Home birth - Full Clinical Guideline

Reference no.: UHDB/06:22/H5

Contents

1. Introduction

The purpose of this guideline is to outline the processes to be followed when supporting women in planned and unplanned homebirths, BBA's and women exploring unassisted birth at home (freebirth). It should be used alongside other relevant UHDB guidance noting any local pathways.

National Maternity Review (2016) recognised that;
"Women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option."

Women choosing to have a baby at home should be 'low risk' and therefore within the remit for midwifery care, however some women who do not fit the suitability criteria may also choose to give birth at home. This guideline provides advice for when women who are not 'low risk' choose to consider birth at home, respecting a woman's right to choose and supporting the midwifery and obstetric team in their communication and risk assessments. Guidance is included when a woman chooses to birth without health professionals present, an unassisted birth.

2. Purpose and Outcomes

This guideline is to support midwives providing care for women who are considering home birth. Birth options, risk assessment and documentation are key elements. Supportive pathways and procedures are included to support midwives in their response to home birth outside of UHDB guidelines, unexpected birth at home or unassisted birth.

3. Key Responsibilities and Duties

The home birth response from UHDB will be from the 2 identified midwives allocated to the shift(s) which cover shifts within any 24 hour period. When a woman booked for birth at home is cared for by a continuity team the attending midwives will be 1 from the continuity team and 1 community midwife. If the continuity of carer midwife is not available then the 2 rostered community midwives will attend. The community midwife not attending at night may be required to attend and provide care as part of the RDH Birth Centre team. The Midwives on duty for the shift should have the home birth equipment and 2 entonox cylinders available to them to allow immediate response to a birth at home.
These shifts are:
Derbyshire
A Shift 08:00-16:00
B Shift 16:00 – 22:00
Night Shift 21:45 – 08:15
Continuity of Carer teams work 2 shifts of 12 hour length

Staffordshire
Day shift 09:00 – 17:00
Overnight on call 17:00- 09:00

Midwives attending home birth outside of day shift hours should follow the local policy for their site (QHB/RDH) for lone working and ensure their location is known when attending and returning from a call. For RDH this is PAU. For QHB this is through the lone worker device and the call out is recorded via MAU.

The midwives will respond to the women who are 37 weeks and greater who are choosing home birth or in response to unplanned home births when requested or Born Before Arrival (BBA) as requested by the ambulance service as per local agreement.

When attending a home birth, discussion of roles and responsibilities for both midwives should take place with regards to:

- Which midwife is leading the care for this woman and birthing the baby
- Who will be responsible for leading neonatal resuscitation?

Midwives are individually accountable for their actions and omissions when delivering care, both share responsibility for the safe delivery of care given to women during home birth. Both midwives must professionally challenge decision making when in attendance at a home birth if they believe it is not in the best interests of the woman and her baby. In situations where both midwives are unable to agree on a safe plan of care support advice should be sought from a senior midwife, matron, obstetrician or manager on call.

The SBAR tool should be used at handover of care between home birth teams/ shifts or at handover from the home birth team to the hospital team.

4. Abbreviations

ARM	-	Artificial rupture of membranes
BBA	-	Born Before Arrival
CLC	-	Consultant-led Care
CTG	-	Cardiotocography
EFM	-	Electronic Fetal Monitoring
EPR	-	Electronic Patient Records
FHR	-	Fetal Heart Rate
MHHR	-	Maternity Hand Held Records
MWLC	-	Midwife Led Care
PPH	-	Post Partum Haemorrhage
QHB	-	Queens Hospital Burton
RDH	-	Royal Derby Hospital
SBAR	-	Situation, Background, Assessment, Recommendations
SROM	-	Spontaneous rupture of membranes
TENS	-	Transcutaneous Electrical Nerve Stimulator
VE	-	Vaginal Examination

5. Management of Home Birth Equipment

- The home birth shift midwives are responsible for ensuring the home birth equipment available to them is checked and in working order at the beginning of each shift, and restocked following use.
- All home birth equipment bags should be checked once daily to confirm the equipment is present and the security seal intact.
- There should be a full check of the equipment and documentation once a week.
- The check should be against the equipment list and signed for.
- The person checking equipment is responsible for replacing any equipment not in working order or out of date stock and escalating any discrepancies.
- Compliance with the checking of home birth equipment is audited at the end of each calendar month by the senior midwife and every six months by the Trust resuscitation team.
- It is the responsibility of the Midwives on each home birth shift to ensure that they have the equipment with them at the start of the shift.

6. Documentation

- All assessments, care plans and records of care delivered must be recorded on the relevant UHDB documentation and appropriate maternity computerized records system. A midwife is accountable for the documentation of the care s/he has delivered. It should be evident in the documentation who has delivered care; each midwife remains accountable for the care they have given and for their respective written entries. It is good practice to review all documentation to confirm it is legible and contemporaneous. Both home birth midwives should review the labour record documentation for completeness and accuracy during and at the end of the care episode.
- Home birth documentation should remain in the Maternity Hand Held record or, if transfer to hospital is required the records will be used for the continuation of care at QHB and RDH.
- If the woman is transferred to a cross border hospital the records should be copied for the continuation of care but the originals returned for storage by the attending community midwives to the relevant Community Team at UHDB.
- Labour and home birth records for women cared for by UHDB Community Midwives but booked at a cross border hospital: the records should be retained and stored in an envelope with name, DOB and NHS number and returned to UHDB file via the return of MHHR process.

- Any event unexpected or emergency or transfer from home to hospital should be reported in the UHDB Datix system by the home birth midwives.

7. Suitability for Home Birth and Risk Assessment

- Suitability criteria for home birth:
  - Midwife led care based on ongoing risk assessment.
  - Gestation > 37 weeks < 41+3
  - No complications antenatally
  - No identified risks/problems for intrapartum/perinatal period
  - Cephalic presentation
  - Singleton pregnancy
  - No known potential for additional neonatal care ie neonatal observations and assessment
- A woman may wish to consider home birth at any point in her pregnancy. A full discussion between the woman and her midwife should take place as soon as possible after the woman has expressed her intention to have a home birth.
- The place of birth should be reviewed at each contact to ensure early identification of any clinical risk factors which may influence suitability for home birth. Opportunity to review place of birth should be given at each contact. On -going risk assessment and opportunity for specialist discussion and review must be offered, see advice for Consultant Led Care and Home Birth outside of guidelines. Acknowledging women may not wish for further discussion, documentation and escalation of this should be made to the Senior Midwifery Team and Obstetric Team to maintain open dialogue.
- The Senior Community Midwife can support in engagement with women who do not meet the criteria for home birth and/or where there is a deviation from low risk care.
- The Midwife within the RDH Birth Options Clinic can also provide additional support with a further referral to the Lead Obstetrician in the clinic should this be required.
- It should also be acknowledged that a woman may become suitable for home birth later in pregnancy after completion of clinical risk assessments and pathways or when gestation reaches 37 weeks if previous premature birth.

7.1. Key information for women when considering home birth

Women should receive clear unbiased information in order to make an informed choice regarding the place of birth, whether planning to birth at home, in a midwife-led unit/co-located birth centre or in an obstetric unit.

The following provides women with key information when considering homebirth:

- Giving birth is generally very safe for both the woman and her baby.
- For multiparous ‘low’ risk women birth it is as safe to birth at home as in hospital with a higher likelihood of “normal” birth
- For nulliparous women the risk of adverse perinatal outcomes appear to be higher at home than hospital and the likelihood of needing to transfer to hospital is high (45%)
- The home birth service would normally address births occurring greater than 37 weeks and less than 41 weeks and 3 days gestation in line with the UHDB offer of post term induction at 41+3. Should a woman go beyond 41+3 please refer to the UHDB guideline Induction of Labour and Augmentation.
- Availability and limitation of home birth service. Discuss how the service is provided locally. Discuss when there are limitations to the care that can be provided at home.
- If the woman has a pre-existing medical condition or has had a previous complicated birth (that makes her at higher risk of developing complications during this pregnancy), she should be advised to give birth in an obstetric unit or co-located Birth centre
- The obstetric unit provides direct access to obstetricians, anaesthetists, neonatologist and other specialist care including epidural analgesia.
- In the unlikely event of something going unexpectedly seriously wrong during labour at home (or in a midwife-led unit), the outcome for the woman and baby could be worse than if they were in the obstetric unit with direct access to specialised care.

- Transfer into the Obstetric Unit or Birth Centre is made by ambulance and response times are dependent on demand on the ambulance service at that time. At times of high activity this could result in a delay in transfer.

7.2. Risk factors

Risk Factors identified that may prompt discussion with a senior midwife or referral for obstetric opinion/care:

- Antenatal complications
- Identified risks/problems for intrapartum/perinatal period
- Non cephalic presentation
- Multiple pregnancy
- Social complexities and safeguarding
- Home environment challenges such as access.

7.3. Home birth risk assessment (Appendix A)

- Completion of the Home Birth Risk Assessment should be completed between 34 and 36 weeks gestation. Should a woman request home birth after 36 weeks the assessment should be completed as soon as is possible.
- The Midwife should be suitably experienced and confident with home birth risk assessment and birth option discussion. A second Midwife should attend to support when appropriate.
- The risk assessment should review clinical and social aspects alongside the environmental and location. All aspects of the birth plan should be discussed to ensure the woman's preferences for her birth and care are understood. The benefits of a low risk birth can be discussed. Potential risks and emergency situations must be discussed to ensure there is informed choice. Safety of the woman and her baby and the attending UHDB Midwives is at the focus of this assessment.
- Should the home birth be against medical and/or midwifery advice, there is potential or declared intention to birth without assistance or there are requests to receive care outside of UHDB guidance then a Senior Community Midwife could attend to support the discussion and risk assessment.

- *During Covid-19 additionally discuss infection control prevention precautions and complete checklist.* Ensure that the woman and her partner are aware of the need for safety of midwives when providing care, particularly in relation to exposure to possible or confirmed COVID-19. This will include explanation of infection control procedures and the wearing of PPE by midwives in homes or hospital settings. Midwives will need additional space to rest and use to don and doff PPE. Additional contact with others present in the household should support social distancing guidance.

8. Women under Consultant Led Care requesting Home Birth

- Women who are consultant led care may express a wish to birth at home and should be provided with evidence based information to enable them to make their choices. The Consultant Obstetrician will advise if home birth is supported from an obstetric perspective. The woman may still wish to consider a home birth if she is advised against.
- The Community Midwife should discuss and arrange a review to assist the woman to have the opportunity to discuss place of birth with the Consultant. If she declines the opportunity the midwife should contact the named consultant to make them aware and provide opportunity for other lines of communication to be explored such as telephone or letter.
- If following discussion regarding her individual needs and the risks of home birth the woman still chooses a home birth the Senior Midwife (community) should be informed at the earliest opportunity to support discussion and risk assessment. This should be escalated to matrons and potentially all Senior Midwives so they are aware of the circumstances in case they are required to support Community Midwives with this during a manager on call shift. Safeguarding may be a consideration in some cases also.

9. Homebirth outside of guidelines and Home Birth against advice

- A woman may choose to birth at home outside of UHDB guidance and that of her Community Midwife and Obstetrician. The Senior Midwife (community) should be informed at the earliest opportunity to support a birth options discussion and risk assessment.

- When a woman chooses a homebirth but her history or circumstances indicate the most appropriate place for birth is a main obstetric unit a multidisciplinary approach should be taken to support the woman. All options available, risks, limitations of care that can be provided at home and the additional care that can be provided in the obstetric unit should be discussed using best available evidence with the support of the Obstetric team. All aspects should be discussed and documentation recording the same be maintained in order that the woman can make an informed choice about the place of birth.
- In the antenatal period there will be opportunity to follow the multidisciplinary approach. In the intrapartum or immediate postnatal period if a woman chooses to remain at home outside of guidance, against the advice of the attending midwives who have a concern or evidence of deviation from normal then this should be escalated to the senior midwife for community or out of hours / weekend the Labour Ward Co-ordinator and Manager on call.
- Safeguarding may be a consideration in some cases and support gained through UHDB safeguarding team.

10. Home Birth notification and Communication

- Each week the list of women reaching 37 weeks gestation who are booked for home birth will be circulated by secure email to the home birth midwives and other relevant areas. Any additional information the attending midwives will need knowledge of should be included. This may be regarding location and parking at the home or the potential for complexity. It is the responsibility of the named community midwife and/or midwife completing the home birth risk assessment to communicate to the senior midwife any relevant information and use the local home birth pro forma in Appendix C. It should be clear whether the birth is against midwifery/medical advice.
- The Senior Midwife will communicate to those on the manager on call rota, the Community Matron and if appropriate will inform the acute areas, ambulance service and cross border units should there be a high risk birth planned at home where there is potential for transfer, unassisted birth or escalation for advice from attending midwives.

11. Unassisted birth at home or Freebirth

- A woman may choose to plan an unassisted birth, unattended professionally by a midwifery or medical team and freebirth at home. The woman has the right to choose this and a Midwife has no right to be in attendance should the woman choose not to contact or engage in care. The woman will assume responsibility for her birth but she may and can have her partner, relative, friend or doula present in a supportive role.
- Midwives understandably are concerned that women giving birth at home without assistance poses increased risks to both the mother and baby. It is important to support Midwives to understand why a woman may choose this option and they also should be aware of the legal position. Every effort should be made to engage with a woman to discuss the options available to her in terms of her accessing midwifery or medical care. It may be that the options of a hospital or attended birth are unacceptable to the woman. Should she choose to birth without assistance she should be made aware of how she accesses emergency support, postnatal care should she wish and also notify the birth. The Senior Midwife (community) should be informed at the earliest opportunity to support discussion.

11.1 Legal considerations

- It is illegal for anyone present during the labour or birth, to be undertaking the roles of a midwife or doctor. According to Article 45 of the Nursing and Midwifery Order (2001), it is a criminal offence for anyone other than a midwife or registered doctor to ‘attend’ a woman during childbirth, except in an emergency. Birth partners, including doulas and family members, may be present during childbirth, but must not assume responsibility, assist or assume the role of a midwife or registered medical practitioner or give midwifery or medical care in childbirth.
- It is not illegal for a woman to give birth unattended by a midwife or healthcare professional. Women are not obliged to accept any medical or midwifery care or treatment during childbirth and cannot be compelled to accept care unless they lack mental capacity to make decision for themselves (Birthrights, 2017).

- It is not appropriate for healthcare professionals to refer a woman to social services with concerns about the unborn baby, solely on the basis that she has declined medical support, as she is legally entitled to do (Birthrights, 2017).
- Support from the UHDB safeguarding team should be sought if there are concerns that the woman lacks mental capacity to make an informed decision or is being prevented from accessing care which would result in unassisted birth or if the newborn will be at risk from the unassisted birth and would not be presented for care.

11.2 Midwife considerations

- It is natural that midwives will feel anxious about the safety of women and families in their care and have a sense of responsibility for outcomes, even if they have no control over them.
- Women have the right to choose care that goes against the advice of their midwife. If a woman chooses to have an unassisted birth, the midwife has a responsibility to inform her about the risks of that decision. The midwife is not responsible for the outcome of the unassisted birth.
- If a woman chooses to have an unassisted birth, the service will need to ensure that the woman is informed that a midwife may not be available to be sent out to her at home during labour and birth, if she changes her mind and wishes attendance during the birth. If the woman decides she wishes to have professional care during labour and birth, she may need to attend the maternity unit. (Royal College of Midwives 2020)

11.3 Recommendations for engaging with women considering unassisted birth

- If a woman indicates to her midwife that she plans to give birth without assistance, the maternity service should reach out to the woman to open a dialogue to provide information, advice and support. Escalate to Senior Midwife for support.
- A birth options conversation should be facilitated with the woman.
- If possible, ensure there is continuity of midwifery carer during the antenatal period to enable a relationship of trust to build and support ongoing dialogue.
- During the conversation(s) give time for the woman to share what is important to her and explore with her why she may want to have an unassisted birth.
- Explain the evidence about any particular individualised risk factors for her and her baby of birthing at home without assistance.
- During the conversation(s) identify any previous trauma and discuss if there is potential benefit in the woman having a debrief or receiving additional support around these events. This may or may not be appropriate at this time and careful consideration should be given to this.
- Explore if there are any misconceptions or misunderstanding about current practice or the midwifery and service provision in the area and provide the woman with accurate information.
- Ask the woman what plan for the birth would feel safe and acceptable to her and consider options of how to provide an individualised plan of care for her.
- Ensure the woman is aware that she will continue to be offered usual antenatal and postnatal care even if she decides to have an unassisted birth.
- Ensure that the woman is informed that a midwife may not be available to be sent out to her at home during labour and birth, if she changes her mind and wishes attendance during the birth. If the woman decides she wishes to have professional care during labour and birth, she may need to attend the maternity unit.
- Give the woman time to consider the communication she has had and review her decision again.

<u>Should the woman decide to plan an unassisted birth, advise the woman of the following information and document clearly in her EPR and MHHR.</u>
<u>Use the Unassisted Birth Pro-Forma to support and record the conversation of the following advice.</u>

1. The maternity units are available for advice, however there is no requirement to inform them of the commencement of labour. The maternity unit (UHDB) will provide care in the available UHDB locations if the woman chooses to attend, it may not be possible to send a Midwife to attend at home should the woman change her decision and request midwife attendance.
2. How to access emergency medical support (999)
3. The role of the ambulance service is to respond to emergency situations and support transfer to a maternity unit. It is not an alternative to a midwifery home birth service.

4. How to register the baby's birth (notify the birth). It is a legal requirement for all babies to be registered with 42 days of birth with the Registrar of Births in the area (county) in which the baby was born. A baby can be registered by their mother or by either parent if they are married. Notification of the birth and registration of NHS number can occur if care is provided but would not usually occur if the birth is unassisted and no care is provided at any point.
5. How she can contact the midwifery service for care (contact numbers) including informing UHDB teams of the birth. PAU at RDH. MAU at QHB as these are 24 hour contact lines.
6. Accessing neonatal screening (NIPE, Hearing Screen, Newborn Blood Spot)
7. Preference for postnatal care

- Ensure communication with all relevant health professionals, escalate to Senior Midwife and inform GP and Health Visitor. Consider if the woman lives in a cross border area or is booked at a cross border unit that they are involved and kept up to date with the woman's wishes and decisions made.

12. Babies born before arrival (BBA) or Unplanned Home Birth

- Alert to an unplanned home birth or baby born before arrival of midwifery staff (at a home birth) or arrival of woman to the maternity unit may occur through the notification from the ambulance service, from the woman herself or an attendee accompanying her.
- If the woman is booked for a planned home birth the home birth midwives should be called to attend if available. If the woman is unattended the ambulance service should be contacted to attend as an emergency response acknowledging the midwives will have a longer response time to get to the property. If the midwives are unable to respond the woman and baby should be advised to accept transfer to the maternity unit with the ambulance service.
- In the event that a woman gives birth before arrival at the maternity unit or unplanned at home due to a precipitate birth then the ambulance service should be contacted to attend. Where possible the midwife should remain on the line to support until the ambulance crew is on scene or the ambulance service are available on another telephone line to those present. The woman and baby should be transferred to the maternity unit booked for care or to a maternity unit if unbooked/concealed pregnancy. Consider and confirm possible concealed pregnancy or safeguarding concerns when a BBA or unplanned home birth occurs.
- *During the Covid 19 Pandemic BBA and unplanned home birth are not being attended and the ambulance service will attend and transfer in. The local agreements outside of the pandemic with the East and West Midlands Ambulance Service will be reviewed. Follow agreed local pathway.*
- If it is possible, the ambulance should be called by the person in attendance with the woman by dialing 999 for an emergency response. If this is not possible or there is concern this requires support then the midwifery staff should call 999 to summon the response.

13. Suspension of home birth service

Suspension of the home birth service may occur in accordance with the UHDB Escalation policy:

- Due to Ambulance Service delays
- Should service capacity be reached due to activity and/or safe and appropriately skilled available staff.
- Due to adverse weather conditions
- The service is suspended due to the Midwives already attending a home birth
- Suspension will occur on the decision of the Manager on Call, Community Senior Midwives or Midwifery Matrons based on activation of the pathways within the Escalation policy.

If suspension occurs it is the responsibility of the decision maker to coordinate the communication to areas and staff potentially impacted.

- Home Birth shift Midwives
- Birth Centre / Labour Ward / PAU RDH MAU QHB
- Manager on Call if applicable
- Ambulance Service

Completion of the Service Suspension spreadsheet should record the event. Datix to be completed outlining reason for suspension.

The Head of Midwifery or Director of Midwifery should be informed of any women affected by a suspension in order that they may communicate an apology.

In the event the UHDB home birth service is unable to provide a response due to service suspension or because the Midwives are at another homebirth the woman and a woman requests attendance at home:

- An apology should be made and advise that care can be provided in the hospital or Birth Centre at UHDB sites.
- If the woman is booked with a cross border hospital she will be advised to contact them to attend at their unit.
- If the woman declines to attend explain that we are able to provide care at the hospital and advise she attends. Should the woman choose to remain at home acknowledge this is her choice but at her own risk. Refer to Unassisted Birth within this guideline.
- Document the conversation and advice given. Ensure the woman is aware of emergency contact numbers, how to access an ambulance and that she is welcome to attend the maternity unit at any time.
- It is not advisable to suggest when the home birth service will next be available as the availability and response cannot be guaranteed until the time the home birth midwives have completed their ongoing care event or the period of suspension has come to an end.
- Acknowledge Midwives have a professional duty of care to women but there is no duty to provide the care in the environment that is the woman's preferred choice when resources do not allow this.
- Inform the Senior Community Midwife or Manager on Call out of hours if a woman chooses to remain at home when the service is suspended.

14. Pre-labour rupture of membranes

- Refer to UHDB guideline Pre-labour Rupture of Membranes at Term (click here)
- In the event of pre-labour spontaneous rupture of membranes at term, the woman will be referred as appropriate following an informed discussion regarding induction of labour and risk factors. If the woman chooses to continue with a home birth the midwife should document fully the potential maternal and neonatal risks and limitations to care at home.
- A copy of the "Pre-labour spontaneous rupture of membranes" patient information leaflet will be provided and completed (located on the Trust intranet).

15. Management of latent phase of labour at home

- If clinical risk assessment indicates that the woman remains low risk for labour and labour is not yet established it may not be appropriate for the home birth midwives to remain in attendance in the home. This decision should be taken following discussion with the woman about her wishes, expectations and any concerns she has.
- Recognise that a woman may experience painful contractions without cervical change, and although she is described as not being in labour, she may well think of herself as being 'in labour' by her own definition offer her individualised support, and analgesia if needed.
- The woman should be given information about what she can expect in the latent first stage of labour and how to work with any pain she experiences give information about what to expect when she accesses care. Guidance and support should also be provided to the woman's birth companions(s).
- Agree a plan of care with the woman, including guidance about who she should contact next and when. This should be documented in the maternity handheld records. Ensure an SBAR occurs to the following shift of home birth midwives and local community midwifery team if follow up actions are required.
- Refer to local Labour Care and Risk assessment UHDB guideline (click here).

16. Risk assessment in labour

- The onset of labour is an opportunity to assess current risk factors and the suitability to continue to labour at home. In case of a handover of care between homebirth shifts this risk assessment should be revisited by both Midwives to confirm that the level of risk remains low and that home labour and

birth remain a safe option. The findings of any midwifery assessments should be discussed with the woman. If, following assessment the woman is found to be at high risk, transfer to the maternity until should be advised.

- Refer to local Labour Care and Risk assessment UHDB guideline (click here). Complete the risk assessment within the UHDB Care in Labour documentation.

17. Assessment of Maternal and Fetal wellbeing and Progress in labour

- Observation of maternal and fetal wellbeing during labour (including vaginal examination) should be undertaken as per local Trust guidelines (click on links): Labour Care and Risk assessment and Fetal Monitoring in pregnancy and Labour: Intermittent Auscultation.
- Any reason for departure from the guideline should be documented in the labour record. Should the woman choose care which is outside the guideline this should be discussed and clearly documented.

18. Amniotomy (artificial rupture of membranes ARM)

- Amniotomy is not part of a normal physiological labour and therefore should be reserved for women with abnormal labour progress RCM (2012). Amniotomy is a simple intervention used frequently by midwives but it is not without risk and the decision to perform amniotomy without the immediate support of the labour ward team should not be taken lightly.
- If there is concern that labour is slowing down, benign measures to intensify contractions such as positional changes and movement may prevent the need for more invasive interventions
- Regardless of the decision whether or not to perform amniotomy a plan of care including
  The timing of reassessment should be recorded in the labour documentation in these circumstances.
- The decision to perform an ARM should be taken following direct consultation with the
  Woman. The discussion should be part of the birth plan and should not take place immediately prior to or during a vaginal examination.
- The indication, explanation, consent and procedure must be recorded in the notes.

19. Transfer to Hospital

- Any deviation from normal labour should be assessed and a management plan documented and if necessary transfer to hospital should be considered.
- If transfer to hospital is deemed necessary the midwife should discuss reasons with the woman and her birth partner and document these including steps made in escalation or any delay in transfer. In an emergency an ambulance should be summoned even if the woman may decline transfer.
- Where possible a Midwife should request the ambulance but if required may delegate the request for an ambulance to another person, Student Midwife or the woman's partner.
- If transfer to hospital is necessary the midwife should:
    - telephone the ambulance service
    - State you are a Health Professional requesting paramedic transfer for a time critical event. State Category 1 (one) response is requested
    - Call the labour ward coordinator on the RDH RED phone 01332 789277 / QHB PRIORITY phone 01283 593173 / or if another cross-border maternity unit call through to their labour ward and discuss with the coordinating Midwife. Make clear the reason for transfer.
    - The transfer should be made to the unit booked for care except in a time critical event when transfer should be made to the closest consultant labour ward. The attending ambulance crew will be involved in this decision.
    - 2 Ambulances should be requested if needed, 1 each for woman and neonate if transfer of them separately may be anticipated
- The midwife should accompany the woman or neonate to hospital in the ambulance.
- In the event that both the woman and neonate are unwell a midwife should accompany each of them regardless if transport takes place via one or two ambulances.
- Handover of care should be undertaken using SBAR: Situation, Background, Assessment, Recommendation.

- Transfer to hospital from a home birth for either the woman or neonate should be reported as an untoward incident using the Trust risk reporting process.

19.1 Calling an ambulance

- Where transfer in labour or post-partum is necessary, it is the responsibility of the midwife to summon an ambulance (via a 999 call).
- The Midwife must make it clear to the call staff that they are a health professional and arranging a 'Health Care Professional (HCP) admission'.
- The call centre staff will ask a series of questions (location/ contact telephone number/patient's age/ is she awake/ breathing?) This will prioritise the urgency of the ambulance request, as per the ambulance protocols.
- The call centre staff will then ask for the reason for admission and whether a health care professional is with the woman.
- If it is an emergency situation, it should be stated that it is 'an obstetric emergency' and a paramedic emergency ambulance requested.

19.2 Maternal transfer

On receipt of the notification of transfer the Labour Ward Coordinator (UHDB sites) will assume the following responsibilities to support transfer:

- The Coordinator will ensure that the Obstetric Team has been informed of impending transfer. An obstetric review by a senior member of the team will take place on arrival unless transfer is indicated as patient choice only as a low risk transfer.
- The coordinator should support the identification of a room to receive the transferred patient and staff to takeover care.
- Consideration should be given to whether the ambulance should be met on arrival to support the event and provide immediate care.

19.3 Transfer of baby

- If the baby requires transfer to hospital in the immediate neonatal period following the birth (e.g. resuscitation was required at birth, baby 'unwell', preterm or small-for-dates), s/he should be transferred via ambulance.
- The Midwife or Paramedic, if in attendance, should notify the Labour Ward of any baby born at home who requires transfer for resuscitation and / or stabilisation.
- On receipt of the notification of transfer the Labour Ward Coordinator (UHDB sites) will assume the following responsibilities to support transfer:
- The coordinating Midwife should liaise with NICU to ensure the senior neonatal on-call team are informed of any baby potentially requiring admission from home and support the response to receive the baby on arrival from the ambulance.
- Support the transferring team with notification to the on call neonatal team for support and review if assistance is not required immediately but following arrival to the maternity unit.

19.4 Events to be considered for transfer to hospital

The following may be considered as reasons for transfer to hospital:

Maternal	Neonatal
Delay in first stage of labour (Refer to UHDB Care in Labour guideline) Maternal request for stronger or repeated analgesia Maternal request for admission / transfer Malpresentation including breech presentation. Malposition Maternal pyrexia in labour *(Equal to or more than 38.0°C on one occasion or equal to or more than 37.5°C on two occasions 2 hours apart)*	Fetal heart rate abnormality Meconium stained liquor Cord presentation Cord prolapse** Low Apgar score Grunting Consistent hypothermia Need for *any* resuscitation** (including the need for inflation breaths or any form of active oxygen support)

Raised diastolic blood pressure (over 90 mmHg) or raised systolic blood pressure (over 140 mmHg) on two consecutive readings taken 30 minutes apart. Antepartum haemorrhage Delay in second stage of labour Shoulder dystocia** Retained placenta Third or Fourth degree tear Complicated perineal trauma for suturing Postpartum haemorrhage Maternal collapse**	Low birthweight

**urgent management of these conditions are shown in appendices.

In the case of **meconium stained liquor** during labour, transfer into hospital needs to be considered taking all other risk factors into account as well as logistics of transport and progress of labour. In case of non-significant meconium stained liquor in the absence of any other risk factors, IA can be continued and transfer to the low risk birthing unit at QHD or RDH can therefore be considered. In case of significant meconium stained liquor, non-significant meconium stained liquor in the presence of other risk factors or when initially clear liquor noted, continuous fetal monitoring is indicated and transfer to the labour ward needs to be advised.

20. Disposal of placenta

The placenta and membranes should be disposed of as for a hospital birth. A placenta bucket and clinical bag should be used to contain and transport it back to the disposal point at the Labour Ward/Birth Centre. If the woman chooses to keep the placenta advice must be given to dispose of it using a common sense approach i.e. if buried it should be deep enough to avoid wild animals. The woman may wish to keep her placenta for other reasons for example encapsulation.

21. Immediate Postnatal care

- The home birth team should remain with the woman and deliver immediate postnatal care and should not leave until the woman and neonate are assessed as being well as a minimum of **2** hours.
- Refer to the Newborn - Care Following Birth clinical guideline (click here) and UHDB Newborn Thermal Care Safety Bundle in this guideline to support assessment of neonate.
- All observations including time and volume of first void of the bladder should be documented in the labour records.
- In the event of a BBA consideration should be given to the presence of any safeguarding issues within the household and further information should be sought from the “planned” maternity unit if needed.
- Further postnatal care will be arranged according to the woman’s needs. Consider if a further visit is appropriate the same day or the following day whichever is soonest.
- The woman should be given appropriate contact telephone numbers and the plan for further postnatal care should be discussed.
- The midwife should ensure that the newborn physical examination (NIPE) is arranged within 72 hours following birth. Hearing screening should be generated automatically.
- Further postnatal care will be arranged according to the woman’s needs. Inform the local midwifery team of the birth to ensure continuity of postnatal care.
- Clinical waste should be removed from the household and disposed of in accordance with Trust policy

22. Monitoring Compliance and Effectiveness

As per agreed business unit audit forward programme.

23. References

National Institute for Health and Care Excellence (2014) Intrapartum care: care of healthy women and their babies during childbirth.

National Perinatal Epidemiology Unit (2016) Birthplace in England research programme. Final report part 1. HMSO. https://www.npeu.ox.ac.uk/birthplace

National Maternity Review (2016) BETTER BIRTHS. Improving outcomes of maternity services in England A Five Year Forward View for maternity care

Nursing and Midwifery Council (2012) Midwives Rules and Standards

Royal College of Midwives (2012). Evidence Based Guidelines for Midwifery-Led Care in Labour. Rupturing Membranes

RCM Clinical Briefing Sheet (2020) 'freebirth' or 'unassisted childbirth' during the COVID-19 pandemic

Birthrights (April 2017) Unassisted Birth Factsheet. Available at https://www.birthrights.org.uk/factsheets/unassisted-birth/

Birthrights (April 2017) Information about consenting to treatment and assessment of mental capacity: https://www.birthrights.org.uk/factsheets/consenting-to-treatment/

Appendix A

RISK ASSESSMENT FOR HOME BIRTHS INCLUDING BIRTH PLAN	
Woman's name	**Date of Assessment** **EDD at date of assessment**
Address	**NHS Number** **Hospital Number**
Contact number Mother	**D.O.B**
Contact number partner/birth partner	**Gravida Parity EDD**
Address of Assessment (include postcode)	**MWLC/ CLC** **Maternity unit booked at:**
Directions to property:	**Community Midwifery Team:** **Named CMW**
Parking directions at property	**GP**
Is the home birth planned against advice?	**Escalation to Senior Midwife / Consultant**

Assessment completed by:		
Name	**Designation**	**Signature**

Clinical review:	
Perform antenatal check	
Latest Hb / Platelets. Consider repeat	
Blood group and Rhesus Factor	
Allergies	
Review pregnancy care and suitability for home birth.	
Has the woman had opportunity for Obstetric or Senior Midwifery discussion as appropriate?	
Is this a home birth against advice? If so please document risk factors and reasons. Identify the risks and reasons home birth is against advice.	

Birth preferences of the woman and discussion of her birth plan. Ensure specifics of birth plan are shared as additional information with the midwifery teams. Waterbirth requested? Discuss advice of not entering pool until Midwife present. Analgesia preference? **Questions or concerns from woman and/or birth partner?**	
Analgesia at home birth. Entonox provision Pethidine RDH teams is no longer recommended for home birth.	
SROM /Prolonged ROM/ SROM in absence of labour	
Fetal monitoring and UHDB guideline	
Assessment of maternal wellbeing and observations	
Abdominal palpation and vaginal examination	
Third stage of labour discussion	
Perineal trauma and repair	
Following discussion does the woman request care outside of UHDB guidelines as per her birth plan? Ensure clear documentation of this and that confirmation of her preferences will be revisited to confirm at the point of care or should there be concern from the attending Midwives.	

Potential risk factors / Emergency situations	
Why transfer to hospital may be necessary **Slow progress /prolonged labour** **Malpresentation eg breech** **Raised blood pressure** **Maternal pyrexia /tachycardia** **APH** **Signs of fetal distress –concerns with heart Rate. Fetal distress (meconium liquor)** **PROM** **Cord Prolapse** **Shoulder dystocia** **Complications after birth** **Baby – resuscitation. Low Apgar.** **Low birthweight. Low temperature.** **Emergency Transfer (including postnatal problems e.g. suturing)** **PPH, Retained placenta.** **Ambulance Delay**	

Location and environmental risk assessment	
Planned room to birth in seen. Access available to woman from 3 sides? Clutter free? Does there need to be adjustments to furniture or alternative room choice? Ensure area for documentation and neonatal resuscitation(raised and flat)	
Is the property of an appropriate level of cleanliness to support birth at home. Smokefree home?	
Pool (if to be used) is seen and checked for suitability – fit for purpose. Birthing pool is fully equipped (liner, sieve) Manual handling assessment (Maternal BMI, access to three sides of the pool, suitable flooring, discuss home insurance, ceiling appropriate for weight bearing load?) Pools filled in advance of labour are not to be used for labour or birth within the home setting until definitive advice on disinfection/safety is available.	
Any unprotected electric sockets near to pool? Is there a large distance from sink to pool for hose pipe to travel?	
Are there any identified hazards to the delivery of care or the safety of staff, woman or birth partners? (another visit may be necessary to check identified hazards have been removed): Are there any building or renovation works which could pose a concern? Discuss necessary safe space for resus/emergency interventions	
Heating and good lighting (Angle poised lamp/torch available or use of headlamp)	
No naked flames (once Entonox) in use	

Access to bathroom and handwashing facilities	
Pets (safe provision/containment)	
Access to the property and planned room for birth: Look at doorways, staircases Assess any potential issues transferring equipment and entonox. Assess for ambulance access and consider if stretcher/trolley could be used if required.	
Protective bedding/flooring should be recommended. Shower curtaining or decorating sheets are useful. Recommend the woman has disposal mats and or old towels/sheets.	
Assess mobile phone signal Is there a landline back up if mobile signal a concern	
Available parking? Any location challenges.	
Attendees at the birth	
Name of Birth Partners/Birth supporters:	
Intended birth supporters present at the meeting?	
Students welcome? If so in which capacity care giver/observer	
Are there other children? If so discuss childcare arrangements. Recommend the children have an identified care giver separate to the birth partner/supporter available at all times if the children are in the home. Discuss childcare should transfer to hospital be advised. Home birth is not a solution to childcare concerns respecting women may wish to be near her children and this could be a source of anxiety for her	
Social Issues	
Are there any social circumstances to be aware of?	
Is there any safeguarding involvement?	
Are there any other areas of concern?	
Postnatal considerations: VTE reassessment. Will a prescription be required. Arrange with GP so available. Anti D Vitamin K Access to NIPE (72 hour recommendation) /Hearing screen for neonate. May need to attend hospital for these.	
Contact numbers: **UHDB local site 24 hour contact number for home birth** **PAU/MAU** **Emergency ambulance**	

Awareness of: Service is available from 37+0 before this gestation women are advised to attend the hospital for labour care. Home birth beyond 42 weeks gestation is advised against. See UHDB Induction of Labour guideline. Own midwife not always on duty. Care will be from home birth shift midwives Midwife availability e.g. simultaneous home births. Suspension of service is possible but every effort made to maintain. Our aim is to achieve a safe outcome for all women and babies in our care. We hope that all women booked for a home birth will achieve that outcome there may be occasions when this may not be possible and transfer into the maternity unit at Royal Derby Hospital / Queens Burton Hospital will be required. Distance/time to hospital Adverse Weather conditions Midwives response time between contact call and arrival Ambulance response times Limitations of service. Limitations of care with equipment carried. Ensure the relevance of this in relation to life support is discussed and documented.	

A copy of this form should be placed in the Maternity records. Please ensure that <u>all teams</u> are aware of any problems regarding access, parking and location of property and any other unresolved or potentially challenging issues

Discussions with woman regarding infection control prevention precautions during Covid-19

- ☐ Woman to contact and seek advice from Community midwife if she suspects herself or if any member of the household become develop any COVID -19 symptoms
- ☐ Discuss transfer to Acute unit for continuous fetal monitoring if woman has symptoms of has confirmed COVID -19 at onset of labour. Home birth is not recommended if the woman or any member of the household has a positive result or is symptomatic or isolating. The safety and wellbeing of the woman and unborn and attending Midwives are priority.
- ☐ The use of Covid Lateral Flow tests are encouraged
- ☐ Birth partners – Prefer only 1 birth partner where possible to minimise contacts for Community midwives
- ☐ No other contact or minimal contact with other household members
- ☐ Aware that the Community Midwives must comply with use of PPE & explain what this will include– even in emergency situations (PPE must be donned prior to attending to the emergency/ or prior to unanticipated birth)
- ☐ Aware that Midwives in attendance must take breaks whilst wearing PPE – identify a suitable area
- ☐ Discuss area for Donning / doffing of PPE
- ☐ Discuss availability area for regular hand washing and minimising contact with hard surfaces
- ☐ Discuss disposal of PPE

Signed …… **Designation** …….

Date ……

Mothers Name …….. **Signature** ……..

Date ……..

Appendix B

Home Birth proforma RDH

Midwifery Team				
Named Midwife				
Name of Woman				
Date of Birth				
Address				
Postcode				
Telephone Number				
EDD		**Parity**		
Students Present				
Week Commencing to go onto rota				
Hospital Booked at				
NHS Number		**Hospital Number**		
GP Name & Address				

Please copy in all senior midwives and email completed form to:

Ethnic Group Information Codes

A	**White**	British	J	**Asian or Asian British**	Pakistani
B	**White**	Irish	K	**Asian or Asian British**	Bangladeshi
C	**White**	Any other white background	L	**Asian or Asian British**	Any other Asian background
D	**Mixed**	White & black Caribbean	M	**Black or Black British**	Caribbean
E	**Mixed**	White & black African	N	**Black or Black British**	African
F	**Mixed**	White & Asian	P	**Black or Black British**	Any other black background
G	**Mixed**	Any other mixed background	R	**Other ethnic groups**	Chinese
H	**Asian or Asian British**	Indian	S	**Other ethnic groups**	Any other ethnic group

Birth Outcome RDH

Delivery

Birth details				Delivery method			
Intended place of delivery				Actual place of delivery			
Reason for change				Type of onset			
Onset of labour date		Time		Gestation		EBL (mls)	
Date of birth		Time		Analgesia			
Presentation before delivery							

Third stage		Date & time placenta delivered	
Delivery of placenta		Examination of placenta	
Placenta findings		Examination of membranes	
Number of membranes		Additional comments for 3rd stage	
Cord details		Number of vessels in cord	
Perineal trauma		Uterus description	
Consent after discussion		Suture materials used	Suturing details
Date & time repair commenced		Date & time repair completed	PR completed
Delivered by		Status	PR normal
Attendants at delivery			

Postnatal Examination

Location examined		Uterus palpable	
Uterus position		Uterus	
Thromboembolism suspected			

Baby Details	Outcome				
Baby surname		Sex		Weight	g
Baby's Ethnic Group				APGAR at 1 min	
Resuscitation required				APGAR at 5 min	
Abnormalities				APGAR at 10 min	
Details of Abnormalities					
Date & time skin to skin initiated			Time of 1st feed		
Has mother been shown how to express?		Choice of feeding			

Perineal repair

Haemostais achieved		Needle count correct		Smoking status	
Sutures to be removed		Swab count correct			
Vaginal tampon used					
Vaginal tampon removed					

Required transfer to hospital	Mum		Baby	Reason	
Form completed by :		Contact Number			

Birth Outcome QHB

Birth Details (Place of Birth)

Home	☐	Waterbirth	☐
Hospital	☐	BBA	☐

Hospital Name ……

Date of Birth …….. Time of Birth …….

Gestation ……. Weeks …… Days

Vertex ☐ Breech ☐ **Analgesia** None ☐ TENS ☐ Entonox ☐ Pethidine ☐

Trauma Sustained None ☐ Labial ☐ 1st Degree ☐ 2nd Degree ☐ 3rd Degree ☐ 4th Degree ☐

Epis ☐ **Sutured** Yes ☐ No ☐

Delivery of Placenta Active ☐ Physiological ☐ Retained ☐

Estimated Blood Loss **……**mls

Delivered By **…… Status……..**

Attendants **……..**

PN Tariff for all homebirths

Baby's Surname

Baby's Ethnic Group

Baby Live ☐ Stillborn ☐ **Sex** Male ☐ Female ☐ Unknown ☐

Abnormalities Yes ☐ No ☐

Apgar 1 Minute…… 5 Minutes …….. 10 Minutes…….

Required Resuscitation Yes ☐ No ☐

Birth Weight **……** Gms **1st Feed** Breast ☐ Bottle ☐ Time 1st Feed ……..

NHS number

Required transfer to Hospital **MUM** Yes ☐ No ☐ **BABY** Yes ☐ No ☐

Smoking Status at Delivery Yes ☐ No ☐

Paper Birth Notification Completed by: ……..

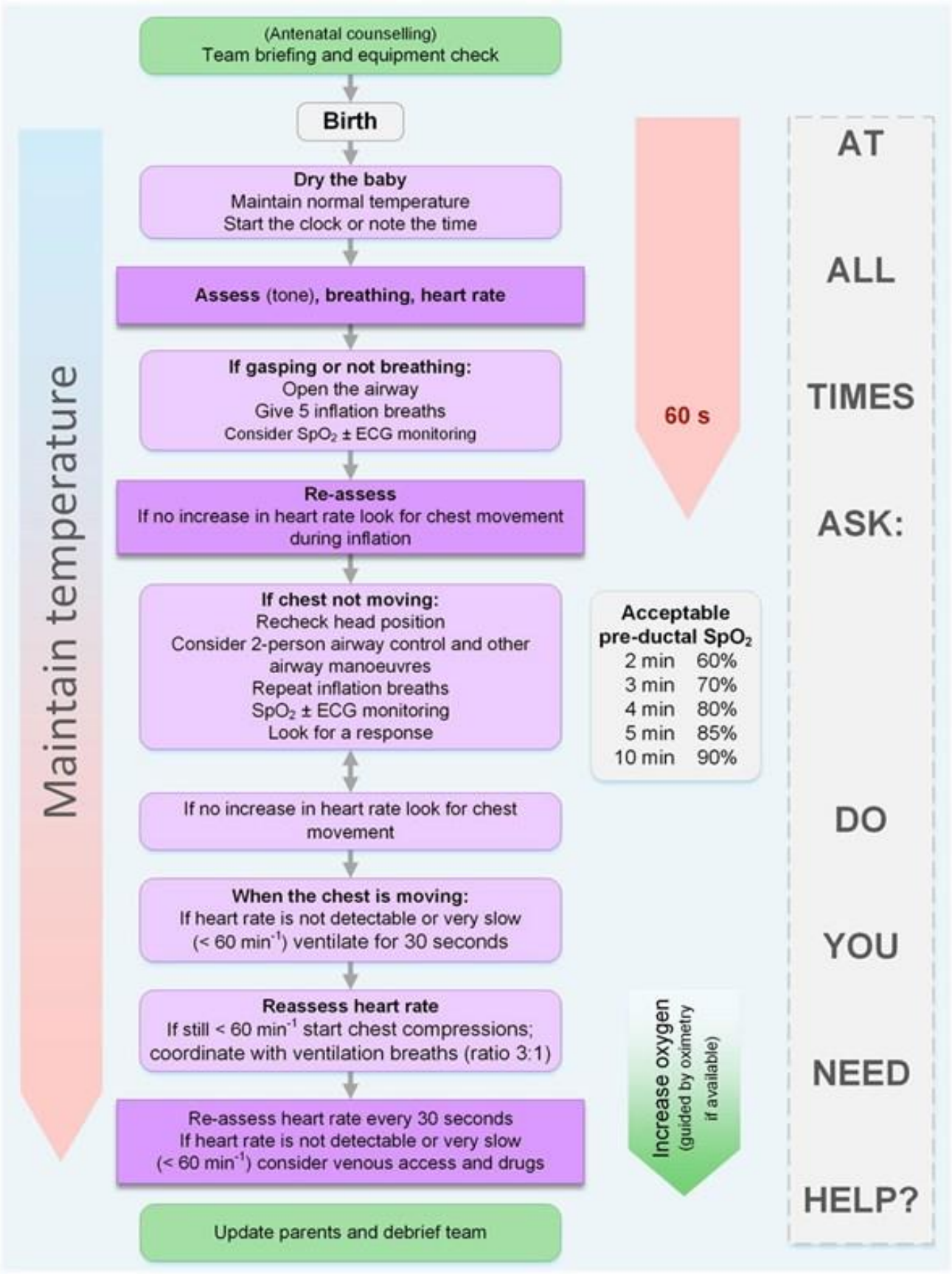
NIPE Date arranged for: …….
Is it completed within 72 hrs – YES/NO
Venue: …….
Any deviations from normal – YES/NO

Hearing performed within 72 hours YES / NO

RETURN FORM TO MATERNITY OFFICE

- Call 999 for urgent paramedic support and request 2 ambulances clearly stating resuscitation of a newborn following birth.
- Call the labour ward coordinator on the RDH RED phone 01332 789277 / QHB PRIORITY phone 01283 593173. Ask them to contact the Neonatal team to receive instructions on location where baby will be admitted and assessed on arrival
- Follow this process for **ANY** baby that needed **ANY** kind of support including inflation breaths or any kind of O2 support. They all need to be transferred in for a review

Appendix D



MANAGEMENT OF CORD PROLAPSE

This is an obstetric emergency.

- **Call 999 for urgent Paramedic assistance for immediate transfer to Consultant Unit**
- **Call the labour ward coordinator on the RDH RED phone 01332 789277 / QHB PRIORITY phone 01283 593173 and provide additional details i.e. gestational age**

Preserve fetal condition;

Fill bladder with 500ml normal saline to raise presenting fetal part (eliminating need for digital displacement). This can either be done via giving set OR 50ml bladder syringe

- Attach spigot to end of catheter, leave giving set attached as sealed unit. Or us a bladder syringe

If bladder filling not possible women should be advised to assume knee chest face down position while awaiting emergency transfer.

During emergency ambulance transfer left-lateral position should be used.

Ausculation of fetal heart rate is not recommended at this stage

Ensure DATIX and Reporting Forms are Completed

ALGORITHM FOR THE MANAGEMENT OF SHOULDER DYSTOCIA AT A HOME BIRTH

When gentle downward traction of baby's head has failed to extract the shoulders after delivery of the head:

- Call 999 to request urgent paramedic assistance and request 2 ambulance crews to transport mother and baby
- Call the labour ward coordinator on the RDH RED phone 01332 789277 / QHB PRIORITY phone 01283 593173

Follow specific manoeuvres to achieve delivery:

- Discourage pushing
- Lie woman flat and move buttocks to the edge of the bed
- Try each manoeuvre over 30 seconds, attempt delivery with gentle traction following manoeuvre, move to next manoeuvre if unsuccessful

1st line manoeuvres

McROBERTS' MANOEUVRE:

- Place woman in supine position
- Hyperflex and abduct maternal hips to assume an exaggerated knee to chest position
- If possible use two assistants to support legs

SUPRAPUBIC PRESSURE (whilst legs in McRoberts):

- Identify fetal back, stand on that side and discourage maternal effort
- Second midwife to exert suprapubic pressure downward and laterally with the palm of the hand through abdominal wall onto posterior surface of anterior fetal shoulder to dislodge it to oblique position
- Initially try continuous pressure for 30 seconds
- If no success then use a rocking motion for 30 seconds

The knee chest position may be an appropriate option to consider either prior to or following 2nd line manoeuvres

2nd line manoeuvres

The 2nd line manoeuvres can be used in no specific order depending on circumstances and experience of the midwife

ROTATIONAL MANOEUVRES:

- Introduce hand into pelvis posteriorly
- Exert internal pressure over posterior aspect of anterior shoulder. If movement occurs to an oblique diameter, try to deliver.
- If no success, keep applying pressure to rotate though 180° then try to deliver

OR

- Apply pressure to posterior aspect of posterior shoulder and continue as above
- If unsuccessful an attempt can be made to apply pressure on the posterior aspect of the anterior shoulder to adduct and rotate the shoulders into the oblique diameter

DELIVERY OF POSTERIOR ARM

Introduce hand into pelvis posteriorly. Find posterior shoulder and follow arm to grasp forearm/wrist/hand. Sweep across chest and face and deliver posterior arm. Deliver posterior shoulder then anterior shoulder.

ALGORITHM FOR THE MANAGEMENT OF MATERNAL COLLAPSE - Basic and Advanced Life Support

- ENSURE **SAFE** ENVIRONMENT
- CALL 999 to request urgent paramedic assistance (request 2 ambulances if directly post-delivery and baby needs transporting in as well)
- Call the labour ward coordinator on the RDH RED phone 01332 789277 / QHB PRIORITY phone 01283 593173

↓

- CHECK **AIRWAY**
- LATERAL LEFT **TILT OR UTERINE DISPLACEMENT**

↓

- Head tilt
- Chin lift
- Assess breathing for up to 10 seconds

↓

IF NOT **BREATHING AND NO SIGNS OF LIFE**
30 CHEST COMPRESSIONS

↓

COMMENCE CPR 30:2

↓

REASSESS BREATHING AND SIGNS OF LIFE EVERY 2 MINUTES

↓

CONTINUE UNTIL PARAMEDICS ARRIVE

Newborn Thermal Care Safety Bundle:
Getting it 'Just Right' to prevent avoidable admissions to NICU

Home birth	Green hat care bundle	Yellow hat care bundle	Red hat care bundle
	☐ ≥37 weeks ☐ ≥ 3000 gram	☐ ≥37 weeks ☐ ≥2500 gram ☐ <3000 gram	☐ < 37 weeks ☐ <2500 gram
☐ ≥37 weeks ☐ no sign of SGA ☐ No complications during labour ☐ Clear liquor ☐ No GBS/Sepsis risk factors ☐ Normal skin colour ☐ Apgar score ≥7 @ 5 minutes	☐ NVD ☐ No complications during labour ☐ Clear liquor ☐ <24 hours ruptured membranes prior to the onset of established labour ☐ No GBS/Sepsis risk factors ☐ Normal skin colour ☐ Temperature ≥36.5°C ☐ No additional observations needed ☐ Apgar score ≥7 @ 5 minutes	☐ LSCS/instrumental ☐ Complications during labour (e.g. shoulder dystocia) ☐ Non-significant meconium ☐ > 24 hours ruptured membranes prior to the onset of established labour but ***no*** signs of infection ☐ GBS ***with*** adequate prophylactic ABX ☐ Temp <36.5°C but ≥36.0°C ☐ Additional observations needed e.g.: • NEWS • Hypoglycaemia • Other (including abstinence)	☐ Mother significantly unwell at time of birth ☐ Offensive liquor ☐ Significant meconium or aspiration ☐ >24 hours ruptured membranes prior to the onset of established labour ***with*** signs of infection ☐ GBS ***without*** adequate prophylactic ABX or colonisation ☐ Temp <36.0°C ☐ Score of 2 amber or 1 red on NEWS ☐ Post feed glucose <2.0 ☐ Early (suspected) neonatal (GBS) infection ☐ Baby on IV ABX ☐ Apgar score <7 @ 5 minutes ☐ Unwell baby; above list is NOT exhaustive and if in doubt, start Red care bundle and inform paediatrician
PLAN OF CARE			
Following birth check temperature and encourage: ☐ Hat on ☐ skin to skin contact ☐ early feeding If temp <36.5°C: ☐ attempt to warm baby with warm blanket/towel and consider improvement of environmental factors (draft etc) ☐ Recheck after 1 hour, if still <36.5°C to contact paediatrician and consider transfer in	☐ Observe and assess effectiveness of second or later feed ☐ Take temperature prior to transfer or discharge. If temp <36.5°C please adjust care plan. Continue to assess wellbeing and commence yellow or red care bundle if risk factors identified	☐ Observe and assess effectiveness of two or more feeds If temp <36.5°C (but ≥36.0°C): ☐ Attempt to warm baby: skin to skin with warm blanket/towel and feeding ☐ Recheck after 1 hour ☐ If after 1 hour ***no*** improvement: o Change to Red Hat Care Bundle o Inform paediatrician and consider transfer Initiate hypoglycaemia protocol	☐ Inform Paediatrician ☐ Attempt to support as many feeds as feasible until successful feeding established If temp < 36.0: ☐ Place the baby on Kanmed heater in cot ☐ Recheck after 1 hour ☐ If after 1 hour ***no*** improvement: o Request review to consider NICU admission o Initiate hypoglycaemia protocol Once stable without Kanmed heater, to monitor temp 3 hourly for 24 hours
DISCONTINUATION OF THE CARE BUNDLE			
Recheck temperature prior to leaving home. Do not leave if temp <36.5°C! Please discuss thermoregulation with parents including environment and bedding to support baby to maintain a good temperature. Remove hat (or replace with their own).	Review after 6 hours If feeding and observations reassuring, please discuss thermoregulation with parents and remove coloured hat (or replace with their own)	When all criteria below are met, please document in notes, discuss thermoregulation with parents and remove coloured hat (or replace with their own) ☐ Baby feeding effectively ☐ Baby maintaining temperature ≥36.5°C ☐ Woman is self-caring ☐ Transfer home considered If applicable: ☐ Observations are discontinued ☐ Discharged by paediatrician	

Documentation Control

Reference Number: UHDB/06:22/H5	**Version:** **UHDB Version 3**	**Status:** **FINAL**	
Version control for UHDB merged document:			
1	June 2020	Cindy Meijer – Risk Support Midwife	Amendments for COVID-19 and merge
2	June 2021	Eileen Morris – Senior midwife Community	Update – full review, include Freebirth
3	March 2022	Claire Brackenbury - Lead Midwife Continuity of Care	Update
Intended Recipients:			
Training and Dissemination: Cascaded electronically through lead sisters/midwives/doctors via NHS.net, Published on Intranet, Article in Business unit newsletter;			
To be read in conjunction with: Labour care and risk assessment; Neonatal Resuscitation; Newborn Care; Obstetric Emergencies			
Keywords:			
Consultation with:	Ambulance services, community midwives		
Business Unit sign off:	23/05/2022: Maternity Guidelines Group: Miss S Rajendran – Chair 26/05/2022: Maternity Governance Group / CD – Miss K Dent		
Divisional sign off:	31/05/2022		
Implementation date:	13/06/2022		
Review Date:	June 2025		
Key Contact:	Cindy Meijer		