difficulties, constipation, haemorrhoids and loss of bowel control including soiling, faecal urgency and flatus incontinence. Check delivery history, ascertain history of bowel problem i.e. irritable bowel syndrome, ulcerative colitis, bowel habit during pregnancy. Provide dietary advice if constipated.

- 7.12.7.6. Constipation is associated with anal fissure so be alert for this, particularly if the woman reports severe pain or blood loss on defecation.
 - 7.12.7.7. Haemorrhoids – assess perineal area, avoid constipation – advice given on diet, and if treatment required i.e. creams/suppositories refer to doctor.
 - 7.12.7.8. Varicose veins – advice given to wear support stockings and keep legs elevated, and record measurements in chart.
 - 7.12.7.9. Pain – appropriate analgesia shall be prescribed and taken by mother if required. Examine perineum to detect sign of infection, oedema, haematoma or inadequate repair.
 - 7.12.7.10. Advise regarding importance of a balanced diet.
 - 7.12.7.11. Haemoglobin (Hb) – check if indicated or mother is symptomatic e.g. dyspnoeic, tachycardia, pale and tired. Check intrapartum blood loss and pregnancy Hb.
 - 7.12.7.12. Rhesus-negative women – check if anti-D immunoglobulin (cord blood results) is necessary and administer following prescription as appropriate. Anti-D to be given as required and per HSE National Guideline. Administration to be recorded in notes. Information leaflet given to mum prior to procedure.
 - 7.12.7.13. Explain the importance of a balanced lifestyle. Advise short daily walks followed by short periods of rest. Check dietary intake and stress the need to eat regularly. Refer to physiotherapist if there are any concerns.
 - 7.12.7.14. Dietary and cultural preferences to be taken into account and facilitated where necessary.
 - 7.12.7.15. Appropriate advice given on maintenance of lactation such as skin-to-skin, frequent feeding.
 - 7.12.7.16. If necessary provide advice on the suppression of lactation such as wearing a supportive bra, regular analgesia, and avoidance of expression of breast milk.
 - 7.12.7.17. Discharge planning begins on the day of birth and is reviewed daily.
 - 7.12.7.18. Enquire that the mother feels confident about care of the baby.
 - 7.12.7.19. Discuss and explain screening tests as they occur (newborn hearing, newborn bloodspot screening).
 - 7.12.7.20. Discuss any investigations to be carried out, i.e. rubella vaccine, full blood count.
 - 7.12.7.21. Provide written information where possible and oral information on:
 - a. Postnatal and breastfeeding support groups
 - b. Postnatal depression
 - c. Family planning
 - d. Registration of the baby’s birth at local level
 - e. If a smoker, quit smoking information
 - f. Sudden infant death syndrome
 - g. Vaccinations
 - h. Health promotion
 - i. Cord care
 - j. Postnatal exercises
 - k. Contact numbers
- 7.12.8. **Psychological/emotional assessment and care**
- 7.12.8.1. Assess the woman on how well she feels.
 - 7.12.8.2. Assess the woman on how she is sleeping.
 - 7.12.8.3. The SECM should listen to the woman’s concerns.
 - 7.12.8.4. Enquire if the woman feels that she has adequate support.

- 7.12.8.5. The woman should have the opportunity to discuss her delivery with appropriate staff; the SECM should offer a debriefing session.
- 7.12.8.6. Enquire if the woman is happy with her responses to her baby.
- 7.12.8.7. The SECM should be especially aware if there is a history of psychiatric illness: if the woman is upset or 'baby blues' do not resolve, then refer to appropriate healthcare personnel.
- 7.12.8.8. Referral to support group if appropriate.
- 7.12.8.9. Information and reassurances should be offered on the normal patterns of emotional changes in the postnatal period and the woman should be made aware that these usually resolve within 10-14 days of giving birth. This information should be offered by the third day (Nice 2006).
- 7.12.8.10. Refer to social worker if appropriate – note the woman's history.
- 7.12.9. **Physiological assessment and care of the newborn baby**
 - 7.12.9.1. A more thorough physical examination of the newborn, recommended within 72 hours after delivery by a paediatrician or a practitioner who holds the relevant skills/qualifications and has been approved to undertake this by the HSE, is accepted as good practice (NCCPC 2006).
 - 7.12.9.2. An examination of the newborn by the SECM should review the following:
 - a. Baseline observations e.g. temperature, respirations, heart rate.
 - b. General observation of the baby's overall appearance and behaviour, movements and posture.
 - c. Check eyes – opacities.
 - d. Note appearance – colour, tone and movements, level of jaundice. A baby who develops jaundice within the first 24 hours after birth should be investigated.
 - e. Skin – note the colour and texture of the skin as well as any birthmarks or rashes.
 - f. Genitalia and anus – completeness and patency.
 - g. Discuss with mother and record urine output and bowel activity, and urine stream in a boy. Check for hypospadias.
 - h. Observe cord.
 - i. Cry – note sound of baby's cry.
 - j. Enquire regarding feeding routine/assess actual feeding technique and mum's competencies.
 - k. Observe for feeding problems, e.g. vomiting excessive, expulsive, projectile, and refer as appropriate.
- 7.12.10 Emotional assessment and care
 - 7.12.10.1. Observe baby/mother interaction.
 - 7.12.10.2. Give time to mother to ask questions regarding baby and help build confidence and competence in caring for baby.
- 7.12.11. Ensure that both parents have received information and demonstration on the following:
 - a. Daily routine newborn care (top and tail).
 - b. Cord care.
 - c. Bathing baby.
 - d. Hand expression demo.
 - e. Bottle-feeding demo and information if required.
- 7.12.12. Ensure that all clinical midwifery documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).

7.12.13. Auditable Standards:

- 7.12.13.1. Is there evidence of mother and baby postnatal care observations recorded?
- 7.12.13.2. Is there evidence of transfer to a hospital for medical care as per eligibility criteria and where appropriate?
- 7.12.13.3. Is there documented evidence regarding this guideline in the midwifery record?

7.13. Guideline for Postnatal Discharge of Women and Babies from the Home Birth Service

- 7.13.1. Each woman has a postnatal check on the day of discharge by the SECM. If a risk factor is identified, appropriate referral is made.
- 7.13.2. Discharge planning is based on care given during pregnancy, childbirth and postnatal period. Follow-up depends on the requirements of this care. Check and organise follow-up as appropriate. This may need direct contact with GP/PHN.
- 7.13.3. Check that follow-up appointments for baby are arranged as necessary (paed/ortho/x-ray/orthodontist),
- 7.13.4. Confirm and document that newborn screening tests have been completed.
- 7.13.5. Information on follow-up Vitamin K, if given orally.
- 7.13.6. Each mother receives information on the following (written if available and verbally):
 - 7.13.6.1. Family planning.
 - 7.13.6.2. Feeding baby and expressing breast milk.
 - 7.13.6.3. Breast examination.
 - 7.13.6.4. Postnatal smear, and advised to attend GP for same.
 - 7.13.6.5. Postnatal GP check for mother and baby at six weeks postnatal.
 - 7.13.6.6. Postnatal exercise, rest and diet.
 - 7.13.6.7. Vaccinations.
 - 7.13.6.8. Newborn hearing (if not already screened).
 - 7.13.6.9. Sudden infant death syndrome.
 - 7.13.6.10. Registration of birth of baby and how to obtain a birth certificate.
 - 7.13.6.11. Entitlements and car safety (refer to appropriate website).
 - 7.13.6.12. Contact number as appropriate for
 - a. Local maternity hospital.
 - b. Local breastfeeding support group.
 - c. Local La Leche League.
 - d. Local postnatal depression support group.
 - e. Public health nurse number.
 - f. Domestic violence support.
 - g. Social worker (if necessary).
 - h. Local community services for mother and baby.
 - 7.13.6.13. Complete discharge planning page in case notes and sign for discharge. Inform public health nursing/GP/ DMO.
 - 7.13.6.14. SECM discharge summary report to be completed and sent to GP/PHN/hospital (Appendix X).
 - 7.13.6.15. Arrange for hospital hand-held notes to be returned to appropriate hospital.
 - 7.13.6.16. Send midwifery record to DMO with payment claim form within one month of discharge to facilitate database entry.
- 7.13.7. Ensure that all clinical midwifery documentation is completed in accordance with Recording Clinical Practice (NMBI 2015) and HSE Home Birth Service Guidelines on Record Keeping (HSE 2016).

7.13.8. **Auditable Standards**

- 7.13.8.1. Is there evidence of a discharge summary to the GP/PHN/hospital?
- 7.13.8.2. Is there documented evidence regarding this guideline in the midwifery record?

8. Monitoring and Audit

- 8.1. Monitoring of compliance with these guidelines shall be undertaken by the DMO or other appropriate healthcare personnel.
- 8.2. Audit of compliance with these guidelines shall be undertaken by the SECM, DMO or other appointed HSE healthcare professionals.

9. Training

The SECM shall ensure that she/he has sourced appropriate education and training to support the compliance with and implementation of these guidelines.

10. Implementation Plan

The Clinical Governance Group for the HSE Home Birth Service developed this document, which has been approved for implementation by the National Implementation Steering Group for the HSE Home Birth Service. This document will be piloted for a year from the approval date. It will be disseminated by the Designated Midwifery Officers to relevant healthcare personnel and to all Self-Employed Community Midwives who provide home birth services on behalf of the HSE.

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12. List of Appendices

- Appendix 1 Equipment Checklist
- Appendix 2 Booking Interview Guide
- Appendix 3 Information Leaflet for the HSE Home Birth Service
- Appendix 4 Application Form/Risk Assessment Criteria/Eligibility Criteria
- Appendix 5 Schedule of Appointments
- Appendix 6 Sweeping of the Membrane
- Appendix 7 I-MEWS Chart
- Appendix 8 BNF01 Form
- Appendix 9 Notification of Birth to DPHN/CHO
- Appendix 10 Discharge summary
- Appendix 11 NRP Algorithm
- Appendix 12 BLS Algorithm
- Appendix 13 Maternal Resuscitation Algorithm

Appendix I: SECM Equipment list (provided by the CMA)

Antenatal/Postnatal Bag contents	
Sphygmomanometer	
Stethoscope	
Urine testing	
Pinard stethoscope/sonicaid and aquagel	
Venepuncture equipment/forms	
Swabs for microbiology	
MSU universal container	
Disposable gloves – latex – non sterile and sterile	
Disposable syringes, needles	
Disposable speculum	
Thermometer	
Torch/good light	
Newborn screening equipment	
Cord clamp and clamp remover	
Sharps bin	
KY Jelly – sterile sachets	
Disposable tape measure	
Alcohol hand cleaner	
Baby weighing scales	
Spare batteries for sonicaid/torch/weighing scales	
Basic delivery pack; includes sterile bowls, drapes	1
Sterile large swabs – Raytec	5
Inco pads	10
Sanitary towels	10
Sterile gloves – correct size for midwife.	6
Non-sterile gloves – correct size for midwife	1 box
Cord clamp	2
Cord scissors	1
Yellow clinical waste bags	1
Yellow clinical waste placenta bags	1
Documentation:	
IMEWS chart	
Fluid balance chart	
Birth notification BN10 form	
Local hospital birth notification form (if required)	
All other listed equipment below or SECM to bring that may not be required	
RESUS	1
Neonatal bulb suction	1
	1

Airways 0 & 00 & 000	1
O2 cylinder	1
O2 tubing	1
Entonox cylinder and connector	1
Disposable mouthpiece	1
Adult self-inflating resuscitation 'ambu' bag with facemask	1
Episiotomy scissors	1
Amni hook	1
Goggles	1
Apron	1
Suture repair kit	1
Vicryl Rapide/Serapid sutures	2
Single-use in/out urinary catheter size 12	1
Self-retaining urinary catheter size 12	1
Urine collection bag	1
10 ml sterile water and syringe	1
IV equipment	
Cannula size 20 g	2
Cannula size 18 g	2
Cannula size 16 g	2
Selection of syringes, needles and vacutainers	
IV dressings	2
Tourniquet	1
Plasters	
Alcohol swabs	
Mepore tape	1
IVI giving set	2
IVI Gelofusin 500ml	2
IVI Hartmann's solution 1 litre	2
IVI NaCl 500mls	2
Drug additive labels	1
Blood bottles and forms	
Drugs	
Syntometrine	5iu/ml x 2
Ergometrine	500mcg x 2
Syntocinon	10 iu Box of 5
Lignocaine 1% 10 ml	2
Vitamin K including oral syringes	

Appendix II: Guidance for Booking Interview Based on the Clinical Judgement

Demographic Details

LMP Details

- Cycle details: An early scan is indicated if the client is unsure of her dates or if pregnancy symptoms are reduced.
- Last cervical smear test.

Medical History

1. Hypertension

Pre-existing
Pregnancy-induced
Pre-eclampsia

2. Cardiac Disease

Ischemic heart disease
Valve disease
Previous heart surgery
Other

3. Respiratory

Asthma
Other

4. Gastro-intestinal

Liver disease
Inflammatory bowel

5. Renal

Recurrent UTIs
Chronic renal failure
Transplant
Other

6. Haematological

Anaemia
Haemoglobinopathies (please specify)
Platelet disorders
Thrombophilia
Deep venous thrombosis
Pulmonary emboli
Previous blood transfusion
Blood transfusion reactions
Blood transfusion acceptable to woman (if not acceptable refer to consultant obstetrician)
Other

7. Metabolic Disorders e.g. PKU

8. Endocrine

Diabetes
Thyroid disease
Other

9. Mental Health

Puerperal psychosis/depression
Depression
Schizophrenia – effective disorder
Other

10. Substance Misuse

Alcohol (include quantity)
Cigarettes (include quantity)

Prescription drugs
Non-prescription drugs
Illicit drugs

11. Neurological

Epilepsy
Migraine
Multiple sclerosis
Stroke history
Other

12. Infection History

Hepatitis B
Hepatitis C
HIV
Group B streptococcus
Sexually transmitted infections
TORCH/MRSA
Other

13. Connective Tissue Disorder

Systemic lupus erythematosus
Rheumatoid arthritis
Anti-phospholipid syndrome
Other

14. Musculoskeletal

Developmental dysplasia of hips
Scoliosis
Spinal/pelvic/hip dysfunctions
Other

16. Anaesthetic Risk

Airway problem
Adverse drug reaction
Other

17. Allergies

Medication and foodstuff
Other (e.g. latex, plasters)

18. Gynaecological History

Last smear (date)
Previous abnormal smears
Pelvic inflammatory disease
Other, e.g. fibroids

19. Would you accept a blood transfusion in the case of emergency?

20. Previous surgery: specify

Partner History/Family History

Are any of the following present in partner history or family history?

Adopted: Self

Partner

- Hypertension
- Pre-eclampsia
- Heart disease
- Mental illness
- Thromboembolism
- Sickle cell disease/thalassaemia
- Infectious diseases
- Developmental dysplasia of hips
- **Congenital Abnormalities**
- Down's syndrome

- Spina bifida
- Other abnormalities
- **Genetic Disorder**
- Cystic fibrosis
- Muscular dystrophy
- **Metabolic disorders**
- Cerebral palsy
- Learning difficulties
- Multiple pregnancies
- Partner – a blood relative (i.e. cousin)
- Self/partner – member of the Travelling Community (Beutler test)

Obstetric History

- Note complications in any pregnancy
- Present pregnancy
- EDD: If women are unsure of gestational age, scans should ideally be performed between 10 and 13 weeks' gestation to get crown/rump measurement, which will determine gestational age. After 14 weeks' gestation, head circumference or bi-parietal diameter should be used.
- Bleeding
- Heartburn ± antacid use
- Lifestyle
- Diet (note any restricted diet e.g. vegetarian)
- Medication
- Other symptoms are noted

Criteria for Oral Glucose Tolerance Tes.

As per HSE (2010) Guidelines for the Management of Pre-Gestational and Gestational Diabetes from the Pre-conception to the Postnatal Period.

Health Education & Advice

Women are given information with an opportunity to discuss issues and ask questions. Verbal information is supported by written information. This is an opportunity for the SECM to identify women who need additional care.

- **Antenatal classes:** Types (yoga, hospital, privately run), availability and how to access.
- **Smoking:** referral to smoking cessation officer or appropriate person.
- **Supplementation in pregnancy:** 400 micrograms of folic acid supplementation daily up to 12 weeks' gestation. Vitamin D for the infant. All up-to-date dietary advice given.
- **Vaccinations in pregnancy:** i.e. pertussis and influenza.
- **BMI:** Ongoing risk assessment to maintain BMI at 35kg/m² or less.
- **Vomiting and Heartburn**
- **Constipation**
- **Haemorrhoids**
- **Varicose veins**
- **Exercises in pregnancy**
- **Infant feeding** to include benefits and management of breastfeeding.
- **Edinburgh Postnatal Depression Scale** or other means of assessment if a mental health risk factor has been identified.
- **Promotion of continence in pregnancy and postnatal**
- **Perineal care:** Massage of the perineum in pregnancy may reduce perineal trauma.
- **Domestic violence:** an opportunity for women to disclose it in an environment in which they feel secure. Refer to **Clinical Care Guideline, Antenatal Routine Enquiry Regarding Violence in the Home (HSE 2012).**

- **Explain and gain verbal consent where necessary on following:**
 - Pregnant women should be advised of their maternity rights and benefits.
 - Ensure that blood tests have been taken and results available on blood group, antibodies and rhesus factor, FBC, rubella, VDRL, HIV, hepatitis B and varicella.
 - Antenatal schedule as outlined in the Maternity and Infant Care Scheme and booking maternity unit/hospital.
 - Purpose of ultrasound scan if necessary.
 - Written information leaflets as appropriate, i.e. optimal foetal positioning.
 - Social worker as appropriate.

Investigations

1. Urinalysis check and MSU taken if appropriate
2. Antenatal screening e.g. blood tests
3. Check B/P
4. Abdominal palpation (if appropriate)
5. Foetal heart auscultation and foetal movements (if appropriate)

Medical examination by doctor for all women

This may have been carried out by the GP/obstetrician

Risk Factor Documented Checklist on Application form – as per HSE Home Birth Service Eligibility Criteria, Tables 1-6.

Appendix III: Information Leaflet, HSE Home Birth Service



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Home Birth Service Address

Date:

Important information about Home Birth Service:

Please keep this letter

Dear

Deciding where you will have your baby is an important decision for you and your partner. I hope that this letter and the attached document **Information for Expectant Mothers Choosing a Home Birth** will help you decide if you are suitable for a home birth. The HSE provides this Home Birth Service free of charge. The HSE has agreements in place with several Self-Employed Community Midwives across Ireland to provide planned home birth services to women who wish to have their baby at home. The service includes care during your pregnancy, during labour and birth, and for up to 14 days after your baby is born.

Your choice

When deciding where to give birth, remember that:

- You are choosing the place of birth **and** you are choosing who will be with you and the type of care that you and your baby will receive.
- You should give birth somewhere you feel safe, comfortable and relaxed, as long as it is safe to do so.
- You don't have to decide on the place of birth now – and even after you have decided, you can change your mind at any time during your pregnancy.
- If you are advised **not** to give birth at home, ask the midwife or doctor to explain why.

How to find out more about having your baby at home

To find out more about having your baby at home, please:

- read the attached document, and
- make contact with a midwife to see who is available to provide you with the Home Birth Service (list of local midwives attached).

Visit with your midwife

Your chosen midwife will arrange to meet you. At this meeting, she or he will take a detailed history from you and decide if a home birth is a safe option for you and your baby.

Depending on your history, your midwife will organise a further assessment at the hospital if needed. If you and your midwife decide to go ahead with your plans for a home birth, your midwife will send **your application form** to the HSE Designated Midwifery Officer (DMO) in your area. This application form includes a consent form signed by you.

Giving your consent

Before signing the consent form, it is important that you carefully read the information provided with the application form. Discuss any concerns or questions with your midwife or doctor or, when you book at a hospital, with your consultant obstetrician.

Signing the consent form means that your midwife and/or doctor has explained to you that if there are any unexpected complications, you may be referred to the hospital doctor for assessment.

Choosing to have your baby at home against medical advice may **put your baby and yourself at risk**.

Signing the form also means that **if there are complications** during your pregnancy, labour or after your baby is born, **you agree to go hospital** to be cared for by the doctors and midwives there. The midwife will advise you of this decision.

Who approves your application for the HSE Home Birth Service?

The Designated Midwifery Officer (DMO) will approve your application for the HSE Home Birth Service based on the information that you and your midwife have provided. The DMO will contact you to confirm that they have or have not accepted your application. Your eligibility for a home birth is continuously assessed right up until your baby is born. If you are not eligible to have your baby at home, or during your pregnancy you become ineligible to have your baby at home, then your midwife and the DMO can help you find a suitable maternity unit/hospital to birth your baby.

What to do if you are eligible

We advise you to book in for care at a maternity hospital of your choice. If you do this, you will get the chance to meet the hospital staff and to make an informed choice about your place of birth. We also advise you to attend a GP if you have not already done so. Your GP will advise if he or she can provide care for you during your pregnancy and after the birth of your baby. The midwife would like to share your antenatal care with your GP and she/he will always consult with your GP or your hospital consultant if you are experiencing any problems during your pregnancy.

Birth plan

During your pregnancy, your midwife will discuss with you and your partner any particular wishes you may have in managing your labour and delivery. She or he will visit your home before the birth to complete your birth plan and finalise all the preparations for this exciting event. You and your baby will need certain items for the birth – your midwife will discuss these with you. At this time there will be lots of questions about the birth and we hope you will find the service offered by the Self-Employed Community Midwives professional and tailored to your meet your needs.

HSE Designated Midwifery Officer visit

If you decide to have your baby at home the DMO will supply you with a home birth pack about a month before you give birth. She or he will visit you in your own home to discuss any issues that you or your partner may have and ensure you are receiving a safe, quality and effective HSE Home Birth Service.

If you have any issues or concerns about the HSE Home Birth Service, please do not hesitate to contact me.

Whatever you decide, I wish you a safe and happy birthing experience.

Yours sincerely

Designated Midwifery Officer for Home Births

Information for expectant mothers choosing a Home Birth

About this document

This document tells you about home births, how safe they are and factors that help to identify women suitable – and not suitable – for home birth. Together, you, your midwife and other medical advisors of your choice will decide if a home birth is a safe option for you and your baby.

Your midwife will be happy to explain the medical terms with this leaflet. So if you are unclear about anything, ask.

Home birth can be a safe option for a healthy woman

You are considered healthy if you have no history of medical or surgical problems that might affect your pregnancy and no present or previous pregnancy complications. Research shows that a planned home birth is a safe alternative to a planned hospital birth for **some** pregnant women. However, this is when the home birth service is structured in a maternity care system with well-trained midwives and a good referral and transportation system¹.

How many women have a home birth in Ireland?

In 2013, 250 women planned a home birth with the HSE Home Birth Service. This represents less than 1% of all births in the country. Factors that may influence a woman in choosing a home birth include:

- availability of a midwife
- support and comfort in the home
- timely availability of emergency services, and
- distance from a maternity hospital.

Short transfer times **may not** always be available across Ireland, so we have to consider the safety of home birth in relation to the availability of services in your area.

¹ De Jonge A, et al (2013) Severe adverse maternal outcomes among low risk women with planned home versus hospital births in the Netherlands: nationwide cohort study. *BMJ*; 346; f3263

De Jonge A, et al 2009 Perinatal mortality and morbidity in a nationwide cohort of 529,688 low-risk planned home and hospital births. *BJOG*. 116(9):1177-84

Who will support me during labour and birth?

Professional support will be provided by your midwife. You may also choose to have your partner or whoever you decide to have with you in labour.

A second midwife, also funded by the HSE, will be present at the birth to support the midwife during your labour and birth of your baby. Your midwife may arrange to introduce you to the second midwife during your pregnancy.

When might home birth not be a safe option?

Pregnancy and childbirth is a process where risks and safety may change at any stage.

Midwives are trained to recognise signs of complications during pregnancy and labour. If complications arise during your pregnancy, labour or following the birth of your child, your midwife may advise you to transfer to hospital care. To view the most recent statistics on planned home birth in Ireland, visit:

<https://www.ucc.ie/en/npec/publications/>

Is it safe to plan a home birth for your first baby?

Yes, it is safe to plan a home birth for your first baby as long as you listen to the advice from your midwife, your GP and your hospital consultant obstetrician.

Data shows that first-time mothers are four times more likely to transfer to hospital during labour (NPEC 2013). The reasons for transfer are to ensure a safe delivery for you and your baby.

You should be aware that the risk to your baby's wellbeing doubles if you are a first-time mother.

The key points from this study are available at:

<https://www.npeu.ox.ac.uk/downloads/files/birthplace/Birthplace-key-findings.pdf>

Risk factors to be considered when approving a home birth

The following risks, if present, may mean that you are not considered suitable for a home birth:

- Previous or existing medical, surgical or mental health conditions
- Previous pregnancy and birth histories that are outlined in the six tables on the application form
- Risks that may develop during your pregnancy
- Environmental risks such as distance from hospital, from midwife, and adequacy of support at home.

The application form has six tables that provide more details. Your midwife will discuss these with you. It is important to ask your midwife any questions you have. You can also look for further information from the following websites.

Useful web sites

Association for Improvements in Maternity Services – Ireland www.aimsireland.ie

Community Midwives Association www.communitymidwives.ie

Home Birth Association of Ireland www.homebirth.ie

Health Service Executive www.hse.ie

National Perinatal Epidemiology Centre www.ucc.ie/en/npec/

Nursing and Midwifery Board of Ireland www.nursingboard.ie

Royal College of Obstetricians and Gynaecologists www.rcog.org.uk

Royal College of Physicians of Ireland www.rcpi.ie

The Child and Family Agency www.tusla.ie

The Department of Children and Youth Affairs www.dcy.gov.ie



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Appendix IV Application Consent Form

**Home Birth Service
(DMO Address)**



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Application/Consent for HSE Home Birth Service Form (December 2016) supersedes all other existing application/consent for home birth forms

Section A: To be completed by applicant

Name (BLOCK CAPITALS):

.....

Address (BLOCK CAPITALS):

.....

.....

Eircode: **Date of Birth:**

Mobile: **Tel:**

E-mail:

Hereby apply to:

.....

(Self-employed community midwife)

To provide such services as can appropriately be given by him/her in connection with motherhood under the terms of the Health Service Executive's Home Birth Service. I understand that the midwife will be required to enter into a formal agreement to provide such service for which he/she will be paid by the HSE and for which I will not be required to pay.

I certify that any particulars that I have given to the midwife are, to the best of my knowledge, accurate and complete and I have not made any arrangements for these services with another midwife.

My expected date of delivery is:

.....

I intend to give birth at:

.....

.....

(Please give details of name and address of location (BLOCK CAPITALS))

*(Please register with a GP and ensure that you have notified him/her of your intended home birth prior to completing the GP's name and address hereunder)

My general practitioner is

Dr.....

Address.....

.....

*(Please ensure you are registered with a maternity unit and inform your named consultant of your intended home birth)

Name of maternity hospital where I have registered for maternity services:

.....

Midwifery services are being provided

by.....

(Name of midwife in full and in block capitals)

- ◆ It is my wish to have my baby at home under the care of the undersigned Self-Employed Community Midwife.
- ◆ I have read and I understand the information pack and eligibility Tables 1 to 6 accompanying this consent form.
- ◆ I understand that the midwife will be the principal carer for me and my child up to the age of 14 days.
- ◆ That a copy of all records created by the midwife in relation to services provided by him/her will be provided by the midwife to the Health Service Executive. This will include any records created where the provision of the service is over and above that which the HSE considers to be a complete Home Birth Service, where such records are created within the time period specified for the delivery of the Home Birth Service, as stipulated below, and I agree as a condition of my participating in the service for the provision of such records to the HSE by my midwife.
- ◆ These records are required by the HSE for the following purposes:
 - To fulfil its statutory obligations
 - For the clinical governance and audit of its Home Birth Service
 - To arrange payment to the midwife for services provided
- ◆ I understand that the Home Birth Service, which is free of charge to me, extends from and includes the date of my first consultation with the SECM until the child is aged 14 days only and that the midwife's indemnity insurance cover and payment by the HSE for services provided under the terms of the Home Birth Service, are confined to this period.
- ◆ The midwife has explained to me that should any unforeseen complications occur, my choosing to have my baby at home could put my baby and myself at greater risk.
- ◆ If a complication arises during my pregnancy/labour/postnatal period, I agree to have the management of my care transferred to a hospital-based team.

- ◆ Records created by the midwife for services provided prior to the date of approval by the HSE of the mother’s application for services, and subsequent to the date the child is aged 14 days, are outside the terms of the Home Birth Service and are not required by the HSE.
- ◆ I agree to emergency transfer by ambulance to the nearest or most appropriate maternity hospital if in the interest of my safety and the safety of my baby the midwife deems it necessary. I hereby give permission to the midwifery and medical/obstetric staff to access my medical/obstetric records.
- ◆ I agree to have a second SECM in attendance at my planned home birth.

Signature of applicant: **Date:**

Section B: To be completed by the Self-Employed Community Midwife:

I, having conducted a risk assessment, consider it safe to provide midwifery services in accordance with the conditions laid down in the memorandum of understanding, contractual agreement, Nursing and Midwifery Board of Ireland (NMBI) guidelines for midwives, and associated documents.

I have read through the information pack and eligibility Tables 1 to 6 accompanying this application form with the expectant mother and we have agreed she is eligible for the HSE Home Birth Service.

I hereby undertake to provide such services for the above-named woman and confirm that the first consultation took place on the:

Date :

I agree to forward the clinical records to the Designated Midwifery Officer following transfer of care of the woman and baby to the public health nurse (not later than one month following the birth) – however, if the clinical records are required at any time by the HSE or maternity hospital where the woman is registered I will submit them upon request.

I have arranged to have a second SECM in attendance at this planned home birth.

Signed:.....

Date:

Please return completed application form to the appropriate Designated Midwifery Officer for this applicant’s address within 10 working days of signing.

Received by DMO:

.....

Date:

.....

HEALTH SERVICE EXECUTIVE
Medical Care for Mothers and Infants

APPLICATION FOR DOMICILIARY MIDWIFERY SERVICES

Additional Information:

1. Mother's name:

.....

2. Gravida:

Para:

3. Previous home birth? Yes/No?

Date:

4. Previous caesarean section?

.....

5. Any other risk factors?

.....

6. Distance to maternity hospital:

.....

7. Distance to midwife:

.....

8. Name of consultant obstetrician:

.....

9. Maternity hospital:

.....

10. Special circumstances

.....

Second midwife details:

.....

.....

.....

Signed SECM:.....

Date:.....

To be completed by the midwife at booking: Please tick the following as appropriate:

Applicant's Name.....

Table 1: Medical conditions requiring planned birth at an obstetric unit				
Has the woman any of the following medical conditions?			Yes	No
Disease area	Medical condition			
Cardiovascular	Confirmed cardiac disease			
	Hypertensive disorders			
Respiratory	Asthma requiring an increase in treatment or hospital treatment in current pregnancy			
	Cystic fibrosis			
Haematological	Haemoglobinopathies – sickle-cell disease, beta-thalassaemia major			
	History of thromboembolic disorders			
	Immune thrombocytopenia purpura or other platelet disorder or platelet count below 100,000			
	Von Willebrand's disease			
	Bleeding disorder in the woman or unborn baby			
Infective	Atypical antibodies that carry a risk of haemolytic disease of the newborn			
	*Risk factors associated with group B streptococcus whereby antibiotics in labour would be recommended			
	Infective hepatitis B or hepatitis C with abnormal liver function tests			
	Carrier of/infected with HIV			
	Toxoplasmosis – women receiving treatment			
	Current active infection of chicken pox/rubella/genital herpes in the woman or baby			
	Tuberculosis under treatment			
Immune	Scleroderma			
	Systemic lupus erythematosus			
Endocrine	Diabetes			
	Maternal thyrotoxicosis			
Renal	Abnormal renal function			
	Renal disease requiring supervision by a renal specialist			
Neurological	Epilepsy			
	Myasthenia gravis			
	Previous cerebrovascular accident			
Gastrointestinal	Liver disease associated with current abnormal liver function tests			
Psychiatric	Psychiatric disorder requiring current in-hospital care			

*Confirmed maternal colonisation with group B streptococcus in current pregnancy, pre-term labour <37weeks, pre-term pre-labour rupture of membranes, pre-labour rupture of membranes longer than 18 hours at onset of labour.

Signed SECM:

Date:

Applicants Name.....

Table 2 Other factors requiring planned birth at an obstetric unit

Has the woman any of the following factors?		Yes	No
Factor	Additional Information		
Previous pregnancy complications	Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty [to be discussed with neonatologists and obstetrician]		
	Previous baby with neonatal encephalopathy		
	Pre-eclampsia requiring preterm birth		
	Placental abruption with adverse outcome		
	Eclampsia		
	Uterine rupture		
	Primary postpartum haemorrhage requiring additional pharmacological treatment or blood transfusion		
	Caesarean section		
	Shoulder dystocia		
	Retained placenta requiring manual removal		
Current pregnancy	Multiple birth		
	Placenta praevia		
	Pre-eclampsia or pregnancy-induced hypertension		
	Post-term pregnancy [For medical review by 40 weeks +10 days' gestation]. Home birth feasible to day 14 post-term.		
	Pre-term labour <37 +0 weeks' gestation		
	Pre-term pre-labour rupture of membranes		
	Body mass index at booking greater than 35kg/m ² or less than 18 kg/m ²		
	Term pregnancy (37+0 to 42+0 weeks' gestation) rupture of membranes for more than 18 hours		
	Placental abruption		
	Anaemia – haemoglobin less than 10g/dl at onset of labour		
	Confirmed intrauterine death		
	Induction of labour		
	Substance misuse		
	Alcohol dependency requiring assessment or treatment		
	Onset of gestational diabetes		
Malpresentation – breech or transverse lie			
Recurrent antepartum haemorrhage			
Fetal indications	Small for gestational age in this pregnancy (less than fifth centile or reduced growth velocity on ultrasound)		
	Abnormal fetal heart rate (FHR)/doppler studies		
	Ultrasound diagnosis of oligo/polyhydramnios		
Previous gynaecological history	Myomectomy		
	Hysterotomy		

Signed SECM: **Date:**

Applicant's Name.....

Table 3 Medical conditions requiring assessment by consultant obstetrician when planning

place of birth. If yes to any of the below, please advise the woman that she will need to be assessed by a consultant obstetrician for eligibility for the HSE Home Birth Service			
Has the woman any of the following factors/medical conditions?		Yes	No
Disease area	Medical condition		
Cardiovascular	Cardiac disease without intrapartum implications		
Haematological	Atypical antibodies not putting the baby at risk of haemolytic disease		
	Sickle-cell trait		
	Thalassaemia trait		
Infective	Hepatitis B/C with normal liver function tests		
Immune	Nonspecific connective tissue disorders		
Endocrine	Hyperthyroidism		
	Unstable hypothyroidism such that a change in treatment is required		
Skeletal/ neurological	Spinal abnormalities		
	Previous fractured pelvis		
	Neurological deficits		
Gastrointestinal	Liver disease without current abnormal liver function		
	Crohn's disease		
	Ulcerative colitis		

Signed SECM..... Date.....

Applicant's Name.....

Table 4: Other factors requiring assessment by consultant obstetrician when planning place of birth. If yes to any of the below, please advise the woman that she will need to be assessed by a consultant obstetrician for eligibility for the HSE Home Birth Service			
Has the woman any of the following factors/medical conditions?		Yes	No
Factor	Additional information		
Previous complications	Stillbirth/neonatal death with a known non-recurrent cause		
	Pre-eclampsia developing at term		
	Placental abruption with good outcome		
	History of previous baby more than 4.5 kg		
	Extensive vaginal, cervical, or third- or fourth-degree perineal trauma		
Current pregnancy	Previous term baby with jaundice requiring exchange transfusion		
	Antepartum bleeding of unknown origin (single episode after 24 weeks of gestation)		
	Body mass index at booking of greater than 35kg/m ² or less than 18 kg/m ²		
	Blood pressure of 140 mmHg systolic or 90 mmHg diastolic on two occasions		
	Clinical or ultrasound suspicion of macrosomia		
	Para 5 or more		
	Recreational drug use		
	Under current outpatient psychiatric care		
	Age over 40 at booking		
	Fetal indications	Fetal abnormality	
Gynaecological history	Major gynaecological surgery		
	Cone biopsy or large loop excision of the transformation zone		
	Fibroids		
	Female circumcision		
Other factors that may need	Lack of family support/peer support network		
	Safeguarding of children and vulnerable persons		

to be considered in liaison with the DMO and SECM may include	Inadequate facilities at home, terrain and location in line with ambulance service		
	Distance from the midwife or *nearest hospital/maternity unit		

*There is no national or international policy or a guideline indicating acceptable duration for transfer from home to hospital when a woman is in labour. The Birthplace National Prospective Cohort Study (2011) states: "effective management of transfer is clearly integral to providing good quality and safe care across a range of birth settings". In this study, team-working and transport issues were factors that staff and stakeholder respondents felt were key in the management of transfer. In the cohort study, the three main reasons for transfer were delay in the first stage of labour, signs of foetal distress, and delay in the second stage. Repair of perineal trauma was the primary reason for transfer after birth. A secondary analysis of the Birthplace National Prospective Cohort Study, **Rowe** (2013) et al, concluded that "transfers from home ... commonly take up to 60 minutes from decision to transfer, to first assessment in an obstetric unit, even for transfers for potentially urgent reasons. Most transfers are not urgent and emergencies and adverse outcomes are uncommon, but urgent transfer is more likely for nulliparous women." It is noted that "in women who gave birth within 60 minutes after transfer, adverse neonatal outcomes occurred in 1-2% of transfers" (Rowe et al, 2013).

Other considerations include the RCOG principle that if LSCS is required, to obtain an optimal outcome the baby should be delivered within 30 minutes of the decision being made.

Another is the HIQA Response Standards for the National Ambulance Service, which requires a first responder to be on scene to a life-threatening or potentially life-threatening emergency within eight minutes in 75% of cases and a transporting vehicle on the scene of a life-threatening and potentially life-threatening emergency within 19 minutes in 80% of cases.

Using the above evidence, the clinical governance group recommend that it is the responsibility of the SECM to transfer the woman as soon as possible once the decision to transfer is made and to communicate clearly with the woman, her partner, ambulance service, the receiving maternity unit, labour ward manager and if necessary the consultant obstetrician and paediatrician on call. The communication must include the reason for the transfer, the current status, and possible preparation that would make handover of care more succinct. The midwife plans the transfer knowing the woman's home distance from the local maternity unit, the usual ambulance response times in that area and other influencing factors such as time of day, weather etc. Harris et al (2011) indicate that midwives in more remote units take account of distance and are more cautious in their decision-making about transfer. Ideally, the woman should be transferred to an obstetric unit within 30-40 minutes from the phone call to the ambulance service requesting the transfer. However, it is recognised and acknowledged that for many women it commonly takes 60 minutes (Rowe et al, 2013). The clinical governance group recommends that all transfers are prospectively reviewed and analysed so that more accurate guidance can be made in future policy documents.

Signed SECM..... **Date**.....

Applicant's Name.....

Table 5: Indications requiring intrapartum transfer		
Have the following issues been discussed with and explained to the woman?	Yes	No
Spontaneous rupture of membranes greater than 18 hours		
Indications for electronic foetal monitoring (EFM) including abnormalities of the foetal heart rate (FHR) on intermittent auscultation		
Confirmed *delay in the first or second stage of labour		
The presence of meconium		
Maternal request for medical (epidural or alternative) pain relief		
Obstetric emergency – including haemorrhage, cord presentation, cord prolapsed, maternal seizure or maternal collapse, shoulder dystocia, neonatal resuscitation		
Retained placenta or incomplete placenta		
Temperature of 38.0°C or above on a single reading or 37.5°C or above on two consecutive readings one hour apart		
Malpresentation or breech presentation diagnosed for the first time at the onset of labour		
A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (over 90 mmHg) or raised systolic (over 140 mmHg)		
Either raised diastolic blood pressure (over 90 mmHg) or raised systolic blood pressure (over 140 mmHg) on two consecutive readings taken 30 minutes apart		
Third- or fourth-degree tear or other complicated perineal trauma requiring suturing		
Any indication of maternal infection		

Prolonged labour guidance (NICE 2014)

***Delay in established first stage of labour**

To define delay in established first stage, take the following into account:

- parity
- cervical dilatation and rate of change
- uterine contractions
- station and position of presenting part
- the woman's emotional state and physical mobility
- referral to the appropriate healthcare professional.

If delay in the established first stage is suspected, assess all aspects of progress in labour when diagnosing delay, including:

- cervical dilatation of less than 2 cm in four hours for first labours
- cervical dilatation of less than 2 cm in four hours or a slowing in the progress of labour for second or subsequent labours
- descent and rotation of the baby's head
- changes in the strength, duration and frequency of uterine contractions fetal and maternal wellbeing.

If delay is diagnosed, transfer the woman to obstetric care if she is at home.

***Delay in established second stage of labour**

For a nulliparous woman:

- Birth would be expected to take place within three hours of the start of the active second stage in most women.
- Diagnose delay in the active second stage when it has lasted two hours and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.

Midwives will need to take into account the transfer time to the local maternity unit, knowing that birth has to take place within three hours from the start of the active second stage.

For a multiparous woman:

- Birth would be expected to take place within two hours of the start of the active second stage in most women.
- Diagnose delay in the active second stage when it has lasted one hour and refer the woman to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.

Midwives will need to take into account the transfer time to the local maternity unit, knowing that birth has to take place within two hours from the start of the active second stage.

Signed SECM..... Date.....

Applicant's Name.....

Table 6: Indications requiring postpartum transfer up to 14 days post-delivery*

(*The following criteria may necessitate immediate transfer to acute services or in some instances they may involve referral to the woman's doctor, and in consultation with the doctor then transfer of care to the acute services. If there is any concern or any need for assessment for the baby when born, refer to the nearest paediatrician.)

Have the following issues been discussed with and explained to the woman?		Yes	No
Mother:	Postpartum haemorrhage (>500 ml) or any amount that causes the mother's condition to deteriorate		
	Pyrexia (38.0°C on one occasion or 37.5°C on two occasions one hour apart)		
	Sustained tachycardia more than 90 beats/minute		
	Tachypnoea more than 20 breaths/minute		
	Dehydration and/or vomiting		
	Mastitis		
	Any abnormality or concern noted as per IMEWS observations		
	Abdominal pain/pelvic pain or tenderness		
	Symptoms of urinary tract infection		
	Offensive lochia		
	Perineal infection or excessive pain		
	Woman generally unwell or seems unduly anxious or distressed		
	Concerns for psychological wellbeing		
	Signs of thromboembolic disease, for example DVT or pulmonary emboli		
	Increase \geq 10 mmHg in the systolic or diastolic blood pressure reading where a baseline has been established two hours following delivery		
Infant	Congenital or genetic abnormality		
	Respiratory symptoms - tachypnoea (RR>60/minute), grunting, rib recession, abnormal colour (for example cyanosis), suspected diaphragmatic hernia, trachea-esophageal fistula/atresia		
	Low Apgar, ongoing central cyanosis Heart rate below 120 or above 160 beats/minute		
	Body temperature of 38°C or above, or 37.5°C or above on two occasions 30 minutes apart, or less than 36°C		
	Oxygen saturation below 95%		
	Cyanosis confirmed by pulse oximetry		
	Bile-stained vomiting, persistent vomiting or abdominal distension		
	Delay in passing urine or meconium >24 hours		
	Fits, jitteriness, abnormal lethargy, floppiness, high-pitched cry, pallor, reduced urinary output, symptoms of dehydration		
	If meconium is present during labour , the woman should be transferred. If there is meconium at the birth, an assessment of the situation occurs. If the baby is vigorous and there are no signs of distress, transfer would not be indicated.		
	The appearance of jaundice less than 24 hours old		
In exceptional circumstances if a baby is born at home to a woman with rupture of the membranes \geq 18 hours	Record the infant's temperature, heart rate, respiratory rate at regular intervals in the first 24 hours following birth, ongoing observation and monitoring for offensive odour, change in skin colour, levels of alertness, feeding pattern, lethargy. Where there is any deviation from the norm in respect of the mother and the baby then transfer to hospital should be considered.		

Signed SECM:

Date:.....

Appendix V: Guidance to the Schedule for Antenatal Care for the HSE Home Birth Service

This schedule is a guide and must be individualised as needs dictate (refer to NICE Antenatal Care Guideline 2008 and Maternity and Infant Care Scheme DOHC).

How the Scheme operates:

The Scheme offers a system of combined care by your chosen general practitioner and the maternity unit/hospital of your choice.

The following schedule of visits is recommended although this may be modified by your general practitioner and/or obstetrician depending on your individual situation.

SCHEDULE OF VISITS		
Number of weeks of your pregnancy	Visit to your general practitioner	Visit to your chosen maternity unit/hospital
Before 12 weeks (preferably as soon as possible after conception)	•	
Before 20 weeks		•
24	•	
28	• <small>(except in case of first pregnancy)</small>	• <small>(in case of first pregnancy)</small>
30	•	
32		•
34	•	
36		•
37	•	
38		•
39	•	
40		•
BIRTH OF THE BABY		
2 weeks after birth (for your baby)	•	
6 weeks after birth (for mother & baby)	•	

Appendix VI: Procedure to Stretch and Sweep Membranes

Prior to formal induction of labour, women should be offered a vaginal examination for membrane sweeping.

The procedure must be discussed with the woman and her partner and the following information will be given:

- Membrane sweeping is not associated with any major maternal adverse effects and is not associated with an increase in maternal or neonatal infection.
- It is associated with discomfort and some pain during examination.
- Some bleeding may occur.
- Abdominal palpation to ensure cephalic presentation and level of engagement.

Verbal informed consent will be obtained prior to the procedure. The SECM shall offer the membrane sweep to women at their appropriate antenatal appointment.

- Prepare for and undertake the examination per vagina "Locate the cervix....." expecting to find a posterior, largely uneffaced, almost closed cervix (do not rupture the membranes).
- Undertake a Bishop's scoring (or similar) assessment of the cervix.

Evaluation of Cervical Ripening (Bishop Score)

The most commonly used methodology to evaluate cervical ripening is the Bishop score because it is simple and has the most predictive value. This score uses cervical dilatation, effacement, consistency, position, and the station of the presenting part.

A Bishop score of 5 or more is considered significant for cervical ripening and favourable for the induction of labour. The Bishop score is calculated as follows:

Dilatation

- | | |
|---------------|----------------------|
| ○ For 0 cm: | 0 points are scored. |
| ○ For 1-2 cm: | 1 point is scored. |
| ○ For 3-4 cm: | 2 points are scored. |
| ○ For 5-6 cm: | 3 points are scored. |

Effacement

- | | |
|---------------|----------------------|
| ○ For 0-30%: | 0 points are scored. |
| ○ For 40-50%: | 1 point is scored. |
| ○ For 60-70%: | 2 points are scored. |
| ○ For 80%: | 3 points are scored. |

Station

- | | |
|-------------------------|----------------------|
| ○ For -3 station: | 0 points are scored. |
| ○ For -2 station: | 1 point is scored. |
| ○ For -1 and 0 station: | 2 points are scored. |
| ○ For +1 to +2 station: | 3 points are scored. |

Consistency

- For firm consistency: 0 points are scored.
- For medium consistency: 1 point is scored.
- For soft consistency: 2 points are scored.

Position

- For posterior position: 0 points are scored.
- For mid position: 1 point is scored.
- For anterior position: 2 points are scored

- Insert one or two fingers between the lower uterine segment and the foetal membranes and move the finger(s) with a sweeping circular action through 360° with some inward pressure. Do this fairly decisively as the woman will be uncomfortable and this will be increased if the procedure is unnecessarily prolonged.
- Remove the examining hand gently.
- Auscultate the foetal heart.
- Assist the woman to dress and resume a comfortable position; discuss the finding. Explain to the woman that she may have some blood-stained loss post-procedure. If this is abnormal in any way, i.e. bright red, she should go to the labour ward.
- Dispose of equipment appropriately and wash hands.
- Document the findings and act accordingly.
- Give the woman the follow-up plan, i.e. induction of labour date, next antenatal appointment.

Appendix VII: IMEWS Chart

**NATIONAL
CLINICAL
EFFECTIVENESS
COMMITTEE**

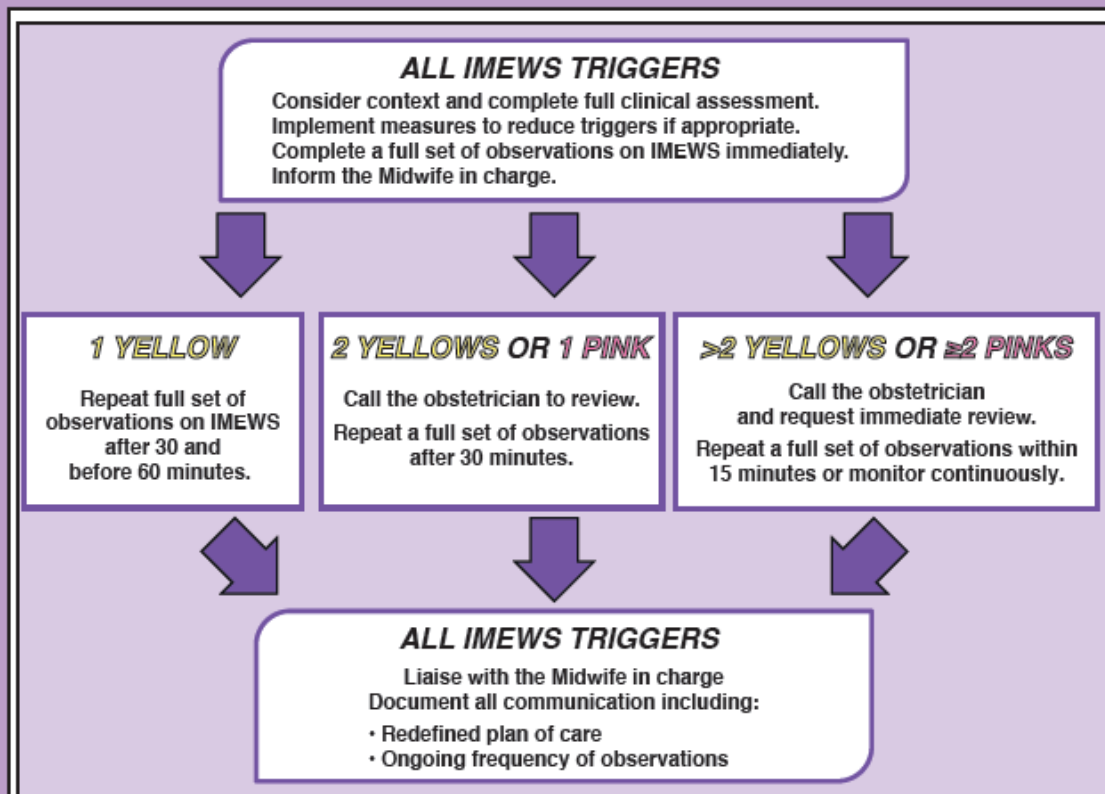
Hospital Name:

Ward:

Woman's Name:
Date of Birth:
Healthcare Record No:
Addressograph

**Irish Maternity Early Warning System (IMEWS)
Escalation Guideline**

Version 1.2



IMPORTANT:

1. If concerned about a woman, escalate care regardless of triggers.
2. If action is not carried out as above, CMM/Midwife in charge must contact the senior obstetrician on duty.
3. Document all communication and management plans in notes.

CONSIDER MATERNAL SEPSIS

Are 2 or more of the following SIRS criteria present?

- Temperature $\geq 38^{\circ}\text{C}$ or $< 36^{\circ}\text{C}$
- Respiratory rate ≥ 20 breaths per min
- Heart rate ≥ 100 beats per min
- White cell count > 16.9 or $< 4.0 \times 10^9/\text{L}$
- Bedside glucose > 7.7 mmol/L (in the absence of diabetes)
- Acutely altered mental status

AND

If infection is suspected after medical review



Intervention: within one hour COMPLETE SEPSIS 6

TAKE 3

1. Appropriate cultures*
2. FBC +/- lactate
3. Start urine output chart

GIVE 3

4. Maintain O_2 (94-98%)
5. Consider IV fluid bolus**
6. IV antibiotics

*e.g. blood, wound, vaginal swab, urine etc
**exercise caution in presence of pre-eclampsia

IMEWS Triggers Key

Woman's Name:
Date of Birth:
Healthcare Record No:
Document Number (eg. 1, 2):
Booking BP: ____ / ____
Gestation at Booking (weeks):



IMEWS Trigger	Normal Values	Yellow Zone	Pink Zone
Respiratory rate (bpm)	11-19	20-24	≤10 or ≥25
SpO ₂ (%)	96-100	-	≤95
Temperature (°C)	36.0-37.4	35.1-35.9 or 37.5-37.9	≤35 or ≥38
Maternal HR (BPM)	60-99	50-59 or 100-119	<50 or ≥120
Systolic BP (mmHg)	100-139	90-99 or 140-159	<90 or ≥160
Diastolic BP (mmHg)	50-89	40-49 or 90-99	<40 or ≥100
AVPU	Alert	-	Voice, Pain or Unresponsive

Contact appropriate doctor for early intervention if the woman triggers one **PINK or two **YELLOW** zones at any one time**

Year:	Date :											Pain Score		
Time :											Pain Score			
Resp. Rate per min	≥25												≥25	
	20-24												20-24	
	11-19												11-19	
	≤10												≤10	
SpO ₂ on H ₂ pulses	96-100%												96-100%	
	≤95%												≤95%	
Temp °C	≥38.0												≥38.0	
	37.5-37.9												37.5-37.9	
	36.0-37.4												36.0-37.4	
	35.1-35.9												35.1-35.9	
	≤35.0												≤35.0	
Maternal Heart Rate	120												120	
	110												110	
	100												100	
	90												90	
	80												80	
	70												70	
	50												50	
Systolic Blood Pressure	170												170	
	160												160	
	150												150	
	140												140	
	130												130	
	120												120	
	110												110	
	100												100	
	90												90	
	70												70	
Diastolic Blood Pressure	110												110	
	100												100	
	90												90	
	80												80	
	70												70	
	60												60	
	50												50	
	40												40	
	Urine	Protein												Protein
		Glucose												Glucose
Other													Other	
Pain Score 0-10													Pain Score	
AVPU Neuro Response	Alert (A)												A	
	Voice (V)												V	
	Pain (P)												P	
	Unresponsive (U)												U	
Total Yellow Zones													Total yellow zones	
Total Pink Zones													Total pink zones	
Initials													Initials	

Instruction Manual for the completion of the 4-part

Birth Notification Form

BNF01



These instructions should be read carefully by all personnel involved in the birth notification system, and should be available for consultation in an area where the forms are completed.

Issued by: National Perinatal Reporting System
Healthcare Pricing Office
Brunel Building
Heuston South Quarter
St. John's Road West
Dublin 8
www.hpo.ie

August 2016

Notification of Birth - To: The Registrar of Births

TYPE OF BIRTH (Live = 1, Still = 2)	PLACE OF BIRTH (Hospital = 1, BBA = 2, Domiciliary = 3)	NAME AND _____
SENSITIVE CASE (YES = 1, NO = 2)	HOSPITAL NO. _____	ADDRESS OF _____
	CASE NO. _____	HOSPITAL _____ 15

INFANT'S DETAILS

DATE OF BIRTH (DDMM/YYYY) _____ 16

TIME OF BIRTH _____

IF MULTIPLE BIRTH ORDER OF BIRTH No. _____ 24 of _____ 25

FORENAME(S) _____

SURNAME _____ 26

SEX (Male = 1, Female = 2, Indeterminate = 3) _____ 27

BIRTHWEIGHT _____ 28 GRAMMES

PERIOD OF GESTATION _____ 32 WEEKS

FATHER'S DETAILS

FORENAME(S) _____

SURNAME _____

BIRTH SURNAME _____

FORMER SURNAME(S) _____

BIRTH SURNAME OF FATHER'S MOTHER _____

ADDRESS _____

COUNTY _____ 34

COUNTRY _____ 37

NATIONALITY _____ 41

OCCUPATION _____ 45

DATE OF BIRTH (DDMMYYYY) _____ 47

PPS NUMBER _____ 55 - _____

MOTHER'S DETAILS

FORENAME(S) _____

SURNAME _____

BIRTH SURNAME _____

FORMER SURNAME(S) _____

BIRTH SURNAME OF MOTHER'S MOTHER _____

ADDRESS _____

COUNTY _____ 64 67

COUNTRY _____ 68

NATIONALITY _____ 72

OCCUPATION _____ 76

DATE OF BIRTH (DDMMYYYY) _____ 78

PPS NUMBER _____ 86 - _____

CIVIL STATUS (Married = 1, Single = 2, Widowed = 3, Separated = 4, Divorced = 5, Civil Partner = 6, Former Civil Partner = 7, Surviving Civil Partner = 8) _____ 95

DATE OF PRESENT MARRIAGE/CIVIL PARTNERSHIP (DDMMYYYY) _____ 96

DATE OF LAST BIRTH (live or still) (DDMMYYYY) _____ 104

NO. OF PREVIOUS LIVE BIRTHS _____ 112

CHILDREN STILL LIVING _____ 114

STILLBIRTHS _____ 116

SPONTANEOUS ABORTIONS _____ 118

PERINATAL DEATH

TYPE OF DEATH (Early Neonatal = 1, Stillbirth = 2) _____ 120

WAS AUTOPSY PERFORMED (Yes = 1, No = 2) _____ 121

AGE AT DEATH _____ 122 DAYS _____ 123 HOURS

PLACE OF DEATH _____ 125

IF STILLBIRTH, DID DEATH OCCUR BEFORE LABOUR (1) _____ 128

DURING LABOUR (2) NOT KNOWN (3)

CAUSE OF DEATH

MAIN DISEASE OR CONDITION IN FOETUS OR INFANT _____ 129

OTHER DISEASES OR CONDITIONS IN FOETUS OR INFANT _____ 134

For Registrar's Use Only: Complete A or B

A: Computerised Offices: If notification is to be entered electronically, enter the system notification in the space below

B: Non-Computerised Offices: If the notification is not being entered electronically, then the information in the section below should be completed and this form should then be forwarded to the Central Statistics Office.

DATE OF REGISTRATION (DDMMYYYY) _____ 139

ENTRY NO. IN REGISTER (for live births only) _____ 147 _____ 150

_____ 151

Registrar's Stamp

Signature of Registrar _____

CONFIDENTIAL: This form is required for registration and statistical purposes only and will be treated as strictly confidential. It should be filled in by the person requiring the birth to be registered and given to the registrar in accordance with the Vital Statistics Regulations.

Signature

Date

BNF01/2014

Appendix IX: Example of Birth Notification Form (36-Hour Birth Notification Form to the CHO/DPHN. Other examples are also in use in different CHO areas).

NOTIFICATION OF BIRTHS ACTS 1907 & 1915

Notification that a Male /Female Live /Still Born child was born at _____ on D.O.B.: ____ / ____ / ____

Mother's Name: _____ D.O.B.: ____ / ____ / ____

Address: _____ Tel.: _____

_____ Occ.: _____

Infant's Surname: _____ Father's Occ.: _____

Confidential: Date of Last Delivery: ____ / ____ / ____ S M W D SEP

Gravida: Para: // Gestation: Apgar: Birth Weight:

Name of G.P.: _____ Address: _____

P.H. Nurse: _____ Health Centre: _____

(Please tick the appropriate box only)

FAMILY HISTORY:

- (1) Deafness (2) Congenital Abnormality (3) Mental Retardation
 (4) Cystic Fibrosis (5) Haemophilia (6) C.D.H.

PRE-NATAL HISTORY:

- (1) Rubella (before 16th. week)
 (2) X-Rays in first 3 months of pregnancy
 (3) R.H. Blood Group incompatibility, (with anti-bodies)
 (4) Other serious Illness: _____

PERINATAL:

- (1) Prematurity (under 36 week) Precipitate Birth Asphyxia
 (2) Prolonged Labour Epidural Birth Injury
 (3) Breech: Forceps: Caesarean: Vac.: S.V.D.:

 Signature: _____

Appendix X: Discharge Summary



The SECM Discharge Summary Report to PHN, GP & Hospital

Mothers Name: _____		
Address: _____		
DOB _____	Tel No. - Home: _____	Mobile _____
GP Name and Address _____		
Gravida _____	Para _____	*Civil Status: L S P M _____
*L = Lone Parenting S = Single P = Partner M = Married		

Labour/Delivery Summary Date of Delivery: _____ Time: _____ Place of delivery: _____ Perineum: _____ Suture Material: _____ Blood Loss: _____ Drugs/Oxytocin required: _____ Placenta: _____ Membranes: _____ Cord Abnormalities: _____	Puerperium Anti D: _____ Rubella Vaccine _____ Last Hb: _____ Breasts: _____ Lochia: _____ Perineum: _____ BP _____ PU _____ BO _____ Postnatal Depression information given: _____ Date of discharge: _____ Postnatal Day: _____
---	--

Infant Details Baby's Name: _____ Address: _____ Fathers Name: _____ Type of Delivery: _____ Gestation at Delivery: _____ Resuscitation Required: _____ Outcome: _____ Gender: _____ Birth Weight (kg): _____ Apgar Score: _____ Head Circumference: _____ Anterior Fontanelle: _____ Posterior Fontanelle: _____ Length: _____ Midwives Examination of Newborn Completed: YES/NO: _____ Outcome: _____	Jaundice: _____ Date of BCG: _____ Vit K Oral 1st dose: _____ 2nd dose: _____ 3rd dose: _____ Vit K IM date: _____ Feeding on Discharge: _____ Last recorded weight: _____ Date of Newborn Blood Spot Screening: _____ Date of GP Examination of Newborn: _____ Audiology Request Form sent to DMC: _____ Cord Clamp On/Off _____ Hips Examination _____
--	---

Progress notes on mother and baby: _____

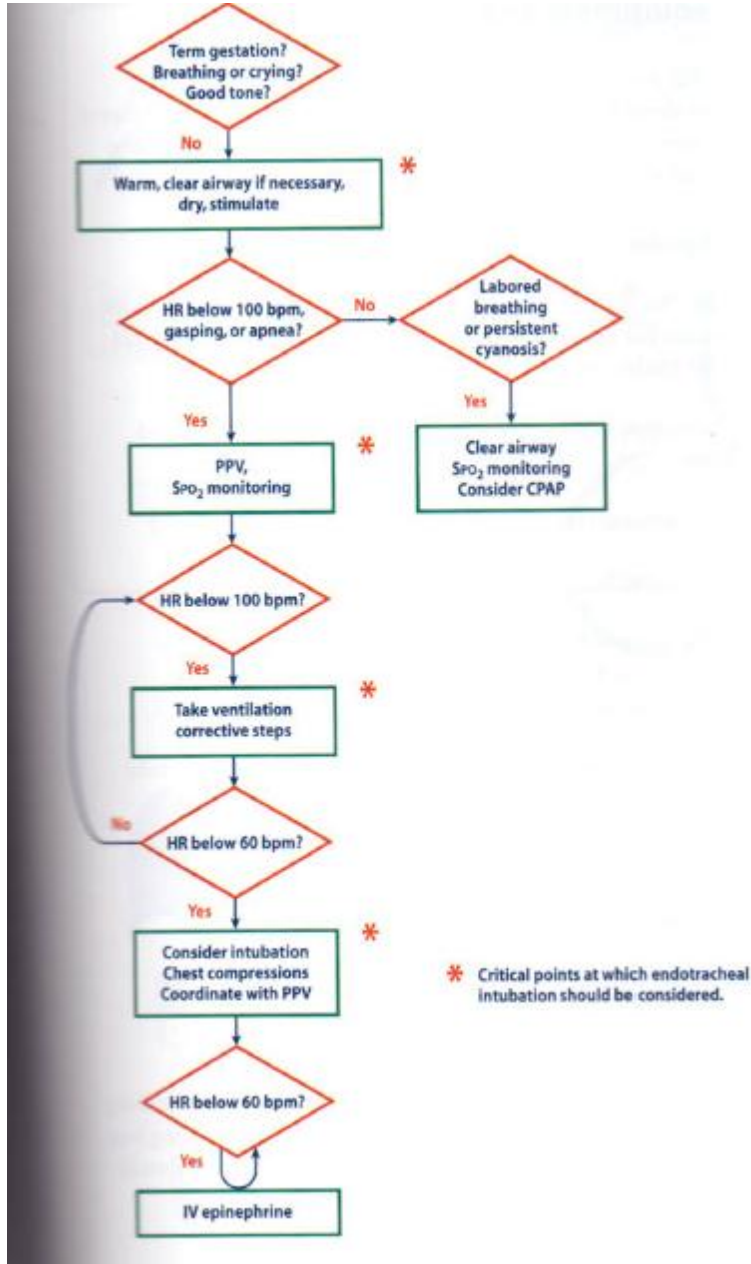
Further information e.g. on appointments required or outstanding: _____

Date of referral to PHN: _____

SECM Signature: _____ Date: _____

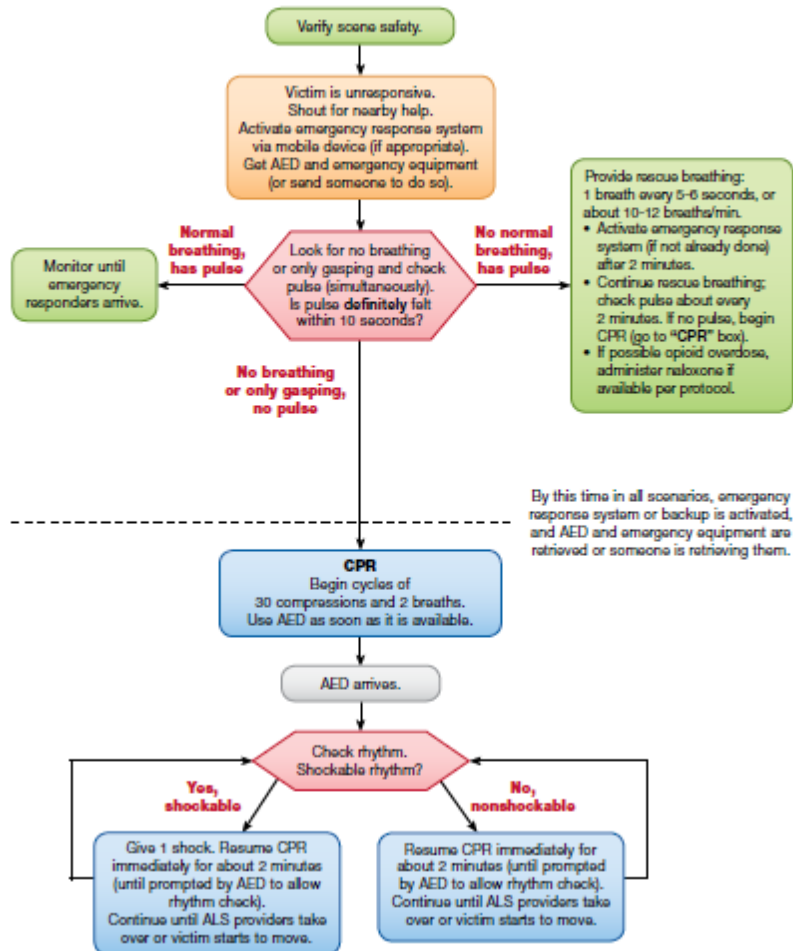
Contact details: _____

Appendix XI: Neonatal Resuscitation Programme 6th Edition Algorithm

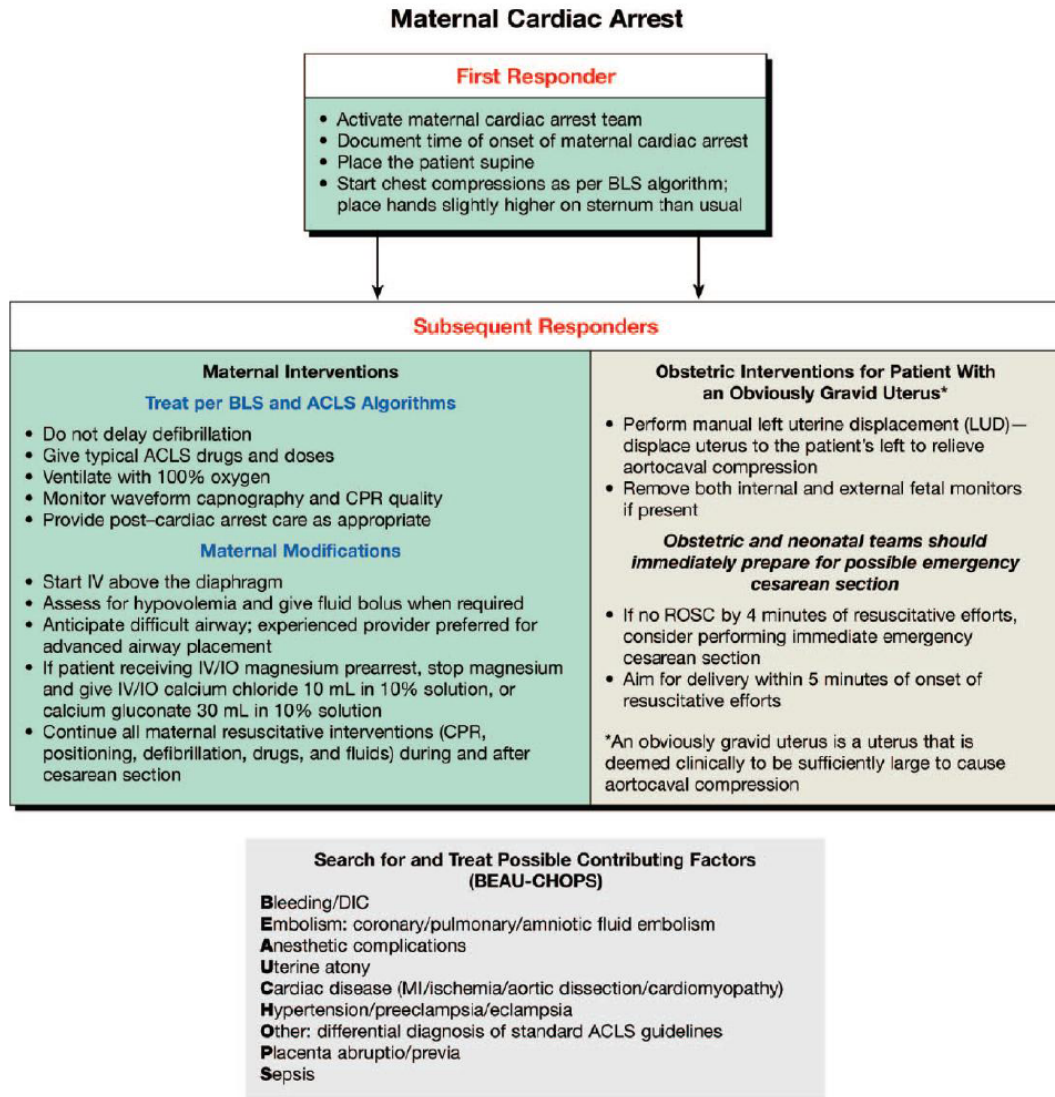


Appendix XII: Basic Life Support Algorithm

BLS Healthcare Provider Adult Cardiac Arrest Algorithm—2015 Update



Appendix XIII: Maternal Cardiac Arrest



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